

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 16, 17, 19, 26, 29 and October 1, 2014.</p> <p>Facility number: 001194 Provider number: 15G628 AIM number: 100245710</p> <p>Surveyors: Christine Colon, QIDP-TC Amber Bloss, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 23, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 4 sampled clients and 2 additional clients (clients #1, #3, #4, #5 and #8), the facility neglected to implement written policy and procedures to prevent</p>	W000149	In regard to ensuring the facility implemented its written policy and procedures to prevent abuse/neglect/exploitation, and to conduct thorough investigations of abuse/neglect, The system failed in the instances cited in this	11/04/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>abuse/neglect and to conduct thorough investigations of allegations of abuse and neglect.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Incident reports (IR) and investigation records was conducted on 9/17/14 at 1:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 9/13/13 involving clients #1, #3 and #8 indicated: "Housemate [client #3] returned home from work and was eating dinner. [Client #8] was sitting at the table with him. [Client #1] was also around the table. [Client #8] told [client #1] to stop looking at [client #3] (client #8's boyfriend). [Client #1] did not stop looking at [client #3]. [Client #8] got upset and pushed [client #1] back to her room in her wheelchair. [Client #8] then punched [client #1] in the ear and shoulder and kicked her in the back. [Client #8] knocked [client #1] down and broke the frames (eyeglasses). Staff went back to room and got [client #8] out of the room. [Client #1] wanted to file a police report. The police were called and came out to make a report. [Client #1] requested to go to hospital. Everything</p>		<p>W for a few reasons:</p> <p>1. Confusion as to exact incidents needing investigated in consumer to consumer abuse and injuries of unknown origin 2. Thorough review of investigation once completed. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Director, Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the guidelines for investigations, to ensure investigations are completed. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>checked out fine, no redness, marks or scratches. Tylenol was prescribed for pain."</p> <p>-BDDS report dated 1/2/14 involving client #1 indicated: "Staff reported verbal abuse from [Staff #13] towards [client #1]. It was reported that [Staff #13] told [client #1] to get her a-- in the bathroom and told her to get her p---y hands off the rolls....The investigation showed that the allegation of verbal abuse was substantiated. It could not be proved exactly what she said but it was concluded based on the interviews with consumers and staff that [Staff #13] had verbal abuse towards [client #1] [Staff #13] was previously on a plan of correction for the tone towards the consumers. [Staff #13] was terminated based on the outcome of the investigation."</p> <p>-BDDS report dated 3/6/14 involving client #3 indicated: "[Client #3] reported he thought he saw an overnight staff smoking Marijuana in the garage. He stated he got up in the middle of the night and heard a noise in the garage. He stated he opened the garage door and smelled marijuana and walked around the van and thought he saw a pipe in her hand and a small black bag. He stated he did not actually see her smoking the</p>		<p>been up-dated to address the timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>marijuana." Further review of the record failed to indicate a thorough investigation was conducted. All staff and all clients were not interviewed in regard to this allegation of neglect.</p> <p>-BDDS report dated 7/21/14 involving client #4 indicated: "[Client #4] fell in breakroom and staff did not witness. Staff was alerted by another consumer that [client #4] had fallen. Unaware if he hit his head, but was complaining that it hurt." Further review of the record failed to indicate an investigation was conducted in regard to this unwitnessed fall with injury.</p> <p>-BDDS report dated 8/12/14 involving client #5 indicated: "At approximately 9:20 P.M., [Nurse] was notified by [Group Home] staff that [client #5] had a plan to kill herself. This was stated previously in the night approximately 6:30 that she was feeling suicidal and was placed on suicide watch per protocol. A fellow consumer alerted staff after 9 P.M. that [client #5] showed her a knife she had in her pocket and planned on harming herself with. That consumer alerted staff. Staff approached [client #5] and asked if she had a knife and if so location and asked about her plan. [Client #5] had the knife in her pocket and stated she planned on harming</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>herself with it. Staff took the knife from [client #5], she had no visible cuts at that time. [Client #5] also stated she planned on taking Ibuprofen overdose. Client was transported to [Hospital name] for evaluation and treatment of suicidal ideations by agency nurse. She was found to have 2 very superficial cuts on her left elbow region with no bleeding noted at ER (Emergency Room) during her assessment." Further review of the record failed to indicate an investigation was completed in regard to this incident.</p> <p>-BDDS report dated 9/9/14 involving client #3 indicated: "[Client #3] was walking into the workshop to begin working when another consumer [Day program consumer] was having a behavior and kicked a trash can. The trash can hit [client #3] on the right shin leaving a small scrape and bruising."</p> <p>A review of the facility's abuse and neglect policy dated 12/12 was conducted on 9/16/14 at 7:30 P.M.. Review of the policy indicated:</p> <p>"Abilities Services, Inc. Abuse, Neglect, and Exploitation" policy dated 12/12 indicated: "It is the policy of Abilities Services, Inc. to protect and advocate for the protection and safety of all consumers in accordance with all applicable federal,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>state, and local laws. Abilities Services also sets forth procedures for staff to report all incidents or suspected incidents of abuse, neglect, exploitation, and violation of rights in accordance with all applicable rules, regulation, and laws. All staff of Abilities Services, Inc, are MANDATORY REPORTERS of observed or suspected abuse, neglect, and exploitation. Definitions: Verbal Abuse: Any yelling, cursing, screaming, threatening, language directed toward any consumer. Physical Abuse: Any hitting, slapping, kicking, biting, throwing at or attempting to do so, toward a consumer emotional anguish....Neglect: Any action that places or potentially places a consumer in a position/situation that results in injury. It is also defined as the intentional withholding of the basic necessities of life....Abilities Services, Inc, prohibits the abuse, neglect, exploitation, and mistreatment of an individual, and violation of an individual's rights, to include but is not limited to the following: corporal punishment....It is a priority to notify immediately if actual or suspected Abuse, Neglect, or Exploitation occurs...Resident Elopement: a cognitively impaired resident who was found outside the facility and whose whereabouts had been unknown."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000154	<p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 9/29/14 at 1:15 P.M. The QIDP indicated staff should follow the facility's abuse/neglect policy. When asked if the facility's policy was implemented in regards to the mentioned BDDS reports and investigations, the QIDP indicated the policy was not implemented. The QIDP indicated there was no documentation available to indicate thorough investigations had been conducted in regard to the mentioned incidents.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 4 sampled clients and 2 additional clients (clients #1, #3, #4, #5 and #8), the facility failed to provide written evidence thorough investigations were conducted of allegations of abuse and neglect.</p>	W000154	In regard to ensuring the facility implemented its written policy and procedures to prevent abuse/neglect/exploitation, and to conduct thorough investigations of abuse/neglect, The system failed in the instances cited in this W for a few reasons:	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Incident reports (IR) and investigation records was conducted on 9/17/14 at 1:30 P.M. Review of the records indicated:</p> <p>-BDDS report dated 9/13/13 involving clients #1, #3 and #8 indicated: "Housemate [client #3] returned home from work and was eating dinner. [Client #8] was sitting at the table with him. [Client #1] was also around the table. [Client #8] told [client #1] to stop looking at [client #3] (client #8's boyfriend). [Client #1] did not stop looking at [client #3]. [Client #8] got upset and pushed [client #1] back to her room in her wheelchair. [Client #8] then punched [client #1] in the ear and shoulder and kicked her in the back. [Client #8] knocked [client #1] down and broke the frames (eyeglasses). Staff went back to room and got [client #8] out of the room. [Client #1] wanted to file a police report. The police were called and came out to make a report. [Client #1] requested to go to hospital. Everything checked out fine, no redness, marks or scratches. Tylenol was prescribed for pain." No documentation was submitted</p>		<p>1. Confusion as to exact incidents needing investigated in consumer to consumer abuse and injuries of unknown origin 2. Thorough review of investigation once completed. To address these issues, ASI has revamped its Incident Reporting process for all Group Homes. Any time an Incident Report is written, the DSP must call the Director, Programming Coordinator, QIDP, and Nurse to report the incident. This begins the notification process for them in case a BDDS report is required or an investigation must be initiated. These individuals are on-call 24-7. The Incident Report is then electronically scanned to these same persons so that the paperwork process follows their actions. There is no opportunity for delay in an investigation process with this notification system. If it is an investigation of unknown injury or consumer to consumer abuse, the QIDP and Nurse conduct the investigation. ASI has up-dated the guidelines for investigations, to ensure investigations are completed. If the allegation involves staff abuse, the Director is notified and she/he initiates the investigation. Staff are immediately suspended in these instances. The policy, procedure, and form for investigating allegations of abuse/neglect/exploitation have been up-dated to address the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>for review to indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 3/6/14 involving client #3 indicated: "[Client #3] reported he thought he saw an overnight staff smoking Marijuana in the garage. He stated he got up in the middle of the night and heard a noise in the garage. He stated he opened the garage door and smelled marijuana and walked around the van and thought he saw a pipe in her hand and a small black bag. He stated he did not actually see her smoking the marijuana." Further review of the record failed to indicate a thorough investigation was conducted. All staff and all clients were not interviewed in regard to this allegation of neglect.</p> <p>-BDDS report dated 7/21/14 involving client #4 indicated: "[Client #4] fell in breakroom and staff did not witness. Staff was alerted by another consumer that [client #4] had fallen. Unaware if he hit his head, but was complaining that it hurt." Further review of the record failed to indicate an investigation was conducted in regard to this unwitnessed fall with injury.</p> <p>-BDDS report dated 8/12/14 involving client #5 indicated: "At approximately 9:20 P.M., [Nurse] was notified by</p>		<p>timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will email the Executive Director with the staff's name and brief description of the allegation. When the investigation is complete, a second email will be send to the ED for him to ensure it is completed in a timely manner. This also ensures that he has been informed and is up-to-date on any allegations. In addition, the Quality Assurance Committee is tracking all staff investigations as an outcome to profile how many are being done each month and to ensure that they are conducted within the 5 days. The Executive Director is on this committee. In regard to allegations of unknown injury or consumer to consumer abuse, the investigating QIDP will send an email to the ED upon the initiation of an investigation as well as at the conclusion of the investigation so that he is able to monitor the timeliness of these events.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[Group Home] staff that [client #5] had a plan to kill herself. This was stated previously in the night approximately 6:30 that she was feeling suicidal and was placed on suicide watch per protocol. A fellow consumer alerted staff after 9 P.M. that [client #5] showed her a knife she had in her pocket and planned on harming herself with. That consumer alerted staff. Staff approached [client #5] and asked if she had a knife and if so location and asked about her plan. [Client #5] had the knife in her pocket and stated she planned on harming herself with it. Staff took the knife from [client #5], she had no visible cuts at that time. [Client #5] also stated she planned on taking Ibuprofen overdose. Client was transported to [Hospital name] for evaluation and treatment of suicidal ideations by agency nurse. She was found to have 2 very superficial cuts on her left elbow region with no bleeding noted at ER (Emergency Room) during her assessment." Further review of the record failed to indicate an investigation was completed in regard to this incident.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 9/29/14 at 1:15 P.M. When asked if there was documentation to indicate thorough investigations were conducted in regards</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000157	<p>to the mentioned incidents, the QIDP indicated there was not.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 3 of 4 sampled clients and 4 additional clients (clients #1, #3, #4, #5, #6, #7 and #8), the facility failed to take sufficient/effective corrective measures in regard to addressing a pattern of medication errors.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports (IR) and investigation records was conducted at the facility's administrative office on 9/17/14 at 1:30 P.M. Review of the records indicated the following medication errors:</p> <p>Incidents involving client #1 indicated:</p> <p>-BDDS report dated 3/11/14 involving</p>	W000157	<p>In response to W157, the facility failed to take sufficient/effective measures in regard to addressing a pattern of medication errors The facility has a process in place that addresses med errors, and changes to the process have occurred Any time a med error is reported, the IR is sent directly to the Director of Administration for review and disciplinary action/retraining Program Coordinators then received the corrective action to administer to the staff All med errors are also being tracked to identify patterns and areas for improvement These med errors are reviewed weekly at the safety meeting to address any issues and establish a plan to correct</p>	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client #1 indicated: "[Staff #11] called manager at 2:45 and stated she had picked [client #1] up from workshop for an outing and forgot her 2 P.M. med. Medication was Baclofen tablet 20 mg (milligram) (muscle relaxer) to be given 1 tablet by mouth 3 times a day....Staff reminded that anytime taking a consumer out, they must take any medications that may need to be given during the time away. Staff also reminded of the importance of administering medications at the prescribed times."</p> <p>-BDDS report dated 3/24/14 involving client #1 indicated: "Consumer received Urea cream 40% (dry skin), Zoloft 50 mg (antidepressant), Zestoretic 10-12.5 (high blood pressure), Oxybutynin 5 mg (urinary incontinence), etodolac 400 mg (pain), clotrimazole 1% (anti-fungal), baclofen 20 mg (muscle relaxer), no adverse affects (sic) were noted from received from (sic) noted them being given earlyby (sic) [Staff #13]. Time due was at 7 AM. [Staff #13] was educated on time of med pass and will be submitted for disciplinary action."</p> <p>-BDDS report dated 5/24/14 involving client #1 indicated: "[Client #1] received her morning dose of ibuprofen 800 mg (pain). The dose administered was the correct medication and correct dose but</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was another consumers (sic) medication. [Staff #14] has been taken off med pass and will receive disciplinary action. Staff will be evaluated to retake Medcore."</p> <p>Incidents involving client #3 indicated:</p> <p>-BDDS report dated 12/5/13 involving client #3 indicated: "[Client #3] came to 3rd shift staff on 12/5/13 at 10:30 P.M. and stated he had not received his Melatonin tab 5 mg (insomnia) give 1 tab by mouth every night at bedtime by staff on second shift. I checked the MAR (Medication Administration Record) and bubble pack and confirmed [client #3] did not receive said medication."</p> <p>-BDDS report dated 1/8/14 involving client #3 indicated: "[Client #3] went home for a visit with his mom on 1/3/14. He was expected to return 1/5/14. [Client #3] did not return to the group home until 1/8/14 due to extreme weather conditions. Manager checked in his meds and noted he ran out of his Melantonin (sic) 5 mg (insomnia), give 1 tablet by mouth every night at bedtime. He missed his dose of this on 1/6/14 and 1/7/14 at 9:30 P.M. Staff advised to send additional meds in case there becomes a reason that the consumer can not (sic) return on their expected return date."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 1/17/14 involving client #3 indicated: "Staff was passing morning medications on 1/18/14. She noted that on 1/17/13 (sic) during morning med pass [Staff #17] did not give [client #3] his Fluconazole tab (anti-fungal) 150 mg give 1 tab by mouth daily every other week. Staff instructed to make sure a triple check MAR when passing meds to ensure meds are given at the prescribed time."</p> <p>-BDDS report dated 4/11/14 involving client #3 indicated: "[Client #3] came to staff on 4/11/14 in the evening and informed her that morning staff [Staff #17] did not give him his Fluconazole tab 150 mg (anti-fungal) give 1 tab by mouth every other week. Staff instructed to make sure to triple check MAR when passing meds to ensure meds are given at the prescribed time."</p> <p>-BDDS report dated 4/12/14 involving client #3 indicated: "[Client #3] missed his dose of Diflucan 150 mg (anti-fungal) on 4/12/14 at 7 A.M. by [Staff #18]. Medication was administered at eve med pass on 4/15/14 at 7 P.M.. Medication was changed and adjusted in the MAR to continue once every week in the evening at 7 P.M.. [Staff #18] will receive disciplinary action."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 9/5/14 involving client #3 indicated: "[Client #3] did not receive his Prevident toothpaste on 9/5/14. Staff will be submitted for disciplinary action."</p> <p>Incidents involving client #4 indicated:</p> <p>-BDDS report dated 6/25/14 involving client #4 indicated: "[Client #4] did not receive his morning dose of doxycycline antibiotic. Staff noted this after medication time, and before leaving shift. Consumer was at workshop at this time. Staff stated she did not read the MAR fully and it was hand written in at the bottom of the first MAR page. This was [client #4]'s second dose of the antibiotic. Staff will be submitted for disciplinary action."</p> <p>-BDDS report dated 7/12/14 involving client #4 indicated: "[Client #4] received his Levaquin (antibiotic) 1 tablet daily for 10 days at the wrong time on 7/12/14. Levaquin is scheduled to be administered at 7 P.M. and it was given at 7 A.M.. Staff will be taken off med pass until medcore is taken as retraining on Monday 7/14/14. Verbal teaching was done via phone. Staff will be submitted for disciplinary action."</p> <p>Incidents involving client #5 indicated:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>-BDDS report dated 5/20/14 involving client #5 indicated: "Staff gave [client #5] 2 Vimpat (epilepsy) instead of the prescribed one pill. Staff will receive disciplinary action per Abilities policy."</p> <p>-BDDS report dated 5/26/14 involving client #5 indicated: "[Client #5] received 3 phenobarbital (epilepsy) at evening med pass on 5/26/14 at 7 P.M.. Correct dose is 2 phenobarbital at evening med pass. Staff was submitted for disciplinary action and verbally reminded to do 6 rights of med pass and do her 3 checks. Staff will undergo a random med audit per [LPN]."</p> <p>-BDDS report dated 8/1/14 involving client #5 indicated: "[Client #5] did not receive her clonazepam .5 mg (epilepsy) at 7 P.M. on 8/1/14. Staff will be submitted for disciplinary action per agency policy."</p> <p>Incidents involving client #6 indicated:</p> <p>-BDDS report dated 6/14/14 involving client #6 indicated: "[Client #6] missed her 7 P.M. dose of Depakote (behaviors) on 6/14/14. This error was found by staff on 6/15/14 when passing evening medications. [Staff #13] was responsible for medication on 6/14/14. Staff will be</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>submitted for disciplinary action."</p> <p>-BDDS report dated 6/25/14 involving client #6 indicated: "[Client #6] received her 9 P.M. melation (sic) (insomnia) at 7 P.M.. Staff stated the reason the med was given early was she did not read the MAR and 'just went by the blue marker.' Staff is trained on the 6 rights of medication administration and also the 3 checks during med pass. Staff will be submitted for disciplinary action."</p> <p>-BDDS report dated 7/31/14 involving client #6 indicated: "[Client #6] went home with her guardian and all meds were sent with her. Guardian administered medications on 7/31/14 at 7 P.M. and 8/1/14 at 7 A.M.. Depakote (behaviors) order is for 2 tabs BID (twice daily). [Client #6] only received 1 tablet for each dose. Guardian contacted on 8/1/14 of [client #6] complaining of headache across forehead about a level 6 of pain and [client #6] feeling like her heart beating fast and her feeling clammy. Staff will go over medications with family prior to them leaving the house."</p> <p>Incidents involving client #7 indicated:</p> <p>-BDDS report dated 5/14/14 involving client #7 indicated: "[Client #7] has a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>med goal to pop out his medication while staff observe and then check before he takes his medication. Staff checked his medications the morning of 5/13/14 saw he had the proper amount of medications. When they went and checked the bubble packs afterwards staff noticed he popped two escitalogram (sic) (depression) had been signed for on 5/13."</p> <p>-BDDS report dated 6/18/14 involving client #7 indicated: "[Client #7] was at work and did not have his dose of Seroquel (bipolar) with his meds. He did not call staff to inform that the med was not in the pack of meds. [Staff name] was responsible for medications at that time. [Client #7] let staff know upon arrival home that his bubble pack did not have any remaining pills, so he needed his Seroquel still. [Staff name] will be submitted for disciplinary action. Verbal teaching done that evening that all meds need to be checked before leaving the house."</p> <p>Incidents involving client #8 indicated:</p> <p>-BDDS report dated 10/24/13 involving client #8 indicated: "Staff notified manager while she was doing meds on 10/24/13 at 7:00 P.M. that [client #8] did not have any Dente 5000 Cre Plus (fluoride), use as directed. [Client #8]</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>missed her dose on 10/24/13 7:00 P.M. and 10/25/13 7:00 A.M.. Manager had faxed a refill into [Pharmacy name] on 10/21/13 at 7:00 A.M.. Manager called [Pharmacy name] the evening on 10/24/13 and did not receive a return call. Manager called again the morning of 10/25/13 and [Pharmacy name] said it was a mistake on their part due to billing issue."</p> <p>-BDDS report dated 12/28/13 involving client #8 indicated: "When [client #8] returned to the group home from a visit with parents on 12/28/13 staff counted her meds in. Staff noted that no Carbamazepin (sic) (epilepsy) had been punched out at 2:30 for Dec. 24th and Dec 27th. [Client #8] said she did not take that dose those days. Medication missed is Carbamazepin (sic) Chewable 100 mg give 2 tabs (200 mg) by mouth 3 times daily. Staff reminded to stress to guardians the importance of administering the correct dose of medications at the prescribed times."</p> <p>-BDDS report dated 3/24/14 involving client #8 indicated: "Consumer received vit d3 (supplement), Lexapro 20 mg (major depression), keppra 1250 mg (epilepsy), co q 10 (antioxidant), clonazepam .5 mg (epilepsy), denta 5000 (fluoride), carbamazepine 110 mg</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(epilepsy), carnitor 1000 mg (supplement) at 6 am by staff. Prescribed time is 7:00 A.M.. Staff was educated on med pass times and submitted for disciplinary action."</p> <p>-BDDS report dated 4/27/14 involving client #8 indicated: "[Client #8] arrived home to group home around 5:00 P.M. from being at home with her family. She told home staff that she did not take her 2:30 P.M. medications: Levocarntin (sic) (supplement) and carbamezipin (sic) chewable tablet (epilepsy). [Client #8] and family will be reminded of the importance of taking all medications as prescribed."</p> <p>-BDDS report dated 6/15/14 involving client #8 indicated: "[Client #8] received her P.M. medications late due to being home for the weekend with family. Family stated they were with [client #8]'s sister and that is the reason medications were not given. Family reminded of importance of medications."</p> <p>-BDDS report dated 7/6/14 involving client #8 indicated: "When [client #8] returned to the group home from a visit with parents on 7/7/14 around 6:30 A.M. staff counted her meds in. Staff noted that no Carbamazepin (sic) (epilepsy) had been punched out at 2:30 P.M. for July</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>6th. [Client #8] said she did not take that dose those days. Medication missed Carbamazepin (sic) Chewable 100 mg give 2 tabs (200 mg) by mouth 3 times daily. [Client #8] then told staff that she had taken her morning meds upon waking up at 4:15 A.M. on 7/7/14. Prescribed time for morning meds is 7 A.M.. Meds received early were Vitamin D3 (supplement), Escitalopram tab 10 mg (major depression), Levetiraceta (sic) Sol 100 mg (epilepsy), Denta 5000 (fluoride), Co Q 10 (antioxidant), Carbamazepin (sic) chew 100 mg, Levocarnitin (sic) sol 10 ml (supplement). Manager spoke with parents regarding ensuring meds are given at the prescribed time."</p> <p>No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/26/14 at 1:55 P.M. The LPN indicated facility staff should administer medications as ordered. When asked if the facility addressed the documented incidents the LPN indicated staff were retrained on Medcore and medication administration.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 4 sampled clients and 2 additional clients (clients #1, #2, #3, #7 and #8), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to monitor clients' programs in regards to revision/implementation/tracking of program objectives.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 9/16/14 from 6:00 A.M. until 7:35 A.M.. At 6:30 A.M., Direct Support Professional (DSP) #1 prompted client #8 to the medication room. Client #8 retrieved her medications, took each medication packet</p>	W000159	<p>In regard to W159, the agency failed to monitor clients' programs in regard to revision/implementation/tracking of program objectives The consumer goals and objectives are reviewed monthly by the QIDP To ensure this is being done and that revisions to goals are being made, QIDP's will submit quarterly progress notes/summary to the Director of Programming and the quarterly progress notes will be reviewed by the Programming Coordinator to ensure they are monitored correctly Staff have been retrained to read and follow all goals for each consumer to ensure they are being followed as written and that staff are assisting the consumers correctly A new QIDP has been hired and trained on the monitoring of consumer</p>	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>out of her medication tray, popped each medication and self administered each medication. Client #8 then stated each of her medications, the reason she took her medications and the side effects of each medication. At 6:40 A.M., DSP #1 prompted client #7 to the medication room. Client #7 retrieved his medications, took each medication packet out of his medication tray, popped each medication and self administered each medication. Client #7 then stated each of his medications, the reason he took his medications and the side effects of each medication.</p> <p>A review of client #1's record was conducted on 9/17/14 at 3:20 P.M.. A review of client #1's Individual Support Plan (ISP) dated 8/14/14 indicated the following: "Will pop out her medications into the medication cup...Will choose a desert off the menu to make...Will be able to read aloud to a staff member...Will clean her wheelchair...Will clean her glasses...Will keep in contact with her friends and family by writing letters, sending cards or calling...Will sit down with a staff member and choose a menu to read. She will then verbalize what items she will need to put on her grocery list...Will notify staff that she is going to take her shower and for them to come in and</p>		<p>programs All tracking in the last quarter is being reviewed to ensure goals are up to date</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>check her hair." Further review of client #1's record failed to indicate the QIDP monitored program data when client #1 made progress and/or completed program objectives for the months of 11/13, 12/13, 1/14, 2/14, 3/14, 4/14, 5/14, 6/14 and 7/14.</p> <p>A review of client #2's record was conducted on 9/17/14 at 2:50 P.M.. The ISP dated 8/27/14 indicated the following: "Will help prepare one aspect of a meal...Will begin to write the days of the week...Will match 5 words with the same word...Will write 5 foods that he wants to put on the grocery list...Will sort fake money into the correct piles...Will wash arm pits with a luffa (sic) each time he showers...Will get his tooth paste out of his bath bucket...Will pop out his Folic acid." Further review of client #2's record failed to indicate the QIDP monitored program data to see if client #2 made progress/regressed and/or completed program objectives for the months of 11/13, 12/13, 1/14, 2/14, 3/14, 4/14, 5/14, 6/14 and 7/14.</p> <p>A review of client #3's record was conducted on 9/17/14 at 2:30 P.M.. The ISP dated 8/27/14 indicated the following: "Will choose 5 words out of the books he has or any words that he would like to learn to spell...Will make a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>list of items he wants to get from the store...Will do his daily physical therapy exercise...Will brush his teeth...Will purchase math workbooks." Further review of client #3's record failed to indicate the QIDP monitored program data to see if client #3 made progress/regressed or completed program objectives for the months of 11/13, 12/13, 1/14, 2/14, 3/14, 4/14, 5/14, 6/14 and 7/14.</p> <p>A review of client #7's record was conducted on 9/18/14 at 2:45 P.M.. The ISP dated 8/27/14 indicated the following : "Will work on a budget to determine what percentage of his pay will go into the categories: Camp, spending, gifts, and out to eat...Will write down the amount of money in his account on an actual check ledger...Will keep a running list of things he wants to talk to staff about...Will pop out his medications into a med cup, he will state why he takes each one of his medications. He will then initial and date the bubble pack." Further review of client #7's record failed to indicate the QIDP monitored program data to see if client #7 made progress and/or completed program objectives for the months of 11/13, 12/13, 1/14, 2/14, 3/14, 4/14, 5/14, 6/14 and 7/14.</p> <p>A review of client #8's record was</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>conducted on 9/18/14 at 3:25 P.M.. The ISP dated 8/14/14 indicated the following: "Will complete a savings account ledger when given a list of deposits and withdrawals that have been made...Will write a mock menu for a week...Will write her work identification: Name, Address, city, state, zip code and phone number...Will sit down with staff and go over one popular menu of her choice to read...Will put a puzzle together upside down...Will pop out her medications." Further review of client #8's record failed to indicate the QIDP monitored program data to see if client #8 made progress and/or completed program objectives for the months of 11/13, 12/13, 1/14, 2/14, 3/14, 4/14, 5/14, 6/14 and 7/14.</p> <p>An interview with the QIDP was conducted on 9/29/14 at 12:15 P.M. The QIDP indicated the clients' program objectives are to be monitored by the QIDP monthly. The QIDP further indicated objectives should be changed when they are accomplished. The QIDP further indicated she was not sure if the prior QIDP monitored each client's objective and made changes once the objectives were completed.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview, the facility failed to develop training/teaching methods to prevent recurrence of urinary</p>	W000242	In regard to W242, the agency failed to develop training/teaching methods to prevent recurrence of urinary accidents/incontinence, the agency has developed a voiding schedule For future	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>accidents/incontinence for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 9/17/14 at 1:34 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports from 9/17/13 to 9/17/14 were reviewed.</p> <p>An internal report dated 4/27/14 indicated Client #1 "said she changed her pants because she got cold, so [staff] went to check her room for (soiled) pants and found the pants [Client #1] was wearing earlier in the day on the floor, soaked in urine." The report indicated Client #1 "was asked to shower and was asked why she felt like she needed to lie and [Client #1] stayed silent. [Client #1] showered and put pants in laundry."</p> <p>An internal report dated 4/2/14 indicated Client #1 "was on (sic) her walker in the commons (common room) (sic) she didn't make it to the restroom. She had a (sic) accident." The report indicated "[Client #1] cleaned up the floor and showered."</p> <p>An internal report dated 5/3/14 indicated "when [staff] went to clean the restroom that [Client #1] uses, [staff] stepped in a puddle of urine." The report indicated staff "had heard [Client #1] get up while</p>		<p>development of training and teaching methods, there will be RN oversight of agency nursing policy and procedures to ensure the appropriate training/teaching methods are in place for each consumer The RN will review the medical files with the agency nurse monthly The RN will complete a written evaluation of the review to the director of programming The nurse will have a specified amount of time to make corrections</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[staff] was in the kitchen but assumed she was just using the restroom. [Client #1] asleep (sic) when accident found. Clothes looked dry but room smells of urine as well."</p> <p>An internal report dated 6/5/14 indicated "[Client #1] reported to staff that she had an accident in her pants. [Client #1] did have a BM (bowel movement) and urinated in her pants." The report indicated "staff got [Client #1] new clothes and helped her get cleaned up."</p> <p>An internal report dated 7/31/14 indicated "[Client #1] told me that she had to use the restroom while getting her out of the van, so she was hurried to the restroom, but still had an accident." The report indicated "[Client #1] cleaned herself up in the shower and cleaned her chair."</p> <p>An internal report dated 9/11/14 indicated "[Client #1] was in her room and it had a strong urine smell. Her laundry basket did not smell of urine, but the side of the room she was on did." The report indicated "[Client #1] admitted to accident and showered."</p> <p>On 9/17/14 at 3:45 PM, record review indicated Client #1's diagnoses included, but were not limited to, cerebral palsy,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>arthritis, back pain/spasm, hypertension, and anxiety disorder. Client #1's ISP (individual support plan) dated 8/14/14 indicated no training/teaching goals and/or strategies for toileting or incontinence.</p> <p>On 9/26/14 at 1:53 PM during an interview, the facility Nurse indicated Client #1 did not have a diagnosis of Neurogenic bladder (a condition whereas an individual lacks the ability to control their bladder due to a physical impairment). The facility Nurse stated Client #1's accidents are a combination of "behavior" and "forgetting" or getting "sidetracked" during activities. The facility Nurse stated Client #1's urinary accidents occurred "not even weekly" and were more frequent during the "night time." The facility Nurse indicated staff were to remind Client #1 to use the restroom but Client #1 did not have a voiding schedule (a training schedule to remind an individual to use the restroom to retrain the bladder to respond at appropriate times). The facility Nurse stated Client #1 did not have any toileting goals in her ISP as "far as she knew." The facility Nurse indicated Client #1 could benefit from training/teaching tools for bladder elimination.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed at the group home.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 9/16/14 from 6:00 A.M. until 7:35 A.M.. Upon entering clients #1, #2, #3, #4, #5, #6, #7 and #8's home, the dining table was observed to be set with 8 place settings. In the middle of the table was a plate covered with aluminum foil which had 8 already prepared sausage and egg biscuit sandwiches. A plate with two slices of toasted bread was in front of client #2's place setting. Beginning at 6:25 A.M., clients #1, #2, #5, #6, #7 and #8 began</p>	W000249	In regard to W249, the agency failed to implement the clients' training objectives when formal and/or informal opportunities existed at the group home, the agency identified that more in depth active treatment schedules are needed to ensure staff and consumers are aware of the goals and opportunities to offer meaningful activity Staff have been retrained on how to assist consumers with all of their goals Active treatment schedules will be re-done by the QIDP and reviewed by the Programming Director and Programming Coordinator All active treatment schedules and goals will be reviewed quarterly Staff will be trained/reminded of goals of each consumer at monthly staff meetings Regular site checks are completed (weekly) by the nurse, QIDP, PC and Assistant to ensure compliance	11/04/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>coming out of their bedrooms and entered into the living/dining area. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not assist in meal preparation. During the entire observation period clients #1, #2, #3, #5, #6, #7 and #8 sat in the living room/dining area with no meaningful activity. Clients #3 and #4 stayed in their bedrooms with no meaningful activity. Clients #2 walked back and forth throughout the group home with no meaningful activity. Direct Support Professionals (DSP) #1 and #2 would walk into the rooms and occasionally check on clients #1, #2, #3, #4, #5, #6, #7 and #8, but did not offer any meaningful activity. DSP #1 administered medications and DSP #2 cooked breakfast.</p> <p>A review of client #1's record was conducted on 9/17/14 at 3:20 P.M.. A review of client #1's Individual Support Plan (ISP) dated 8/14/14 indicated the following objectives that could have been implemented during the observation: "Will choose a dessert off the menu to make...Will be able to read aloud to a staff member...Will clean her wheelchair...Will clean her glasses...Will keep in contact with her friends and family by writing letters, sending cards or calling...Will sit down with a staff member and choose a menu to read. She</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>will then verbalize what items she will need to put on her grocery list."</p> <p>A review of client #2's record was conducted on 9/17/14 at 2:50 P.M.. The ISP dated 8/27/14 indicated the following objectives that could have been implemented during the observation: "Will help prepare one aspect of a meal...Will begin to write the days of the week...Will match 5 words with the same word...Will write 5 foods that he wants to put on the grocery list...Will sort fake money into the correct piles."</p> <p>A review of client #3's record was conducted on 9/17/14 at 2:30 P.M.. The ISP dated 8/27/14 indicated the following objectives that could have been implemented during the observation: "Will choose 5 words out of the books he has or any words that he would like to learn to spell...Will make a list of items he wants to get from the store...Will do his daily physical therapy exercise."</p> <p>A review of client #4's record was conducted on 9/17/14 at 2:10 P.M.. The ISP dated 8/27/14 indicated the following objectives that could have been implemented during both observations: "Will be able to write or recite his identification information: address, city, state, phone number...Will make a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>shopping list...will choose to write a letter or send a card to a friend or relative...Will look at the menu and pack his lunch for workshop...Will exercise 30 to 60 minutes...Will measure out the serving size for his main dish."</p> <p>A review of client #5's record was conducted on 9/17/14 at 3:40 P.M.. The ISP dated 5/13/14 indicated the following objectives that could have been implemented during the observation: "Will write each purchase down in her check ledger...Will count her money with staff every morning."</p> <p>A review of client #6's record was conducted on 9/18/14 at 2:25 P.M.. The ISP dated 6/3/14 indicated the following objectives that could have been implemented during the observation: "Will write down all her deposits and withdrawals for her checking account...Will assist staff with counting her money...Will begin to look up jobs on the internet."</p> <p>A review of client #7's record was conducted on 9/18/14 at 2:45 P.M.. The ISP dated 8/27/14 indicated the following objectives that could have been implemented during the observation: "Will work on a budget to determine what percentage of his pay will go into</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the categories: Camp, spending, gifts, and out to eat...Will write down the amount of money in his account on an actual check ledger...Will keep a running list of things he wants to talk to staff about."</p> <p>A review of client #8's record was conducted on 9/18/14 at 3:25 P.M.. The ISP dated 8/14/14 indicated the following objectives that could have been implemented during the observation: "Will complete a savings account ledger when given a list of deposits and withdrawals that have been made...Will write a mock menu for a week...Will write her work identification: Name, Address, city, state, zip code and phone number...Will sit down with staff and go over one popular menu of her choice to read...Will put a puzzle together upside down."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 9/29/14 at 12:15 P.M.. The QIDP indicated facility staff should implement training objectives at all times of opportunity.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility Nurse failed to develop a sufficient care plan for the signs and symptoms of a malfunctioning shunt for 1 additional client (Client #7).</p> <p>Based on record review and interview, the facility Nurse failed to develop a bruising care plan for a client with frequent and/or recurrent bruising for 1 of 4 sampled clients (Client #1).</p>	W000331	In regard to W331, the agency must provide clients with nursing services in accordance with their needs, the agency Nurse failed to develop a sufficient care plan for the signs and symptoms of a malfunctioning shunt and failed to develop a bruising care plan for frequent and/or recurrent bruising. The agency has an RN to provide oversight for all plans submitted by the agency nurse. This recently began and all files are being reviewed by the RN to ensure	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings include:</p> <p>1) On 9/17/14 at 1:34 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports from 9/17/13 to 9/17/14 were reviewed. A BDDS report dated 2/20/14 indicated "[Client #7] went to have a CT (computerized tomography) scan done today (2-20-14) to check his shunt due to the frequency of his headaches and vomiting increasing along with his irritability." The report indicated "these are signs we were told to watch for, for possible problems with his shunt. After CT scan was complete [Client #7] had an appointment with [doctor] his neurologist. CT scan showed enlargement of the ventricles in the brain. He was then sent for X-rays of his head, neck, chest abdomen." The report indicated "after returning to [neurologist]'s office, x-rays showed that the catheter is loose but still attached to the valve in his brain." The report indicated "[Client #7] has been scheduled for surgery on February 27th at 9am."</p> <p>A BDDS report dated 2/27/14 indicated "[Client #7] had a CT scan on 2-20-14 ordered by [neurologist]. CT scan showed enlargement of the ventricles in the brain. He was then sent for X-rays of his head, neck, chest and abdomen. After</p>		<p>plans are developed as needed. The RN will submit a monthly report to the Leadership Team for any noted issues and follow up will be completed by the Director of Programming The RN will also review all care plans for each individual consumer to ensure protocol are all in place Upon changes or new issues noted by the doctor, the COC will be forwarded to the RN so that she can review the plan written by the agency nurse This will happen within 24 hours of any changes Bruising care plan and shunt protocol are being included</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>returning to [neurologist]'s office, x-rays showed that the catheter is loose but still attached to the valve in his brain." The report indicated "[Client #7] had exploration shunt surgery today (2-27-14) to check catheter and shunt for malfunction. Catheter was replaced, surgery went well." The report indicated "[Client #7] has had no headaches or vomiting since surgery. And no other complications. [Client #7] is expected to be released from the hospital on 2-28-14."</p> <p>-A follow up BDDS report dated 3/3/14 indicated "[Client #7] continued to do well in the hospital that day. He was discharged from the hospital the next day (2-28-14) at 9am."</p> <p>An internal incident report dated 4/14/14 indicated Client #7 had complaint of "head" and "neck" pain. The report indicated Client #7 "was telling staff his neck was sore. Later on the outing (sic) staff asked where was the pain (sic) he said back of his head." The report indicated "staff kept asking how he was feeling (sic) he said at one time it was feeling better. Staff gave [Client #7] allergy med at 8:30pm."</p> <p>An internal incident report dated 6/14/14 at 10:30 AM indicated Client #7 had a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>complaint of "head" pain. The report indicated Client #7 "came to staff and complained of having a headache. He asked for Tylenol. He said it's on the opposite side of his shunt." The report indicated "[Client #7] took Tylenol (pain reliever) and continued doing activity. All parties notified."</p> <p>An internal incident report dated 6/14/14 at 6:40 PM, indicated Client #7 had complaint of head pain. The report indicated Client #7 "complained of headache in his forehead area. [Client #7] did not take PRN (given as needed medication), as we did not have it with us. [Client #7]'s headache was gone by the time we got home at 9:15 (pm)."</p> <p>An internal incident report dated 6/15/14 indicated Client #7 had complaint of headache. The report indicated "[Client #7] got in the van after work and said he had a headache." The report indicated staff "asked him when it started and he got a Tylenol from staff."</p> <p>An internal incident report dated 6/16/14 indicated Client #7 had complaint of head pain and was "vomiting in GHQ (group home) van." The report indicated "consumers were on way home when [Client #7] started vomiting in van. He informed staff that he also vomited twice</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>@ (at) [place of employment]. He believes it is caused by his shunt. [Client #7] also had headache." The report indicated "staff administered Tylenol and did vitals. All parties notified." An additional note of the incident report indicated "CT scan negative."</p> <p>An internal incident report dated 6/23/14 indicated Client #7 had complaints of head and stomach pain. The report indicated Client #7 "was complaining of a headache. Staff gave [Client #7] some medicine. [Client #7] went to the bathroom and threw up." The report indicated "staff is monitoring [Client #7]. He is now laying (sic) down in his room."</p> <p>On 9/17/14 at 3:10 PM, record review indicated Client #7's diagnoses included, but were not limited to, mild intellectual disabilities, chronic paranoia, schizophrenia, OCD (obsessive compulsive disorder), dwarfism, and hydrocephalus (build up of fluid inside skull that leads to brain swelling). Record review indicated Client #7 had a "High Risk Plan" dated 4/11/14 for "Pain Health Issues" included the following plan:</p> <p>-"Shunt due to hydrocephalus, headaches may occur, watch for front headaches, increased tiredness, nausea, change in</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>mental status report findings to nurse."</p> <p>Review of the shunt risk plan indicated the risk plan did not include symptoms of irritability, restlessness, decrease in appetite, lethargy, vomiting, imbalance, double vision, confusion, and/or incontinence. The shunt risk plan did not indicate when to give Client #7 a PRN (given as needed) pain medication, when to take vital signs, and/or when to seek emergency treatment.</p> <p>On 9/17/14 at 4:25 PM, the facility Nurse indicated Client #7's shunt high risk plan dated 4/11/14 was the most current plan. The facility Nurse stated she "didn't know" Client #7 needed a more thorough shunt risk plan. The facility Nurse indicated Client #7 could benefit from a more thorough shunt risk plan.</p> <p>2) On 9/17/14 at 1:34 PM, the facility BDDS (Bureau of Developmental Disabilities Services) reports and internal incident/accident reports from 9/17/13 to 9/17/14 were reviewed. An internal report dated 3/31/14 indicated "staff was doing [Client #1]'s skin assessment. We found a light bruise on the side of her right knee. [Client #1] said it's from the shower." The report indicated "all parties notified."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An internal report dated 3/24/14 indicated "2 bruises were found on [Client #1]'s left calf." The report indicated "[Client #1] was asked if she knew where the bruises came from and she said she thinks from her bed, but she's not 100% sure. All parties notified."</p> <p>An internal report dated 4/17/14 indicated "[Client #1] was showering when staff went in to do skin checks. Staff spotted a purple bruise on [Client #1]'s right thigh. She said she got it from hitting her leg on bed."</p> <p>An internal report dated 4/29/14 indicated "[Client #1] was sitting her wheelchair when staff noticed 3 new bruises on her left leg. She claims they are from bumping her leg on the bedrail."</p> <p>An internal report dated 5/01/14 indicated "while doing skin assessment, 8 (eight) bruises were found on [Client #1]'s legs. Three on right leg, one on upper thigh and two on outside calf of left leg." The report indicated "[Client #1] says she is unsure of where bruises came from."</p> <p>An internal report dated 8/23/14 indicated "[Client #1] has a bruise on her right shin. Appears to be from socks</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>being too tight." The report indicated "[Client #1] told staff 8-24 it was from hitting her leg on her bed."</p> <p>An internal report dated 8/24/14 indicated staff "noticed she had bruising on her right leg between her knee and ankle. [Client #1] claimed she got it from hitting it on her bed." Further review failed to indicate the facility addressed client #1's leg hitting the bed.</p> <p>On 9/17/14 at 3:45 PM, record review indicated Client #1's diagnoses included, but were not limited to, cerebral palsy, arthritis, back pain/spasm, hypertension, and anxiety disorder. Record review indicated no care plan for bruising.</p> <p>On 9/26/14 at 1:53 PM during an interview, the facility's Nurse indicated Client #1 did not have a bruising care plan. The Nurse indicated Client #1 got bruises from independently transferring in/out of her bed and in/out of her wheelchair. The Nurse stated Client #1 did not have "much use of legs" and "sits very forcefully" when transferring to her wheelchair. The Nurse stated staff encourage Client #1 to wear "tall socks and pants" to help protect her legs." The Nurse indicated Client #1 could benefit from a bruise care plan to prevent recurrent bruising.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000336	<p>9-3-6(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility Nurse failed to perform nursing quarterly examinations/assessments for 4 of 4 sampled clients (#1, #2, #3, and #4).</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 9/17/14 at 3:45 PM, record review indicated Client #1's diagnoses included, but were not limited to, cerebral palsy, arthritis, back pain/spasm, hypertension, and anxiety disorder. Record review indicated Client #1's last nursing quarterly review was dated 11/26/13. Record reviewed indicated no nursing quarterly reviews for 2/14, 5/14, or 8/14. On 9/17/14 at 4:10 PM, record review indicated Client #2's diagnoses included, but were not limited to, intellectual disabilities, fragile "X" (a chromosomal defect), and chronic constipation. Record 	W000336	In regard to W336, the facility nurse failed to perform nursing quarterly examinations/assessments, the agency has contracted with an RN to provide oversight for all consumer nursing plans and records submitted by the agency nurse. This recently began, and all files are being reviewed by the RN to ensure plans are developed as needed and that all nursing paperwork and notes are complete. The RN review all findings with the agency nurse and follow up with the agency nurse. The RN will submit a monthly report to the Leadership Team for any noted issues and follow up will be completed by the Director of Programming Nursing quarterly are being submitted by the agency nurse to the agency RN to ensure they are complete. The RN will immediately notify the Director of Programming if the nursing notes are not received. Programming Director will	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>review indicated Client #2's last nursing quarterly review was 11/26/13.</p> <p>3. On 9/17/14 at 4:30 PM, record review indicated Client #3's diagnoses included, but were not limited to, mild intellectual disabilities, low back pain, condyloma acumintum (genital warts). Record review indicated Client #3's last nursing quarterly review was dated 11/21/13.</p> <p>4. On 9/17/14 at 4:47 PM, record review indicated Client #4's diagnoses included, but were not limited to, Down's syndrome, mild intellectual disabilities, hypothyroidism, gout of left ankle and foot, and dyslipidemia (metabolic disorder). Record review indicated Client #4 had nursing quarterly evaluations on 11/26/13 and 5/12/14.</p> <p>On 9/17/14 at 4:25 PM during an interview, the facility Nurse indicated Clients #1, #2, #3, and #4 did not have updated nursing quarterlies. The Nurse stated she was still "new" to the facility and had not "caught up" with all tasks needed. The Nurse indicated she did take vitals and had some notes from assessments but those were not complete and were not filed.</p> <p>9-3-6(a)</p>		ensure they are to the RN within 24 hours of any notification that she has not received them on time.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview, the facility failed to assure medications administered to 3 of 4 sampled clients and 4 additional clients (clients #1, #3, #4, #5, #6, #7 and #8) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Incident reports (IR) and investigation records was conducted at the facility's administrative office on 9/17/14 at 1:30 P.M.. Review of the records indicated the following medication errors:</p> <p>Incidents involving client #1 indicated:</p> <p>-BDDS report dated 3/11/14 involving client #1 indicated: "[Staff #11] called manager at 2:45 and stated she had picked [client #1] up from workshop for an outing and forgot her 2 P.M. med. Medication was Baclofen tablet 20 mg (milligram) (muscle relaxer) to be given 1 tablet by mouth 3 times a day....Staff</p>	W000368	<p>In response to W368, the agency failed to assure medications administered were in compliance with the physician's orders, the facility nurse has reviewed all client's MAR to ensure instructions are clear and that any issues with administration are identified and the doctor contacted For future issues, the newly contracted pharmacy will note any potential issues with administration of medications during quarterly reviews On a monthly basis, the MAR will also be reviewed by the contracted RN as a additional check to the agency Nurse Any noted issues will be documented in nursing notes and handled accordingly Random monthly med evaluations are conducted to decrease med errors Additionally, ASI has policy for med errors that includes retraining and disciplinary action Upon consumers being gone, ASI nurse will review meds with the family before leaving ASI nurse will review meds with the family before leaving The agency nurse is also conducting weekly med pass evals at the group home All med errors are reviewed weekly in safety</p>	11/04/2014
---------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>reminded that anytime taking a consumer out, they must take any medications that may need to be given during the time away. Staff also reminded of the importance of administering medications at the prescribed times."</p> <p>-BDDS report dated 3/24/14 involving client #1 indicated: "Consumer received Urea cream 40% (dry skin), Zoloft 50 mg (antidepressant), Zestoretic 10-12.5 (high blood pressure), Oxybutynin 5 mg (urinary incontinence), etodolac 400 mg (pain), clotrimazole 1% (anti-fungal), baclofen 20 mg (muscle relaxer), no adverse affects (sic) were noted from received from (sic) noted them being given earlyby (sic) [Staff #13]. Time due was at 7 AM. [Staff #13] was educated on time of med pass and will be submitted for disciplinary action."</p> <p>-BDDS report dated 5/24/14 involving client #1 indicated: "[Client #1] received her morning dose of ibuprofen 800 mg (pain). The dose administered was the correct medication and correct dose but was another consumers medication. [Staff #14] has been taken off med pass and will receive disciplinary action. Staff will be evaluated to retake Medcore."</p> <p>Incidents involving client #3 indicated:</p>		<p>committee All disciplinary action for med errors follows a strict policy of retraining and progressive disciplinary action. The person filing the BDDS will write the actual disciplinary action that the staff with the med error received. The Staff who committed the med errors received retraining, disciplinary action, and additional monitoring following the med error to ensure that the staff passed meds correctly the next time. When there is a med error, the staff that had the med error will be observed at the next med pass following the error. This is to ensure they understand what they did wrong and to immediately observe any issues that might play a role in the med errors when they are passing meds.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 12/5/13 involving client #3 indicated: "[Client #3] came to 3rd shift staff on 12/5/13 at 10:30 P.M. and stated he had not received his Melatonin tab 5 mg (insomnia) give 1 tab by mouth every night at bedtime by staff on second shift. I checked the MAR (Medication Administration Record) and bubble pack and confirmed [client #3] did not receive said medication."</p> <p>-BDDS report dated 1/8/14 involving client #3 indicated: "[Client #3] went home for a visit with his mom on 1/3/14. He was expected to return 1/5/14. [Client #3] did not return to the group home until 1/8/14 due to extreme weather conditions. Manager checked in his meds and noted he ran out of his Melantonin 5 mg (insomnia), give 1 tablet by mouth every night at bedtime. He missed his dose of this on 1/6/14 and 1/7/14 at 9:30 P.M.. Staff advised to send additional meds in case there becomes a reason that the consumer can not return on their expected return date."</p> <p>-BDDS report dated 1/17/14 involving client #3 indicated: "Staff was passing morning medications on 1/18/14. She noted that on 1/17/13 (sic) during morning med pass [Staff #17] did not give [client #3] his Fluconazole tab (anti-fungal) 150 mg give 1 tab by mouth</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>daily every other week. Staff instructed to make sure a triple check MAR when passing meds to ensure meds are given at the prescribed time."</p> <p>-BDDS report dated 4/11/14 involving client #3 indicated: "[Client #3] came to staff on 4/11/14 in the evening and informed her that morning staff [Staff #17] did not give him his Fluconazole tab 150 mg (anti-fungal) give 1 tab by mouth every other week. Staff instructed to make sure to triple check MAR when passing meds to ensure meds are given at the prescribed time."</p> <p>-BDDS report dated 4/12/14 involving client #3 indicated: "[Client #3] missed his dose of Diflucan 150 mg (anti-fungal) on 4/12/14 at 7 A.M. by [Staff #18]. Medication was administered at eve med pass on 4/15/14 at 7 P.M.. Medication was changed and adjusted in the MAR to continue once every week in the evening at 7 P.M.. [Staff #18] will receive disciplinary action."</p> <p>-BDDS report dated 9/5/14 involving client #3 indicated: "[Client #3] did not receive his Prevident toothpaste on 9/5/14. Staff will be submitted for disciplinary action."</p> <p>Incidents involving client #4 indicated:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 6/25/14 involving client #4 indicated: "[Client #4] did not receive his morning dose of doxycycline antibiotic. Staff noted this after medication time, and before leaving shift. Consumer was at workshop at this time. Staff stated she did not read the MAR fully and it was hand written in at the bottom of the first MAR page. This was [client #4]'s second dose of the antibiotic. Staff will be submitted for disciplinary action."</p> <p>-BDDS report dated 7/12/14 involving client #4 indicated: "[Client #4] received his Levaquin (antibiotic) 1 tablet daily for 10 days at the wrong time on 7/12/14. Levaquin is scheduled to be administered at 7 P.M. and it was given at 7 A.M.. Staff will be taken off med pass until medcore is taken as retraining on Monday 7/14/14. Verbal teaching was done via phone. Staff will be submitted for disciplinary action."</p> <p>Incidents involving client #5 indicated:</p> <p>-BDDS report dated 5/20/14 involving client #5 indicated: "Staff gave [client #5] 2 Vimpat (epilepsy) instead of the prescribed one pill. Staff will receive disciplinary action per Abilities policy."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>-BDDS report dated 5/26/14 involving client #5 indicated: "[Client #5] received 3 phenobarbital (epilepsy) at evening med pass on 5/26/14 at 7 P.M.. Correct dose is 2 phenobarbital at evening med pass. Staff was submitted for disciplinary action and verbally reminded to do 6 rights of med pass and do her 3 checks. Staff will undergo a random med audit per [LPN]."</p> <p>-BDDS report dated 8/1/14 involving client #5 indicated: "[Client #5] did not receive her clonazepam .5 mg (epilepsy) at 7 P.M. on 8/1/14. Staff will be submitted for disciplinary action per agency policy."</p> <p>Incidents involving client #6 indicated:</p> <p>-BDDS report dated 6/14/14 involving client #6 indicated: "[Client #6] missed her 7 P.M. dose of Depakote (behaviors) on 6/14/14. This error was found by staff on 6/15/14 when passing evening medications. [Staff #13] was responsible for medication on 6/14/14. Staff will be submitted for disciplinary action."</p> <p>-BDDS report dated 6/25/14 involving client #6 indicated: "[Client #6] received her 9 P.M. melation (sic) (insomnia) at 7 P.M.. Staff stated the reason the med was given early was she did not read the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>MAR and 'just went by the blue marker.' Staff is trained on the 6 rights of medication administration and also the 3 checks during med pass. Staff will be submitted for disciplinary action."</p> <p>-BDDS report dated 7/31/14 involving client #6 indicated: "[Client #6] went home with her guardian and all meds were sent with her. Guardian administered medications on 7/31/14 at 7 P.M. and 8/1/14 at 7 A.M.. Depakote (behaviors) order is for 2 tabs BID (twice daily). [Client #6] only received 1 tablet for each dose. Guardian contacted on 8/1/14 of [client #6] complaining of headache across forehead about a level 6 of pain and [client #6] feeling like her heart beating fast and her feeling clammy. Staff will go over medications with family prior to them leaving the house."</p> <p>Incidents involving client #7 indicated:</p> <p>-BDDS report dated 5/14/14 involving client #7 indicated: "[Client #7] has a med goal to pop out his medication while staff observe and then check before he takes his medication. Staff checked his medications the morning of 5/13/14 saw he had the proper amount of medications. When they went and checked the bubble packs afterwards staff noticed he popped</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>two escitalogram (sic) (depression) had been signed for on 5/13."</p> <p>-BDDS report dated 6/18/14 involving client #7 indicated: "[Client #7] was at work and did not have his dose of Seroquel (bipolar) with his meds. He did not call staff to inform that the med was not in the pack of meds. [Staff name] was responsible for medications at that time. [Client #7] let staff know upon arrival home that his bubble pack did not have any remaining pills, so he needed his Seroquel still. [Staff name] will be submitted for disciplinary action. Verbal teaching done that evening that all meds need to be checked before leaving the house."</p> <p>Incidents involving client #8 indicated:</p> <p>-BDDS report dated 10/24/13 involving client #8 indicated: "Staff notified manager while she was doing meds on 10/24/13 at 7:00 P.M. that [client #8] did not have any Dente 5000 Cre Plus (fluoride), use as directed. [Client #8] missed her dose on 10/24/13 7:00 P.M. and 10/25/13 7:00 A.M.. Manager had faxed a refill into [Pharmacy name] on 10/21/13 at 7:00 A.M.. Manager called [Pharmacy name] the evening on 10/24/13 and did not receive a return call. Manager called again the morning of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>10/25/13 and [Pharmacy name] said it was a mistake on their part due to billing issue."</p> <p>-BDDS report dated 12/28/13 involving client #8 indicated: "When [client #8] returned to the group home from a visit with parents on 12/28/13 staff counted her meds in. Staff noted that no Carbamazepin (sic) (epilepsy) had been punched out at 2:30 for Dec. 24th and Dec 27th. [Client #8] said she did not take that dose those days. Medication missed is Carbamazepin (sic) Chewable 100 mg give 2 tabs (200 mg) by mouth 3 times daily. Staff reminded to stress to guardians the importance of administering the correct dose of medications at the prescribed times."</p> <p>-BDDS report dated 3/24/14 involving client #8 indicated: "Consumer received vit d3 (supplement), Lexapro 20 mg (major depression), keppra 1250 mg (epilepsy), co q 10 (antioxidant), clonazepam .5 mg (epilepsy), denta 5000 (fluoride), carbamazepine 110 mg (epilepsy), carnitor 1000 mg (supplement) at 6 am by staff. Prescribed time is 7:00 A.M.. Staff was educated on med pass times and submitted for disciplinary action."</p> <p>-BDDS report dated 4/27/14 involving</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client #8 indicated: "[Client #8] arrived home to group home around 5:00 P.M. from being at home with her family. She told home staff that she did not take her 2:30 P.M. medications: Levocarntin (sic) (supplement) and carbamezipin (sic) chewable tablet (epilepsy). [Client #8] and family will be reminded of the importance of taking all medications as prescribed."</p> <p>-BDDS report dated 6/15/14 involving client #8 indicated: "[Client #8] received her P.M. medications late due to being home for the weekend with family. Family stated they were with [client #8]'s sister and that is the reason medications were not given. Family reminded of importance of medications."</p> <p>-BDDS report dated 7/6/14 involving client #8 indicated: "When [client #8] returned to the group home from a visit with parents on 7/7/14 around 6:30 A.M. staff counted her meds in. Staff noted that no Carbamazepin (sic) (epilepsy) had been punched out at 2:30 P.M. for July 6th. [Client #8] said she did not take that dose those days. Medication missed Carbamazepin (sic) Chewable 100 mg give 2 tabs (200 mg) by mouth 3 times daily. [Client #8] then told staff that she had taken her morning meds upon waking up at 4:15 A.M. on 7/7/14.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Prescribed time for morning meds is 7 A.M.. Meds received early were Vitamin D3 (supplement), Escitalopram tab 10 mg (major depression), Levetiraceta (sic) Sol 100 mg (epilepsy), Denta 5000 (fluoride), Co Q 10 (antioxidant), Carbamazepin (sic) chew 100 mg, Levocarnitin (sic) sol 10 ml (supplement). Manager spoke with parents regarding ensuring meds are given at the prescribed time."</p> <p>A review of the facility's "Medication Administration System" Dated 12/12 was conducted on 9/16/14 at 4:30 P.M. and indicated:</p> <p>"Purpose: To ensure medications (administration, destruction, errors) are handled in a safe, appropriate manner...To ensure the medical well being of the individuals served are met with the highest level of service possible, Abilities Services, Inc. employees are trained annually and capable of handling a variety of medication situations....The individual administering the medication will initial completion of each dose given on the MAR and the bubble pack after the medication has been administered as trained."</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/26/14 at 1:55 P.M.. The LPN indicated all staff</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000369	<p>are trained on medication administration prior to working at the group home. The LPN also indicated staff are retrained annually and as needed on medication administration and further indicated staff should administer medications as ordered. The LPN indicated client #8's family had been informed of the need to administer her medication as ordered.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and</p>	W000369	In response to W369, the facility failed to ensure that staff	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>interview, the facility failed for 1 of 4 clients observed during the morning medication administration (client #6) to ensure staff administered 1 of 6 of the client's medications, as ordered without error.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 9/16/14 from 6:00 A.M. until 7:30 A.M.. At 6:25 A.M., client #6 walked into the dining area, grabbed a sausage and egg biscuit sandwich off the dining table and ate the sandwich while talking with Direct Support Professional (DSP) #2. At 6:52 A.M., DSP #1 administered client #6's prescribed oral medications. DSP #1 administered client #6's "Omeprazole 40 mg (milligram) (heartburn) capsule." Review of the medication packet label and the Medication Administration Record (MAR) dated 9/2014 was done at 6:55 A.M. and indicated "Omeprazole 40 mg capsule...1 capsule 30 minutes before breakfast." Client #6 did not take her medication 30 minutes before breakfast.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 9/26/14 at 1:55 P.M.. The LPN indicated DSP #1 should have administered the clients' medications as ordered. The LPN further</p>		<p>administered client's medications as ordered without error, the facility nurse has reviewed all client's MAR to ensure instructions are clear and that any issues with administration are identified and the doctor contacted For future issues, the newly contracted pharmacy will note any potential issues with administration of medications during quarterly reviews On a monthly basis, the MAR will also be reviewed by the contracted RN as a additional check to the agency Nurse Any noted issues will be documented in nursing notes and handled accordingly Random monthly med evaluations are conducted to decrease med errors Additionally, ASI has policy for med errors that includes retraining and disciplinary action for staff Upon consumers being gone, ASI nurse will review meds with the family before leaving The agency nurse is also conducting weekly med pass evals at the group home All med errors are reviewed weekly in safety committee All disciplinary action for med errors follows a strict policy of retraining and progressive disciplinary action. The person filing the BDDS will write the actual disciplinary action that the staff with the med error received. If there is a med error, the staff that had the med error will be observed at the next med pass following the error. This is</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000391	<p>indicated staff should have followed the directions on the label.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and interview, for 1 of 6 medications administered to 1 of 4 clients observed during the morning medication administration (client #8), the facility failed to remove from use the medication container with a worn label.</p> <p>Findings include:</p> <p>A morning observation was conducted on 9/16/14 from 6:00 A.M. until 7:35 A.M.. At 6:30 A.M., client #8 was observed during medication administration was completed with Direct Support Professional (DSP) #1. DSP #1 retrieved a bottle of liquid medication, poured the liquid into a small plastic medication cup and administered the liquid medication to</p>	W000391	<p>to ensure they understand what they did wrong and to immediately observe any issues that might play a role in the med errors when they are passing meds. Documentation of the observation will be submitted to the Director of Programming for review.</p> <p>In response to W391, the facility failed to remove from use the medication with a worn label, the agency nurse has checked all meds to date for worn labels All have been replaced if necessary Staff have been trained to contact the agency nurse if they encounter a worn label Every other week the nurse will do a check of all meds in the group home to help identify any issue with labels as soon as possible Labels needing replaced will be ordered by the agency nurse Programming Coordinators will also do monthly checks of medications for worn labels</p>	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client #8. Review of the bottle indicated the medication was Levetiracetam Oral Solution. The bottle label was worn and the directions in regard to dosage amount to be given, route of medication and times to be given were worn off the label. Review of the Medication Administration Record (MAR) dated 9/1/14 indicated: "Levetiracetam Oral Solution 100 mg (milligrams)/ml (milliliters)...Give 12.5 ml (1250 mg) by mouth twice daily." When asked how she (DSP #1) reconciled the medication label and the MAR to ensure proper medication administration, DSP #1 took a clear plastic orange colored bottle out of the medication closet and handed the bottle to this surveyor and stated "That is the same medication." When asked how she verified the medication with the worn label on the bottle, DSP #1 did not respond.</p> <p>An interview with the facility's Licensed Practical Nurse (LPN) was conducted on 9/26/14 at 1:55 P.M.. The LPN indicated all medications are to have a label and further indicated the labels are not to be worn.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W000455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, for 1 of 4 clients observed during the morning medication administration (client #7).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 9/16/14 from 6:00 A.M. until 7:35 A.M.. At 6:25 A.M., client #7 sat on a chair in the living room and ran his hands through his hair. Client #7 then picked his nose and lips. Client #7 stood up, walked over to client #6 and poked her in her stomach. At 6:40 A.M., Direct Support Professional (DSP) #1 prompted client #7 to the medication room. Client #7 retrieved his medications, took each medication packet out of his medication tray, popped each medication onto his bare hand and put each medication into his mouth. Client #7 did not and was not prompted to wash his hands.</p> <p>An interview with the Licensed Practical</p>	W000455	<p>In response to W455, the facility failed to maintain proper hygiene practices and prevent cross contamination during medication administration, the facility has retrained staff in universal precautions and the facility has retrained staff in universal precautions and the facility has implemented use of hand sanitizer at each group home for clients and staff to use during med passes. Med pass evaluations are completed weekly by the agency nurse to ensure compliance and random med pass evals are completed monthly by the nurse, QIDP or PC. Additionally, when there is a med error, the staff that had the med error will be observed at the next med pass following the error. This is to ensure they know what they did wrong and to immediately observe any issues that might play a role in the med errors when they are passing meds. Documentation of the observation will be submitted to the Director of Programming for review and possible scheduling of additional monitoring based on results of observation.</p>	11/04/2014
---------	--	---------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000484	<p>Nurse (LPN) was conducted on 9/26/14 at 1:55 P.M.. The LPN indicated staff should have prompted client #7 to wash his hands before administering his medications. The LPN indicated client #7 should not have popped his oral medications onto his bare hands without washing his hands.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) residing in the group home to provide condiments at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 9/16/14 from 6:00 A.M. until 7:35 A.M.. Upon entering clients #1, #2, #3, #4, #5, #6, #7 and #8's home,</p>	W000484	In regard to W484, the facility failed to provide condiments at the dining table, staff have been retrained on the condiments that should be available at each meal. Additionally, each menu lists needed condiments. Program Coordinators will do weekly checks of a meal time to ensure condiments are being made available.	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000488	<p>the dining table was observed to be set with 8 place settings. In the middle of the table was a plate covered with aluminum foil which had 8 already prepared sausage and egg biscuit sandwiches. A plate with two slices of toasted bread was in front of client #2's place setting. At 6:25 A.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 began coming out of their bedrooms and entered into the living/dining area and began eating breakfast. No butter/margarine, jelly, ketchup, salt and pepper were observed on the table for clients #1, #2, #3, #4, #5, #6, #7 and #8's use.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 9/29/14 at 12:15 P.M.. The QIDP indicated condiments should be provided for clients to use at all meal times.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the facility failed to assure 8 of 8 clients residing at the group home (clients #1,</p>	W000488	In response to W488, the facility failed to assure clients were involved in meal preparation and served themselves at meal times	11/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#2, #3, #4, #5, #6, #7 and #8) were involved in meal preparation and served themselves at meal times as independently as possible.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 9/16/14 from 6:00 A.M. until 7:35 A.M.. Upon entering clients #1, #2, #3, #4, #5, #6, #7 and #8's home, the dining table was observed to be set with 8 place settings. In the middle of the table was a plate covered with aluminum foil which had 8 already prepared sausage and egg biscuit sandwiches. A plate with two slices of toasted bread was in front of client #2's place setting. At 6:25 A.M., clients #1, #2, #3, #4, #5, #6, #7 and #8 began coming out of their bedrooms and entered into the living/dining area and began eating breakfast. Clients #1, #2, #3, #4, #5, #6, #7 and #8 did not assist in preparing their meal.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 9/29/14 at 12:15 P.M.. The QIDP indicated clients were capable assisting in meal preparation and further indicated they should be assisting in preparation at meal time.</p>		<p>as independently as possible, the facility has retrained the staff on assisting clients at meal time. Additionally, the Program Coordinators will do weekly checks at meal time preparation to provide guidance to the staff and observe staff assisting the clients. Any identified issues will be brought to the weekly supervision meeting to allow for discussion and identified training needs.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W009999	<p>9-3-8(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(b)</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 26 medication errors, involving 1 of 4 sampled clients (client #1), to report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of</p>	W009999	In response to W9999, the facility failed to report a med error to BDDS in a timely manner, the facility has reviewed records for any late filings All BDDS will be reviewed by the Programming Director to ensure that filings take place in the required amount of time All staff filing BDDS reports have been re-notified that the reporting guidelines A plan for absences and time off will be established to cover filings in case of a nurse or QIDP being out	11/04/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Developmental Disabilities Services (BDDS) reports, Internal Incident reports (IR) and investigation records was conducted at the facility's administrative office on 9/16/14 at 2:45 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 5/24/14...Date of Knowledge: 5/24/14...Submitted Date: 5/27/14 involving client #1 indicated: "[Client #1] received her morning dose of ibuprofen 800 mg (pain). The dose administered was the correct medication and correct dose but was another consumers medication. [Staff #14] has been taken off med pass and will receive disciplinary action. Staff will be evaluated to retake Medcore."</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 9/16/14 at 5:50 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...16. A medication error or medical treatment error as follows: a. wrong medication given; b. wrong</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/01/2014
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medication dosage given; c. missed medication; d. medication given wrong route; e. medication error that jeopardizes an individual's health and welfare and requires medical attention."</p> <p>An interview with the Licensed practical Nurse (LPN) was conducted on 9/26/14 at 1:55 P.M.. The LPN indicated this incident was not immediately reported to BDDS. The LPN further indicated the incident should have been reported within 24 hours to BDDS.</p> <p>9-3-1(b)</p>				