

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 02/03/2015
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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W 000 Bldg. 00	<p>This visit was a post certification revisit to a full recertification and state licensure survey completed on October 1, 2014.</p> <p>Dates of survey: January 28, 29, and February 3, 2015.</p> <p>Facility number: 001194 Provider number: 15G628 AIM number: 100245710</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed February 16, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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, the facility failed to develop and/or implement abuse/neglect policies and</p>	W 149	In regard to W149, the facility failed to develop/ and or implement abuse/neglect policies and procedures to prevent	03/05/2015

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.

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	<p>procedures to prevent recurrent falls in the bathroom for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies to thoroughly investigate neglect in regards to lack of supervision while a client remained on the floor for an unknown amount of time due to a fall and/or seizure for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies and procedures to prevent and to thoroughly investigate ingestion of hazardous material in regards to a suicide attempt for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect polices and procedures to prevent medication errors with potential for harm for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies to thoroughly investigate an allegation of client to client abuse for 1 of 4 sampled clients (#2).</p>		<p>recurrent falls in the bathroom, the agency reviewed the falls as part of the monitoring of thresholds tracked and knew there were procedures being put in place to prevent falls, however the actual incidents were not thoroughly investigated To ensure this does not occur, ALL incident reports that are BDDS reportable will be thoroughly investigated utilizing the agency investigation forms and procedures All investigations will be reviewed in weekly safety and or HRC committee meetings All investigations will be assigned by Director to appropriate PC or QIDP Once investigations are completed and reviewed they will be attached to the correlating BDDS report paperwork This will ensure proper procedures were implemented, followed and changed as needed All falls, even falls not BDDS reportable such as witnessed falls have some level of an internal investigation, including but not limited to inquiries and questions asked to determine the cause and to put corrective/protective measures in place to prevent the next fall Tracking for trends and patterns is done for all falls and reviewed in HRC and Safety meetings All falls are reported on an incident report form</p>	

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	<p>Findings include:</p> <p>1) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed. The review indicated Client #1 had a BDDS report dated 12/14/14 which indicated "[Client #1] was in the shower (sic) staff noted her going in the shower at approximately 8PM, Staff (sic) checked on [Client #1] at approximately 8:15PM and was still in the shower and she said she was ok. At 8:21 Pm (sic) staff heard a bang coming from the hallway. Staff immediately responded and checked in the bathroom and found [Client #1] laying (sic) on the floor." The report indicated "[Client #1] was laying (sic) on her left side with the back of her head against the bathroom closet. No injury apparent (sic) staff did not move her and called 911. She was noted to be in a seizure, staff did not obtain vitals as they did not want to move her until paramedics arrived. Staff contacted LPN (licensed practical nurse) and [Client #1] was transported to [hospital]. Labs were obtained and CT (computed tomography) scan with no findings. [Client #1] was released to home with no new orders, and to take Ibuprofen (anti-inflammatory) as needed for pain." The report indicated</p>			
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	<p>"seizure plan will be updated and trained on. Staff will be with [Client #1] during shower activity to ensure safety."</p> <p>A BDDS report dated 1/1/15 indicated "[Client #1] was using the restroom when staff heard a noise from the bathroom and went to check. [Client #1] was found sitting on the floor having seizure like activity non convulsive (sic)." The report indicated "No injuries found. Helmet was on at time of fall. Vitals WNL (within normal limits). [Client #1] was taken to her bedroom to rest. Cause of seizures are unknown." The report indicated "[Client #1] will continue to wear her helmet during wake hours. [Client #1] was monitored by staff though out (sic) the evening. Seizure protocol will continue to be followed."</p> <p>A BDDS follow up report dated 1/9/15 indicated "[Client #1] fell while using the restroom. Helmet was in place."</p> <p>A BDDS report dated 1/14/15 indicated "[Client #1] was in the bathroom brushing her teeth when staff heard her fall. She had her helmet on. 911 (emergency hotline) was phoned by staff. EMT (emergency medical technician) arrived and [Client #1] was coming out of her seizure. [Client #1] was not transported." The report indicated</p>			

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	<p>"[Client #1] protocol is in place and (sic) does not need to (sic) sent to the hospital for a fall if her helmet is on and no distress or injury noted. No injury was noted and no distress. [Client #1] recovered from her seizure and continued the evening with no distress and no injuries." The report indicated "[Client #1] was monitored by staff and vitals obtained through out the evening, night and in the morning to monitor."</p> <p>A follow up BDDS report dated 1/16/15 indicated "[Client #1] fell in the bathroom when she was in brushing her teeth. Staff heard the fall. No injuries noted. Hospital transport was not needed deemed stable by emts (sic)." The BDDS section "Describe systemic actions being taken to assume health and safety issues" indicated the following:</p> <p>"1) Triggers of seizures are unknown 2) Seizure medications are taken as prescribed 3) Neurologist is seen and has been notified 4) [Client #1]'s health is stable."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities. Record review indicated Client #1's "High Risk</p>			

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	<p>Plan" dated 3/24/14 for seizures indicated "history of Epilepsy since age of 3 year (sic) old with complex partial seizure to grand mal seizures. Ranging from one or more a week. Usually result in not being able to talk or respond approximately an hour post seizure. History of Grand mal seizures through apx (approximately) 2 times a year leading to hospitalizations last 11-6-13, due to fall. Staff will manage seizures with maintaining comfort and safety for consumer and following med list for PRNS (given as needed) as listed." The high risk plan indicated "if change in condition is noted, difficulty breathing, change in skin color, convulsions, 911 will be called."</p> <p>Record review indicated Client #1's ISP (Individual Support Plan) included a "Seizure Protocol". Client #1's seizure protocol indicated it had been updated 12/14/14 to include "Bathing Protocol." Client #1's updated "Bathing Protocol" indicated the following:</p> <p>"1) When bathing staff will need to be in the bathroom during shower activity (sic) curtain may be pulled for privacy.</p> <p>2) Staff to check on [Client #1] during shower by asking her if she is ok.</p> <p>3) If bathing [Client #1] needs to be</p>			

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	<p>monitored more frequently bath water can not come past her waist line.</p> <p>4) IF STRONG FEELINGS OF SEIZURE ACTIVITY</p> <p>a. Encourage her to wait until she feel (sic) safe</p> <p>b. If requests a shower or bath (bath preferred) during that time staff will need to be in the same room as her during the entire process (curtain may be pulled 3/4 of the way)</p> <p>c. If seizure occurs during this time the water will be drained</p> <p>d. Head padded with towel</p> <p>e. If head is hit hard during this time 911 to be phoned immediately."</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated Client #1 did not have a specific fall plan because her falls were seizure related. The Nurse indicated Client #1 did have a seizure risk plan which addressed Client #1's fall potential while bathing and/or showering. The Nurse indicated Client #1's bathing protocol of her seizure plan was updated on 12/14/14 after her fall incident on 12/14/14 to include additional monitoring during bathing/showering. The Nurse indicated Client #1 has a physician prescribed helmet to protect her head during falls and staff are to ensure Client #1 has the helmet on. The Nurse</p>			

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	<p>indicated the physician indicated Client #1 did not need further medical treatment for a fall in the bathroom if she had her helmet on and if there were no other signs or symptoms of injury. The Nurse indicated Client #1's fall plan was not further updated for fall precautions in the restroom due to privacy. The Nurse indicated no investigations were completed for any of Client #1's falls in the restroom other than to ensure Client #1 had her helmet on at the time of the fall. The Nurse indicated Client #1 was allowed to use the restroom by herself if she was wearing the helmet. The Nurse indicated there was no further documentation to indicate a thorough investigation was completed or that additional precautions were added with each subsequent bathroom fall.</p> <p>During an interview on 1/29/15 at 11:35AM, the Administrator indicated falls were not typically investigated and was unsure which falls would require an investigation. The Administrator indicated she understood the facility should ensure risk plans were adequate, being implemented as written, and staff supervision was sufficient to prevent falls.</p> <p>2) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental</p>			

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	<p>Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated Client #1 had a BDDS report dated 11/24/14 which indicated "[Client #1] was in (facility owned) day services when she was noted to have slid of (sic) the sofa and on to (sic) the floor. She was found after lunch when staff went to get her for medication administration." The report indicated "[Client #1] will continue to be monitored though out (sic) the day and invited to come to join in activities."</p> <p>A follow up BDDS report dated 11/24/14 indicated "[Client #1] was noted to slid (sic) off the sofa at day services onto the floor without injury." The report indicated "Time on the floor was unknown (sic) it was less than 30 minutes as it was after lunch and before med pass. Staff was alerted by another consumer that she slid onto the floor. [Client #1] requires limited supervision at day services and is prompted multiple times to engage in activities."</p> <p>Record review indicated Client #1's ISP included a "Seizure Protocol." Client #1's seizure protocol dated 5/9/14 indicated it had been updated 12/14/14 to include "Bathing Protocol." Client #1's updated "Bathing Protocol" of Client #1's "Seizure Protocol" indicated the</p>			

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	<p>following (all inclusive with the exception of Client #1's "Bathing Protocol"):</p> <p>"[Client #1] has various types of seizures. -may continue to have her fine motor skills through out (sic) the seizure. -may collapse to the ground and convulse -may wring hands together -may appear to stare past you -she may feel a seizure coming on.</p> <p>[Client #1] is having epileptic discharges, which are small currents through the brain that are similar to the start of a seizure, but are not fully transmitted to seizure like activity. Her medications appear to help stop the full seizure from happening and stop it at a discharge. She may feel an aura prior to the seizure activity.</p> <p>Protocol: If [Client #1] is feeling an increase in seizure like activity:</p> <ol style="list-style-type: none"> 1) Encourage deep breathing 2) Ask if she would like to rest 3) Reassure that every thing will be ok 4) Monitor every 30 minutes 5) Ask if [Client #1] is feeling an aura <ol style="list-style-type: none"> a. If tired and asked to lay (sic) down assure her that she may b. Monitor for seizure activity 			

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	<p>c. Check every 30 minutes when laying (sic) down</p> <p>d. Ensure no hazardous object in area</p> <p>e. If side rail available please use (to) ensure safety</p> <p>f. Avoid any community outings when strong feelings of seizures are present."</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated Client #1 did not have a specific fall plan because her falls were seizure related. The Nurse indicated Client #1's incidents at the facility owned day program services would be investigated by her and the Administrator as necessary. The Nurse indicated no investigation was done for Client #1 being found on the floor after an extended period of time. The Nurse indicated although she understood which incidents were BDDS (Bureau of Developmental Disabilities Services) reportable, she did not know falls were to be investigated, which falls were to be investigated, nor who would have been responsible to complete such investigations. The Nurse indicated she did not know why or how long Client #1 was left unsupervised when she was found on the floor. The Nurse indicated the Administrator and the QIDP (Qualified Intellectual Disabilities Professional) would normally do abuse/neglect investigations as necessary.</p>			

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	<p>During an interview on 1/29/15 at 11:35AM, the Administrator indicated falls were not typically investigated and she was unsure which falls would require an investigation. The Administrator indicated she understood the facility should ensure risk plans were adequate, being implemented as written, and staff supervision was sufficient to prevent falls.</p> <p>3) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated Client #1 had a BDDS report dated 1/22/15 which indicated "[Client #1] was at (sic) group home when she came to staff and informed them she called 911 (emergency hotline) because she drank shampoo, conditioner, and hair products in attempt to end her life. Police arrived along with paramedics. [Client #1] was transported by ambulance to [hospital] for observation and eval (evaluation)." The report indicated "[Client #1] was taken tp (sic) [hospital] inpatient psychiatric facility under an emergency order of detainment. She was taken by [police] department handcuffed per [police] policy." The report indicated "[Client #1] will stay at [inpatient psychiatric facility], and discharge</p>			

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	<p>instructions will be followed upon receiving them."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities. Record review indicated Client #1's ISP (individual support plan) dated 5/13/14 indicated Client #1 "can verbally state her wants and needs" and had "behavior issues" of "depression, SIB (self-injurious behavior), Attention Seeking behaviors, Poor (sic) judgement-Social Situations."</p> <p>Record review indicated Client #1's 3/24/14 "Risk Profile" indicated (not all inclusive) "suicidal ideation" and "seizures." Client #1's "High Risk Plan" for "Suicidal Ideation" which indicated "will be followed by a behavioral specialist and monitored for mood changes. Will attend therapy sessions as needed and be followed by a psychiatrist."</p> <p>Record review indicated Client #1 had a BSP (behavior support plan) dated 5/13/14 which indicated the targeted behaviors of "depressive characteristics" and "social boundaries." Client #1's BSP indicated "reactive strategies" which included "Suicide Talk or Threats" and "Suicide Watch." Client #1's BSP</p>			

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	<p>reactive strategies for suicide "talk or threats" included the following:</p> <p>"* If [Client #1] is thinking about, talking about or threatening to hurt herself, immediately contact the House Manager, QDIP (sic) (Qualified Intellectual Disabilities Professional), and/or Behavior Specialist to inform them of the behavior. Next steps will be determined at this time to ensure her safety.</p> <p>* Talk with [Client #1] to understand how she is feeling. Stay calm and use a kind, matter of fact tone. If there is an issue, focus on the issue and how to solve it.</p> <p>* Ask [Client #1] if she has a plan to harm herself and to explain the plan.</p> <p>* If no plan, encourage [Client #1] to use various coping strategies such as writing down feelings, drawing how she feels, listening to music, etc.</p> <p>-- Have staff do a visual check on [Client #1] every 10-15 minutes to make sure that she is safe.</p> <p>--When [Client #1] is in her room, keep the door to her room open unless she is changing clothes.</p> <p>--[Client #1] is to have no access to medication or knives (even eating utensils) without supervision due to past</p>			

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	<p>behavior.</p> <p>--[Client #1] is to be monitored during bathing due to past behavior."</p> <p>Client #1's BSP indicated a "Suicide Watch" plan which indicated the following (not all inclusive):</p> <p>"If a suicide watch is put in place:</p> <ul style="list-style-type: none"> * any item that she could use to harm herself will be removed from her bedroom and her bathroom. These items include the following: * cords, belts, shoelaces or long items that could be used to wrap around her neck * anything made of glass such as picture frames, dishes * sharp, pointed objects such as razors, needles, scissors * poisons such as cleaners, sprays or perfumes * anything else that she could use to harm herself." <p>Record review indicated a hand-written timeline by DSP (direct support professional) #1 of the events of 1/22/15. The statement indicated the following:</p> <p>"3:00(PM) [Client #1] was picked up from workshop but was acting sad.</p> <p>3:30(PM) [Client #1] arrived home and</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 02/03/2015
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>sat in commons (common area).</p> <p>4:00(PM) [Client #1] was still sitting in commons.</p> <p>4:30(PM) [Client #1] was trying to eat dinner. She ate 50% then vomited all over table. I walked her to the front bathroom and took her vitals. Pulse was 114 but blood pressure and temp (temperature) were okay. [Client #1] kept dry heaving in the trash can. [Client #1] sat in commons until 5:30 (PM).</p> <p>5:30(PM) [Client #1] said she was going to lay (sic) down for awhile</p> <p>6:00(PM) Dispatch called the RGH (group home) phone and said they received a call from [Client #1] and that she said she drank 3 bottles of shampoo & (and) conditioner and some hair dye. Dispatch said help was on the way.</p> <p>6:05(PM) 4 police officers and approximately 8 paramedics arrived @ (at) the house. [Client #1] said she was trying to kill herself. Paramedics found 3 empty bottles of shampoo, but no hair dye in [Client #1]'s room.</p> <p>6:20(PM) [Client #1] was on stretcher yelling "[DSP #1], help me! I'm dying!" The whole time I was communicating</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>with [House Manager]. I gave paramedics all medical information needed. I made copies of [Client #1]'s mar (medication administration record). [Client #1] left with ambulance @ 6:30pm on 1-21-15."</p> <p>On 1/28/15 at 10:36 AM, record review indicated no further investigation. Record review indicated no documentation which included statements from day service program staff, residential staff, or residents to indicate whether [Client #1] had made suicidal comments and whether her BSP (behavior support plan) suicide plan or a suicide watch should have been implemented.</p> <p>During an concurrent interview on 1/29/15 at 12:56 PM, the facility Nurse indicated she contacted DSP (direct support professional) #1 and asked her to write out a timeline of events surrounding Client #1's suicide attempt. The Nurse indicated she does investigation of any necessary incidents which involve medical aspects but did not know a suicide attempt would need to be investigated for potential neglect. The Nurse indicated the QIDP (Qualified Intellectual Disabilities Professional) would be responsible for any client behavioral issues which needed to be addressed. The QIDP indicated she 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 02/03/2015
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>new in her position and would not have known an investigation should have been completed. The Nurse indicated no other potential witnesses were interviewed to investigate whether Client #1's suicide protocol and watch should have been implemented as written in her BSP (Behavior Support Plan).</p> <p>4) A BDDS report dated 10/21/14 indicated "On 10-20-2014 it was discovered that [Client #1] received the wrong dose of phenobarbital (anti-convulsant) on 10-17 (14), 10-18 (14), and 10-19 (14) in the AM. The correct dose was 64.8 mg total BID (twice daily)." The report indicated the MAR (medication administration record) dated 10/14 was adjusted to medication that was correct to what Pharmacy (sic) sent. Previous dose was 34.4 (mg, milligrams) tabs BID. Pharmacy sent 64.8 mg tabs. [Physician] was notified and no new orders received. No adverse effects noted from wrong dose."</p> <p>A BDDS report dated 11/11/14 indicated "[Client #1] did not receive her morning dose of Clonazepam (Klonopin, benzodiazepine) 0.5 mg Vimpat (anti-convulsant) 150 mg phenobarbital (anti-convulsant) 64.8 mg. The medication was signed off but not passed." The report indicated staff</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>received disciplinary action and retraining.</p> <p>A BDDS report dated 12/29/14 indicated "[Client #1] went home with mother for holiday. She started a titration on 12-24-2014 of switch from Clonazepam (benzodiazepine) to Onfi (clobazam, anti-convulsant). Clonazepam was supposed to be given in the morning and noon and Onfi in the evening. Onfi and Clonazepam was (sic) given in the morning clonazepam at noon and Onfi at night. This was from 12-24-2014 to 12-28-2014. No side effects noted." The BDDS report indicated "[Physician] was contacted and [physician] gave orders of starting the titration over. So order is as follows. Clonazepam 0.5mg in morning and noon and onfi (sic) at night, week 1. Clonazepam 0.5 mg morning only. Onfi at night no noon Clonazepam week 2. Week 3 Onfi in the morning and night and no clonazepam. Family is sent home with medications and daily list of medication."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities.</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated she</p>			

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

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	<p>agreed Client #1's medication administration errors had the potential for harm as she has uncontrollable seizures, recurrent falls due to seizures, and depression with suicidal ideations. The Nurse indicated in each incident, the staff faced disciplinary act and/or retraining as indicated by facility policy.</p> <p>5) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated "Female consumer (Client #3) was walking out of her bedroom and pass (sic) [Client #2]. As she walked passed (sic) she hit him in the chest with a stress ball. This was not witnessed. Police were called to the home by the consumer that was hit. Statements were taken by officer. There was no redness." The report indicated "Police were called to the house by [Client #2]. Statements were taken by officer. Staff were reminded to keep a close eye on consumer were (sic) about for safety."</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated no investigation was completed regarding Client #2's allegation of client to client abuse. The Nurse indicated when the police arrived, Client #2 was discovered attempting to create an injury on himself</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065			
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	<p>and blamed Client #3 for the redness. The Nurse indicated she was not responsible for client to client abuse allegations.</p> <p>During an interview on 1/29/15 at 11:35AM, the Administrator indicated there was no further documentation available to review which indicated Client #2's allegation of client to client abuse was investigated. The Administrator indicated it was facility policy to investigate allegations of client to client abuse.</p> <p>On 1/29/15 at 3:04 PM, the facility "ABUSE, NEGLECT, AND EXPLOITATION" policy (dated January 2014) was reviewed and 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, 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, regulations, and laws."</p> <p>This deficiency was cited on 10/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>						

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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W 154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to investigate a trend of falls in the bathroom for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to investigate potential neglect in regards to adequate supervision for a client with a history of falls due to seizures who was found on the floor after an unknown amount of time due to a fall and/or seizure for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview,</p>	W 154	<p>In regard to W154, the facility failed to develop/ and or implement abuse/neglect policies and procedures to prevent recurrent falls in the bathroom, the agency reviewed the falls as part of the monitoring of thresholds tracked and knew there were procedures being put in place to prevent falls, however the actual incidents were not thoroughly investigated To ensure this does not occur, ALL incident reports that are BDDS reportable will be thoroughly investigated utilizing the agency investigation forms and procedures All investigations will be reviewed in weekly safety and or HRC</p>	03/05/2015

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	<p>the facility failed to thoroughly investigate ingestion of hazardous material in regards to a suicide attempt for 1 of 4 sampled clients (#1).</p> <p>Based on record review and interview, the facility failed to develop and/or implement abuse/neglect policies to thoroughly investigate an allegation of client to client abuse for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>1) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated Client #1 had a BDDS report dated 12/14/14 which indicated "[Client #1] was in the shower (sic) staff noted her going in the shower at approximately 8PM, Staff (sic) checked on [Client #1] at approximately 8:15PM and was still in the shower and she said she was ok. At 8:21 Pm (sic) staff heard a bang coming from the hallway. Staff immediately responded and checked in the bathroom and found [Client #1] laying (sic) on the floor." The report indicated "[Client #1] was laying (sic) on her left side with the back of her head against the bathroom closet. No injury apparent (sic) staff did not move her and called 911. She was</p>		<p>committee meetings All investigations will be assigned by Director to appropriate PC or QIDP Once investigations are completed and reviewed they will be attached to the correlating BDDS report paperwork This will ensure proper procedures were implemented, followed and changed as needed and to ensure abuse/neglect and exploitation is ruled out as part of the investigation and is addressed and investigated if found All falls, even falls not BDDS reportable such as witnessed falls have some level of an internal investigation, including but not limited to inquiries and questions asked to determine the cause and to put corrective/protective measures in place to prevent the next fall Tracking for trends and patterns is done for all falls. All falls are reported on an incident report form</p>	

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--	--

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	<p>noted to be in a seizure, staff did not obtain vitals as they did not want to move her until paramedics arrived. Staff contacted LPN (licensed practical nurse) and [Client #1] was transported to [hospital]. Labs were obtained and CT (computed tomography) scan with no findings. [Client #1] was released to home with no new orders, and to take Ibuprofen (anti-inflammatory) as needed for pain." The report indicated "seizure plan will be updated and trained on. Staff will be with [Client #1] during shower activity to ensure safety."</p> <p>A BDDS report dated 1/1/15 indicated "[Client #1] was using the restroom when staff heard a noise from the bathroom and went to check. [Client #1] was found sitting on the floor having seizure like activity non convulsive (sic)." The report indicated "No injuries found. Helmet was on at time of fall. Vitals WNL (within normal limits). [Client #1] was taken to her bedroom to rest. Cause of seizures are unknown." The report indicated "[Client #1] will continue to wear her helmet during wake hours. [Client #1] was monitored by staff though out (sic) the evening. Seizure protocol will continue to be followed."</p> <p>A BDDS follow up report dated 1/9/15 indicated "[Client #1] fell while using the</p>			

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--	--

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	<p>restroom. Helmet was in place."</p> <p>A BDDS report dated 1/14/15 indicated "[Client #1] was in the bathroom brushing her teeth when staff heard her fall. She had her helmet on. 911 (emergency hotline) was phoned by staff. EMT (emergency medical technician) arrived and [Client #1] was coming out of her seizure. [Client #1] was not transported." The report indicated "[Client #1] protocol is in place and (sic) does not need to (sic) sent to the hospital for a fall if her helmet is on and no distress or injury noted. No injury was noted and no distress. [Client #1] recovered from her seizure and continued the evening with no distress and no injuries." The report indicated "[Client #1] was monitored by staff and vitals obtained through out the evening, night and in the morning to monitor."</p> <p>A follow up BDDS report dated 1/16/15 indicated "[Client #1] fell in the bathroom when she was in brushing her teeth. Staff heard the fall. No injuries noted. Hospital transport was not needed deemed stable by emts (sic)." The BDDS section "Describe systemic actions being taken to assume health and safety issues" indicated the following:</p> <p>"1) Triggers of seizures are unknown</p>			

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	<p>2) Seizure medications are taken as prescribed</p> <p>3) Neurologist is seen and has been notified</p> <p>4) [Client #1]'s health is stable."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities. Record review indicated Client #1's "High Risk Plan" dated 3/24/14 for seizures indicated "history of Epilepsy since age of 3 year (sic) old with complex partial seizure to grand mal seizures. Ranging from one or more a week. Usually result in not being able to talk or respond approximately an hour post seizure. History of Grand mal seizures through apx (approximately) 2 times a year leading to hospitalizations last 11-6-13, due to fall. Staff will manage seizures with maintaining comfort and safety for consumer and following med list for PRNS (given as needed) as listed." The high risk plan indicated "if change in condition is noted, difficulty breathing, change in skin color, convulsions, 911 will be called."</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated Client #1 did not have a specific fall plan because her falls were seizure related. The Nurse indicated Client #1 did have a seizure</p>			

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	<p>risk plan which addressed Client #1's fall potential while bathing and/or showering. The Nurse indicated Client #1's bathing protocol of her seizure plan was updated on 12/14/14 after her fall incident on 12/14/14 to include additional monitoring during bathing/showering. The Nurse indicated no investigations were completed for any of Client #1's falls in the restroom other than to ensure Client #1 had her helmet on at the time of the fall. The Nurse indicated Client #1 was allowed to use the restroom by herself if she was wearing the helmet. The Nurse indicated there was no further documentation to indicate a thorough investigation was completed.</p> <p>During an interview on 1/29/15 at 11:35AM, the Administrator indicated falls were not typically investigated and was unsure which falls would require an investigation. The Administrator indicated she understood the facility should ensure risk plans were adequate, being implemented as written, and staff supervision was sufficient to prevent falls.</p> <p>2) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated Client #1 had a BDDS report</p>			

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	<p>dated 11/24/14 which indicated "[Client #1] was in (facility owned) day services when she was noted to have slid of (sic) the sofa and on to (sic) the floor. She was found after lunch when staff went to get her for medication administration." The report indicated "[Client #1] will continue to be monitored though out (sic) the day and invited to come to join in activities."</p> <p>A follow up BDDS report dated 11/24/14 indicated "[Client #1] was noted to slid (sic) off the sofa at day services onto the floor without injury." The report indicated "Time on the floor was unknown (sic) it was less than 30 minutes as it was after lunch and before med pass. Staff was alerted by another consumer that she slid onto the floor. [Client #1] requires limited supervision at day services and is prompted multiple times to engage in activities."</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated Client #1's incidents at the facility owned day program services would be investigated by either herself, the QIDP (Qualified Intellectual Disabilities Professional), and/or the Administrator as necessary. The Nurse indicated no investigation was done for Client #1 being found on the floor after an extended period of time.</p>			

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	<p>The Nurse indicated although she understood which incidents were BDDS (Bureau of Developmental Disabilities Services) reportable, she did not know falls were to be investigated, which falls were to be investigated, nor who would have been responsible to complete such investigations. The Nurse indicated she did not know why or how long Client #1 was left unsupervised when she was found on the floor. The Nurse indicated the Administrator and the QIDP (Qualified Intellectual Disabilities Professional) would normally do abuse/neglect investigations as necessary.</p> <p>During an interview on 1/29/15 at 11:35AM, the Administrator indicated falls were not typically investigated and was unsure which falls would constitute an investigation. The Administrator indicated she understood the facility should ensure risk plans were adequate, being implemented as written, and staff supervision was sufficient to prevent falls.</p> <p>3) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated Client #1 had a BDDS report dated 1/22/15 which indicated "[Client #1] was at group home when she came to</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 02/03/2015
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>staff and informed them she called 911 (emergency hotline) because she drank shampoo, conditioner, and hair products in attempt to end her life. Police arrived along with paramedics. [Client #1] was transported by ambulance to [hospital] for observation and eval (evaluation)." The report indicated "[Client #1] was taken tp (sic) [hospital] inpatient psychiatric facility under an emergency order of detainment. She was taken by [police] department handcuffed per [police] policy." The report indicated "[Client #1] will stay at [inpatient psychiatric facility], and discharge instructions will be followed upon receiving them."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities. Record review indicated Client #1's ISP (individual support plan) dated 5/13/14 indicated Client #1 "can verbally state her wants and needs" and had "behavior issues" of "depression, SIB (self-injurious behavior), Attention Seeking behaviors, Poor (sic) judgement-Social Situations."</p> <p>Record review indicated Client #1's 3/24/14 "Risk Profile" indicated (not all inclusive) "suicidal ideation" and "seizures." Client #1's "High Risk Plan"</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>for "Suicidal Ideation" which indicated "will be followed by a behavioral specialist and monitored for mood changes. Will attend therapy sessions as needed and be followed by a psychiatrist."</p> <p>Record review indicated Client #1 had a BSP (behavior support plan) dated 5/13/14 which indicated the targeted behaviors of "depressive characteristics" and "social boundaries." Client #1's BSP indicated "reactive strategies" which included "Suicide Talk or Threats" and "Suicide Watch." Client #1's BSP reactive strategies for suicide "talk or threats" included the following:</p> <p>** If [Client #1] is thinking about, talking about or threatening to hurt herself, immediately contact the House Manager, QDIP (sic) (Qualified Intellectual Disabilities Professional), and/or Behavior Specialist to inform them of the behavior. Next steps will be determined at this time to ensure her safety.</p> <p>* Talk with [Client #1] to understand how she is feeling. Stay calm and use a kind, matter of fact tone. If there is an issue, focus on the issue and how to solve it.</p> <p>* Ask [Client #1] if she has a plan to</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>harm herself and to explain the plan.</p> <p>* If no plan, encourage [Client #1] to use various coping strategies such as writing down feelings, drawing how she feels, listening to music, etc.</p> <p>-- Have staff do a visual check on [Client #1] every 10-15 minutes to make sure that she is safe.</p> <p>--When [Client #1] is in her room, keep the door to her room open unless she is changing clothes.</p> <p>--[Client #1] is to have no access to medication or knives (even eating utensils) without supervision due to past behavior.</p> <p>--[Client #1] is to be monitored during bathing due to past behavior."</p> <p>Client #1's BSP indicated a "Suicide Watch" plan which indicated the following (not all inclusive):</p> <p>"If a suicide watch is put in place:</p> <p>* any item that she could use to harm herself will be removed from her bedroom and her bathroom. These items include the following:</p> <p>* cords, belts, shoelaces or long items that could be used to wrap around her neck</p> <p>* anything made of glass such as picture frames, dishes</p> <p>* sharp, pointed objects such as razors,</p>			

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	<p>needles, scissors</p> <p>* poisons such as cleaners, sprays or perfumes</p> <p>* anything else that she could use to harm herself."</p> <p>Record review indicated a hand-written timeline by DSP (direct support professional) #1 of the events of 1/22/15. The statement indicated the following:</p> <p>"3:00(PM) [Client #1] was picked up from workshop but was acting sad.</p> <p>3:30(PM) [Client #1] arrived home and sat in commons (common area).</p> <p>4:00(PM) [Client #1] was still sitting in commons.</p> <p>4:30(PM) [Client #1] was trying to eat dinner. She ate 50% then vomited all over table. I walked her to the front bathroom an and took her vitals. Pulse was 114 but blood pressure and temp (temperature) were okay. [Client #1] kept dry heaving in the trash can. [Client #1] sat in commons until 5:30 (PM).</p> <p>5:30(PM) [Client #1] said she was going to lay (sic) down for awhile.</p> <p>6:00 (PM) Dispatch called the RGH</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>(group home) phone and said they received a call from [Client #1] and that she said she drank 3 bottles of shampoo & (and) conditioner and some hair dye. Dispatch said help was on the way.</p> <p>6:05 (PM) 4 police officers and approximately 8 paramedics arrived @ (at) the house. [Client #1] said she was trying to kill herself. Paramedics found 3 empty bottles of shampoo, but no hair dye in [Client #1]'s room.</p> <p>6:20 (PM) [Client #1] was on stretcher yelling "[DSP #1], help me! I'm dying!" The whole time I was communicating with [House Manager]. I gave paramedics all medical information needed. I made copies of [Client #1]'s mar (medication administration record). [Client #1] left with ambulance @ 6:30pm on 1-21-15."</p> <p>On 1/28/15 at 10:36 AM, record review indicated no further investigation. Record review indicated no documentation which included statements from day service program staff, residential staff, or residents to indicated whether [Client #1] had made suicidal comments and whether her BSP (behavior support plan) suicide plan or a suicide watch should have been implemented.</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>During an concurrent interview on 1/29/15 at 12:56 PM, the facility Nurse indicated she contacted DSP (direct support professional) #1 and asked her to write out a timeline of events surrounding Client #1's suicide attempt. The Nurse indicated she does investigations of any necessary incidents which involve medical aspects but did not know a suicide attempt would need to be investigated for potential neglect. The Nurse indicated the QIDP (Qualified Intellectual Disabilities Professional) would be responsible for any client behavioral issues which needed to be addressed. The QIDP indicated she was new in her position and would not have known an investigation should have been completed. The Nurse indicated no other potential witnesses were interviewed to investigate whether Client #1's suicide protocol and watch should have been implemented as written in her BSP (Behavior Support Plan).</p> <p>4) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated "Female consumer (Client #3) was walking out of her bedroom and pass (sic) [Client #2]. As she walked passed (sic) she hit him in the chest with a stress ball. This was not witnessed. Police were</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>called to the home by the consumer that was hit. Statements were taken by officer. There was no redness." The report indicated "Police were called to the house by [Client #2]. Statements were taken by officer. Staff were reminded to keep a close eye on consumer were (sic) about for safety."</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated no investigation was completed regarding Client #2's allegation of client to client abuse. The Nurse indicated when the police arrived, Client #2 was discovered attempting to create an injury on himself and blamed Client #3 for the redness. The Nurse indicated she was not responsible for client to client abuse allegations.</p> <p>During an interview on 1/29/15 at 11:35AM, the Administrator indicated there was no further documentation available to review which indicated Client #2's allegation of client to client abuse was investigated. The Administrator indicated it was facility policy to investigate allegations of client to client abuse.</p> <p>This deficiency was cited on 10/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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W 157 Bldg. 00	<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, the facility failed to develop and/or implement sufficient corrective action in regards to recurrent falls in the bathroom which had the potential for harm for 1 of 4 sampled clients (#1).</p> <p>Findings include:</p> <p>On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) from 10/1/14 to 1/28/15 were reviewed and indicated Client #1 had a BDDS report dated 12/14/14 which indicated "[Client #1] was in the shower (sic) staff noted her going in the shower at approximately 8PM, Staff (sic) checked on [Client #1] at approximately 8:15PM and was still in the shower and she said she was ok. At 8:21 Pm (sic) staff heard a bang coming from the hallway. Staff immediately responded and checked in the bathroom and found [Client #1] laying (sic) on the floor." The report indicated "[Client #1]</p>	W 157	In regard to W157, the facility failed to develop/ and or implement abuse/neglect policies and procedures to prevent recurrent falls in the bathroom, the agency reviewed the falls as part of the monitoring of thresholds tracked and knew there were procedures being put in place to prevent falls, however the actual incidents were not thoroughly investigated to ensure protocol was being followed. The agency identified the seizures as the reason for the falls, but needed to investigate the possibility of the seizures being caused by anything else. All incident reports that are BDDS reportable will be thoroughly investigated utilizing the agency investigation forms and procedures All investigations will be reviewed in weekly safety and or HRC committee meetings This allows for a team review of the incident and procedures needed All investigations will be assigned by Director to appropriate PC or QIDP Once investigations are	03/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2015
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
--	--

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	<p>was laying on her left side with the back of her head against the bathroom closet. No injury apparent (sic) staff did not move her and called 911. She was noted to be in a seizure, staff did not obtain vitals as they did not want to move her until paramedics arrived. Staff contacted LPN (licensed practical nurse) and [Client #1] was transported to [hospital]. Labs were obtained and CT (computed tomography) scan with no findings. [Client #1] was released to home with no new orders, and to take Ibuprofen (anti-inflammatory) as needed for pain." The report indicated "seizure plan will be updated and trained on. Staff will be with [Client #1] during shower activity to ensure safety."</p> <p>A BDDS report dated 1/1/15 indicated "[Client #1] was using the restroom when staff heard a noise from the bathroom and went to check. [Client #1] was found sitting on the floor having seizure like activity non convulsive (sic)." The report indicated "No injuries found. Helmet was on at time of fall. Vitals WNL (within normal limits). [Client #1] was taken to her bedroom to rest. Cause of seizures are unknown." The report indicated "[Client #1] will continue to wear her helmet during wake hours. [Client #1] was monitored by staff though out (sic) the evening. Seizure protocol will continue</p>		<p>completed and reviewed they will be attached to the correlating BDDS report paperwork This will ensure proper procedures were implemented, followed and changed as needed This will also ensure staff receive sufficient corrective action if needed All falls, even falls not BDDS reportable such as witnessed falls have some level of an internal investigation, including but not limited to inquiries and questions asked to determine the cause and to put corrective/protective measures in place to prevent the next fall Tracking for trends and patterns is done for all falls. All falls are reported on an incident report form</p>	

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--	---	--	---

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--	--

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	<p>to be followed."</p> <p>A BDDS follow up report dated 1/9/15 indicated "[Client #1] fell while using the restroom. Helmet was in place."</p> <p>A BDDS report dated 1/14/15 indicated "[Client #1] was in the bathroom brushing her teeth when staff heard her fall. She had her helmet on. 911 (emergency hotline) was phoned by staff. EMT (emergency medical technician) arrived and [Client #1] was coming out of her seizure. [Client #1] was not transported." The report indicated "[Client #1] protocol is in place and (sic) does not need to (sic) sent to the hospital for a fall if her helmet is on and no distress or injury noted. No injury was noted and no distress. [Client #1] recovered from her seizure and continued the evening with no distress and no injuries." The report indicated "[Client #1] was monitored by staff and vitals obtained through out the evening, night and in the morning to monitor."</p> <p>A follow up BDDS report dated 1/16/15 indicated "[Client #1] fell in the bathroom when she was in brushing her teeth. Staff heard the fall. No injuries noted. Hospital transport was not needed deemed stable by emts (sic)." The BDDS section "Describe systemic actions being</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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	<p>taken to assume health and safety issues" indicated the following:</p> <p>"1) Triggers of seizures are unknown 2) Seizure medications are taken as prescribed 3) Neurologist is seen and has been notified 4) [Client #1]'s health is stable."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities. Record review indicated Client #1's "High Risk Plan" dated 3/24/14 for seizures indicated "history of Epilepsy since age of 3 year (sic) old with complex partial seizure to grand mal seizures. Ranging from one or more a week. Usually result in not being able to talk or respond approximately an hour post seizure. History of Grand mal seizures through apx (approximately) 2 times a year leading to hospitalizations last 11-6-13, due to fall. Staff will manage seizures with maintaining comfort and safety for consumer and following med list for PRNS (given as needed) as listed." The high risk plan indicated "if change in condition is noted, difficulty breathing, change in skin color, convulsions, 911 will be called."</p> <p>Record review indicated Client #1's ISP</p>			

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	<p>(Individual Support Plan) included a "Seizure Protocol". Client #1's seizure protocol indicated it had been updated 12/14/14 to include "Bathing Protocol." Client #1's updated "Bathing Protocol" indicated the following:</p> <p>"1) When bathing staff will need to be in the bathroom during shower activity (sic) curtain may be pulled for privacy.</p> <p>2) Staff to check on [Client #1] during shower by asking her if she is ok.</p> <p>3) If bathing [Client #1] needs to be monitored more frequently bath water can not come past her wait line.</p> <p>4) IF STRONG FEELINGS OF SEIZURE ACTIVITY</p> <p>a. Encourage her to wait until she feel (sic) safe</p> <p>b. If requests a shower or bath (bath preferred) during that time staff will need to be in the same room as her during the entire process (curtain may be pulled 3/4 of the way)</p> <p>c. If seizure occurs during this time the water will be drained</p> <p>d. Head padded with towel</p> <p>e. If head is hit hard during this time 911 to be phone immediately."</p> <p>During an interview on 1/29/15 at 12:56</p>			

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	<p>PM, the facility Nurse indicated Client #1's bathing protocol of her seizure plan was updated on 12/14/14 after her fall incident on 12/14/14 to include additional monitoring during bathing/showering. The Nurse indicated Client #1's has a physician prescribed helmet to protect her head during falls and staff are to ensure Client #1 has the helmet on. The Nurse indicated the physician indicated Client #1 did not need further medical treatment for a fall in the bathroom if she had her helmet on and if there were no other signs or symptoms of injury. The Nurse indicated Client #1's fall plan was not further updated for fall precautions in the restroom due to privacy. The Nurse indicated there was no further documentation that an IDT (interdisciplinary team) conference was held to discuss Client #1's privacy concerns versus the need for safety precautions. The Nurse indicated Client #1 was allowed to use the restroom by herself if she was wearing the helmet. The Nurse indicated there was no further documentation to indicate additional precautions were added with each subsequent bathroom fall.</p> <p>This deficiency was cited on 10/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065
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W 331 Bldg. 00	<p>9-3-2(a)</p> <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's Nurse failed to update a seizure plan as necessary to prevent recurrence of falls in the bathroom as a result of seizures for 1 of 4 clients (#1).</p> <p>Based on record review and interview, the facility's Nurse failed to ensure medications were administered as ordered by the physician for 1 of 4 clients (#1).</p> <p>Findings include:</p> <p>1) A BDDS (Bureau of Developmental Disabilities Services) report dated 10/21/14 indicated "On 10-20-2014 it was discovered that [Client #1] received the wrong dose of phenobarbital (anti-convulsant) on 10-17 (14), 10-18 (14), and 10-19 (14) in the AM. The correct dose was 64.8 mg (milligrams) total BID (twice daily)." The report indicated the MAR (medication administration record) for 10/14 was adjusted to medication that was correct to</p>	W 331	In regard to W331, the agency Nurse failed to develop a sufficient updated care plan for seizures. To ensure plans are updated appropriately and in the files, all files are being reviewed by the RN and contracted RN to ensure plans are developed as needed. 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 Continuity of Care 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. Weekly IDT meetings will reflect discussion of issues and changes needed and follow up IDT meeting minutes will be distributed following the meeting to agency Directors to review	03/05/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2015
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	<p>what Pharmacy (sic) sent. Previous dose was 34.4 (mg, milligrams) tabs BID. Pharmacy sent 64.8 mg tabs. [Physician] was notified and no new orders received. No adverse effects noted from wrong dose."</p> <p>A BDDS report dated 11/11/14 indicated "[Client #1] did not receive her morning dose of Clonazepam (Klonopin, benzodiazepine) 0.5 mg, Vimpat (anti-convulsant) 150 mg, phenobarbital (anti-convulsant) 64.8 mg. The medication was signed off but not passed." The report indicated staff received disciplinary action and retraining.</p> <p>A BDDS report dated 12/29/14 indicated "[Client #1] went home with mother for holiday. She started a titration on 12-24-2014 of switch from Clonazepam (benzodiazepine) to Onfi (clobazam, anti-convulsant). Clonazepam was suppose (sic) to be given in the morning and noon and Onfi in the evening. Onfi and Clonazepam was (sic) given in the morning clonazepam at noon and Onfi at night. The was from 12-24-2014 to 12-28-2014. No side effects noted." The BDDS report indicated "[Physician] was contacted and [physician] gave orders of starting the titration over. So order is as follows. Clonazepam 0.5mg in morning</p>			

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	<p>and noon and onfi (sic) at night, week 1. Clonazepam 0.5 mg morning only. Onfi at night no noon Clonazepam week 2. Week 3 Onfi in the morning and night and no clonazepam. Family is sent home with medications and daily list of medication."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities.</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility's Nurse indicated she agreed Client #1's medication administration errors had the potential for harm as she has uncontrollable seizures, recurrent falls due to seizures, and depression with suicidal ideations. The Nurse indicated in each incident, the staff faced disciplinary act and/or retraining as indicated by facility policy.</p> <p>2) On 1/28/15 at 10:36 AM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/14 to 1/28/15 were reviewed and indicated Client #1 had a BDDS report dated 12/14/14 which indicated "[Client #1] was in the shower (sic) staff noted her going in the shower at approximately 8PM, Staff (sic) checked on [Client #1] at approximately 8:15PM and was still in</p>			

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	<p>the shower and she said she was ok. At 8:21 Pm (sic) staff heard a bang coming from the hallway. Staff immediately responded and checked in the bathroom and found [Client #1] laying (sic) on the floor." The report indicated "[Client #1] was laying (sic) on her left side with the back of her head against the bathroom closet. No injury apparent (sic) staff did not move her and called 911. She was noted to be in a seizure, staff did not obtain vitals as they did not want to move her until paramedics arrived. Staff contacted LPN (licensed practical nurse) and [Client #1] was transported to [hospital]. Labs were obtained and CT (computed tomography) scan with no findings. [Client #1] was released to home with no new orders, and to take Ibuprofen (anti-inflammatory) as needed for pain." The report indicated "seizure plan will be updated and trained on. Staff will be with [Client #1] during shower activity to ensure safety."</p> <p>A BDDS report dated 1/1/15 indicated "[Client #1] was using the restroom when staff heard a noise from the bathroom and went to check. [Client #1] was found sitting on the floor having seizure like activity non convulsive (sic)." The report indicated "No injuries found. Helmet was on at time of fall. Vitals WNL (within normal limits). [Client #1] was taken to</p>			

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	<p>her bedroom to rest. Cause of seizures are unknown." The report indicated "[Client #1] will continue to wear her helmet during wake (sic) hours. [Client #1] was monitored by staff though out (sic) the evening. Seizure protocol will continue to be followed."</p> <p>A BDDS follow up report dated 1/9/15 indicated "[Client #1] fell while using the restroom. Helmet was in place."</p> <p>A BDDS report dated 1/14/15 indicated "[Client #1] was in the bathroom brushing her teeth when staff heard her fall. She had her helmet on. 911 (emergency hotline) was phoned by staff. EMT (emergency medical technician) arrived and [Client #1] was coming out of her seizure. [Client #1] was not transported." The report indicated "[Client #1] protocol is in place and does not need to sent to the hospital for a fall if her helmet is on and no distress or injury noted. No injury was noted and no distress. [Client #1] recovered from her seizure and continued the evening with no distress and no injuries." The report indicated "[Client #1] was monitored by staff and vitals obtained through out the evening, night and in the morning to monitor."</p> <p>A follow up BDDS report dated 1/16/15</p>			

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	<p>indicated "[Client #1] fell in the bathroom when she was in brushing her teeth. Staff heard the fall. No injuries noted. Hospital transport was not needed deemed stable by emts (sic)." The BDDS report section "Describe systemic actions being taken to assume health and safety issues" indicated the following:</p> <p>"1) Triggers of seizures are unknown 2) Seizure medications are taken as prescribed 3) Neurologist is seen and has been notified 4) [Client #1]'s health is stable."</p> <p>On 1/28/15 at 11:36 AM, record review indicated Client #1's diagnoses included, but were not limited to, seizure disorder and intellectual disabilities. Record review indicated Client #1's "High Risk Plan" dated 3/24/14 for seizures indicated "history of Epilepsy since age of 3 year (sic) old with complex partial seizure to grand mal seizures. Ranging from one or more a week. Usually result in not being able to talk or respond approximately an hour post seizure. History of Grand mal seizures through apx (approximately) 2 times a year leading to hospitalizations last 11-6-13, due to fall. Staff will manage seizures with maintaining comfort and safety for consumer and following med list for PRNS (given as</p>			

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	<p>needed) as listed." The high risk plan indicated "if change in condition is noted, difficulty breathing, change in skin color, convulsions, 911 will be called."</p> <p>Record review indicated Client #1's ISP (Individual Support Plan) included a "Seizure Protocol." Client #1's seizure protocol indicated it had been updated 12/14/14 to include "Bathing Protocol." Client #1's updated "Bathing Protocol" indicated the following:</p> <p>"1) When bathing staff will need to be in the bathroom during shower activity (sic) curtain may be pulled for privacy.</p> <p>2) Staff to check on [Client #1] during shower by asking her if she is ok.</p> <p>3) If bathing [Client #1] needs to be monitored more frequently bath water can not come past her waist line.</p> <p>4) IF STRONG FEELINGS OF SEIZURE ACTIVITY</p> <p>a. Encourage her to wait until she feel (sic) safe</p> <p>b. If requests a shower or bath (bath preferred) during that time staff will need to be in the same room as her during the entire process (curtain may be pulled 3/4 of the way)</p> <p>c. If seizure occurs during this time the</p>			

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	<p>water will be drained</p> <p>d. Head padded with towel</p> <p>e. If head is hit hard during this time 911 to be phone (sic) immediately."</p> <p>During an interview on 1/29/15 at 12:56 PM, the facility Nurse indicated Client #1's bathing protocol of her seizure plan was updated on 12/14/14 after her fall incident on 12/14/14 to include additional monitoring during bathing/showering. The Nurse indicated Client #1's has a physician prescribed helmet to protect her head during falls and staff are to ensure Client #1 has the helmet on. The Nurse indicated the physician indicated Client #1 did not need further medical treatment for a fall in the bathroom if she had her helmet on and if there were no other signs or symptoms of injury. The Nurse indicated Client #1's fall plan was not further updated for fall precautions in the restroom due to privacy. The Nurse indicated there was no further documentation that an IDT (interdisciplinary team) conference was held to discuss Client #1's privacy concerns versus the need for safety precautions. The Nurse indicated Client #1 was allowed to use the restroom by herself if she was wearing the helmet. The Nurse indicated there was no further documentation to indicate additional precautions were added with each</p>			

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W 999 Bldg. 00	subsequent bathroom fall. This deficiency was cited on 10/1/14. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)	W 999	There is no information on W9999 It is not listed in the actual survey	03/05/2015	