

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>This visit was done in conjunction with the post certification revisit to the investigation of complaint #IN00157853 conducted on November 7, 2014.</p> <p>Dates of Survey: December 2, 3, 5, 8, 15 and 16, 2014.</p> <p>Facility number: 005592 Provider number: 15G736 AIM number: 200859310</p> <p>Surveyor: Christine Colon, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 5, 2015 by Dotty Walton, QIDP.</p>	W000000		
W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 1 additional client (client F) to ensure privacy while using the toilet.</p>	W000130	In response to the facility not ensuring privacy to clients, staff have been retrained on privacy of clients Also, management will be monitoring med pass times daily	01/15/2015

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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W000149	<p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/2/14 from 6:15 A.M. until 8:15 A.M.. At 6:30 P.M., client F sat on the toilet with the light off and the bathroom door open. Direct Support Professional (DSP) #2 walked up to the opened bathroom door and stood outside the door with client F's prescribed medications as he wiped himself, flushed the toilet, exited the bathroom and was administered his medications by DSP #2. Client F did not and was not prompted to close the bathroom door. There was no training regarding privacy while client F used the toilet.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 12/5/14 at 3:20 P.M.. The QIDP indicated all clients should have privacy while using the bathroom.</p> <p>9-3-2(a)</p>				<p>to ensure privacy is maintained Management will reduce monitoring to 3 times a week after a full 3 weeks of privacy being maintained If a staff does not provide privacy for a client, individual disciplinary action will take place and retraining in ensuring privacy to individuals we serve</p>		
	483.420(d)(1)						

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	<p>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 for 2 of 3 sampled clients (clients A and C), the facility neglected to implement written policy and procedures to prevent alleged abuse/neglect in regard to conducting thorough investigations in regard to injuries of unknown origin, allegations of abuse and a missing medication.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 12/2/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-Investigation record dated 1/2/14 involving client A indicated: "[Staff #20] texted the Director of Programming and said that she should talk to [Staff #21] because she had a bad attitude when she came to work on 1/2/14 and that she saw her push [client A] in the head." Further review of the record failed to indicate all staff who worked at the group home were interviewed and failed to indicate all clients who reside at the group were interviewed in regard to this allegation of</p>	W000149	<p>In response to W149, the facility neglected to implement written policy and procedures to prevent alleged abuse/neglect in regard to 1.supervision of clients, 2. alleged physical and verbal abuse by staff, 3. conducting thorough investigations and implementing client C's watchful eye protocol. All staff has been retrained on watchful eye protocol, and supervision of clients especially related to consumer to consumer aggression. In response to investigations, any time an Incident Report is written, the DSP must call the 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. The IR's are sent to the PD at the same time they are scanned to the others and the PD is notified by text of all IR's. The safety committee is following up weekly on any BDDS reportable injuries. All IR's that require investigation are noted by PD assistant and marked to be reviewed in 5 days to ensure all investigations are completed.</p>	01/15/2015
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	<p>abuse.</p> <p>-Investigation record dated 1/31/14 involving client C indicated: "Missing one Nadolol in 5 P.M. pack. Date of missing pill unknown." Further review of the record failed to indicate all staff who worked at the group home were interviewed in regard to the missing medication.</p> <p>-IR dated 3/24/14 involving client A indicated: "While shower (sic) [client A], staff noticed scrapes and bruises over [client A]'s back and a bruise on each arm. When (staff) questioned [client A] as to what occurred to cause the injuries and he stated that he was afraid. When asked why he's afraid he stated that [Facility owned day program client] did it and that he is scared of [Facility owned day program client]." Further review of the report failed to indicate the facility conducted a thorough investigation in regard to the allegation of abuse.</p> <p>-BDDS report dated 3/24/14 involving client A indicate: "QDDP (Qualified Developmental Disabilities Professional) received a message that [client A] has three bruises on his arms. One on his upper right arm and 2 on his right forearm. Staff was not sure where these bruises came from." Review of the report</p>		<p>Director of Administration will also review all investigations. Additionally, as a part of our state recertification process we are implementing a section on investigations for middle management and up. 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 report format of this document to ensure it is more complete. 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 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</p>		

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	<p>failed to indicate an investigation was conducted in regard to the injuries of unknown origin.</p> <p>-BDDS report dated 3/26/14 involving client A indicated: "WHile (sic) getting [client A] dressed this morning staff noticed three bruises on his right knee (brownish-Purple), a bruise on his right elbow and his left hand all brownish purple. Staff asked [client A] where he got them and he replied he didn't know. QDDP (Qualified Developmental Disabilities Professional) asked [client A] where he got them and he said the one on his hand from his wheelchair. He said he didn't know about his knee and elbow. QDDP will do an investigation to determine where the bruises came from." Review of the record failed to indicate an investigation was conducted in regard to the injuries of unknown origin.</p> <p>A review of the facility's abuse and neglect policy dated 12/12 was conducted on 12/4/14 at 7:30 P.M.. Review of the policy indicated:</p> <p>"Abilities Services, Inc. Abuse, Neglect, and Exploitation" 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, state, and</p>		<p>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>				

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	<p>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>			

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W000154	<p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 12/5/14 at 3:20 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 all incidents of abuse and neglect are to be thoroughly investigated.</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.</p> <p>Based on record review and interview for 2 of 3 sampled clients (clients A and C), the facility failed to provide written evidence investigations were conducted in regard to injuries of unknown origin, allegations of abuse and a missing medication.</p>	W000154	<p>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: 1. Confusion as to exact incidents needing investigated in consumer to consumer abuse and injuries of</p>	01/15/2015			

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	<p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 12/2/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-Investigation record dated 1/2/14 involving client A indicated: "[Staff #20] texted the Director of Programming and said that she should talk to [Staff #21] because she had a bad attitude when she came to work on 1/2/14 and that she saw her push [client A] in the head." Further review of the record failed to indicate all staff who worked at the group home were interviewed and failed to indicate all clients who reside at the group were interviewed in regard to this allegation of abuse.</p> <p>-Investigation record dated 1/31/14 involving client C indicated: "Missing one Nadolol in 5 P.M. pack. Date of missing pill unknown." Further review of the record failed to indicate all staff who worked at the group home were interviewed in regard to the missing medication.</p> <p>-IR dated 3/24/14 involving client A indicated: "While shower (sic) [client</p>		<p>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 timeliness and thoroughness of the investigation. When a Director initiates an investigation, she will</p>		

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	<p>A], staff noticed scrapes and bruises over [client A]'s back and a bruise on each arm. When (staff) questioned [client A] as to what occurred to cause the injuries and he stated that he was afraid. When asked why he's afraid he stated that [Facility owned day program client] did it and that he is scared of [Facility owned day program client]." Further review of the report failed to indicate the facility conducted an investigation in regard to the allegation of abuse.</p> <p>-BDDS report dated 3/24/14 involving client A indicate: "QDDP (Qualified Developmental Disabilities Professional) received a message that [client A] has three bruises on his arms. One on his upper right arm and 2 on his right forearm. Staff was not sure where these bruises came from." Review of the report failed to indicate a thorough investigation was conducted in regard to the injuries of unknown origin.</p> <p>-BDDS report dated 3/26/14 involving client A indicated: "WHile (sic) getting [client A] dressed this morning staff noticed three bruises on his right knee (brownish-Purple), a bruise on his right elbow and his left hand all brownish purple. Staff asked [client A] where he got them and he replied he didn't know. QDDP (Qualified Developmental</p>		<p>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>				

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W000189	<p>Disabilities Professional) asked [client A] where he got them and he said the one on his hand from his wheelchair. He said he didn't know about his knee and elbow. QDDP will do an investigation to determine where the bruises came from." Review of the record failed to indicate an investigation was conducted in regard to the injuries of unknown origin.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated thorough investigations should be conducted for injuries of unknown origin and allegations of abuse. The QIDP indicated all clients and all staff at the group home were not interviewed in regard to the injuries of unknown origin and abuse.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her</p>			

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	<p>duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients and 3 additional clients (clients A, B, C, D, E and F), to ensure staff were sufficiently trained to 1. assure competence in proper administration of medications as ordered, 2. following client C's "G-Tube High Risk Plan." and 3. following client F's line of sight protocol.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 12/2/14 from 6:15 A.M. until 8:15 A.M.. At 6:30 A.M., Direct Support Professional (DSP) #2 began administering client F's prescribed medications. At 6:35 A.M., a review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Abilify (schizophrenia) 15 mg (milligram) tablet, 1 tablet at 8:00 A.M....Folic Acid 1 mg (supplement), 1 tablet at 8:00 A.M....Loratadine 10 mg tablet (allergies), 1 tablet at 8:00 A.M....Propranolol 20 mg (high blood pressure), 1 tablet at 8:00 A.M." Client F's medications were not administered at 8:00 A.M. as ordered.</p>	W000189	In response to w189, the facility failed to ensure staff were sufficiently trained to 1. assure competence in proper administration of medications as ordered, 2. following client A's "G-Tube High Risk Plan." and 3. following client C's line of sight protocol. All training files have been reviewed. All specific consumer training is completed upon hire, as changes are made, and annually. Staff has been retrained as part of the poc. The nurse, QIDP, and PC are on a weekly scheduled rotation to observe staff in the group home setting following plans and medication passes. Any issues noted will be reviewed in weekly safety meetings. All training files are maintained by the records coordinator and notices are sent for anyone missing a training and there is a specific time period to complete the training before they are removed from the work schedule.	01/15/2015

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	<p>At 6:40 A.M., DSP #2 began administering client B's prescribed medications. At 6:45 A.M., review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Folic Acid 1 mg (supplement), 1 tablet at 8:00 A.M....Intuniv 2 mg (low blood pressure), 1 tablet at 8:00 A.M....Intuniv 4 mg, 1 tablet at 8:00 A.M." Client B's medications were not administered at 8:00 A.M. as ordered.</p> <p>At 6:50 A.M., DSP #2 began administering client A's prescribed medications. At 6:55 A.M., review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Divalproex ER (extended release) (seizures) 250 mg, 1 tablet at 8:00 A.M....Furosemide 20 mg (fluid retention), 1 tablet at 8:00 A.M., Levothyroxine 25 mcg (micrograms) (hypothyroidism), 1 tablet at 8:00 A.M....Risperidone 2 mg (bipolar), 1 tablet at 8:00 A.M.." Client A's medications were not administered at 8:00 A.M. as ordered.</p> <p>At 7:04 A.M., DSP #2 began administering client D's prescribed</p>			

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	<p>medications. At 7:08 A.M., review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Calcium and Vitamin D 500 mg/400 mg (supplement), 1 tablet at 8:00 A.M.." Client D's medications were not administered at 8:00 A.M. as ordered.</p> <p>At 7:18 A.M., DSP #2 began administering client C's prescribed medications. At 7:22 A.M., review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Ranitidine 150 mg (Gastroesophageal reflux disease), 1 tablet at 8:00 A.M....Tizanidine 4 mg (muscle spasms), 1 tablet at 8:00 A.M....Carbamazepine 20 mg (bipolar), 1 tablet at 8:00 A.M....Citalopram 20 mg (antidepressant), 1 tablet at 8:00 A.M., Invega 6 mg (schizophrenia), 1 tablet at 8:00 A.M., Levetiracetam 1000 mg (seizures), 1 tablet at 8:00 A.M., Losartan 100 mg (hypertension), 1 tablet at 8:00 A.M.." Client C's medications were not administered at 8:00 A.M. as ordered.</p> <p>A review of the facility's "Medication Administration System" Dated 12/12 was conducted on 12/4/14 at 7:30 P.M. and indicated:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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	<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 Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated staff are trained on the facility's medication administration upon hire and then annually. The QIDP indicated staff should pass medications as ordered by the physician and further indicated staff should follow the policy at all times. The QIDP indicated medications should be administered within 30 minutes before or 30 minutes after the prescribed time. The QIDP indicated staff should have checked the label three times prior to dispensing the medications to prevent medication errors. The QIDP further indicated the agency's nurse retrains staff after medication errors occur.</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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	<p>2. A morning observation was conducted at the group home on 12/2/14 between 6:15 A.M. and 8:15 A.M.. At 7:57 A.M., DSP #2 began administering client C's medications and feeding client C via his G tube (feeding tube) as he laid in his bed. DSP #2 did not line the black line on the button attached to client C and the black line on the tube together. DSP #2 did not pull on the tube lightly and there was no stomach acid in the tubing. DSP #2 did not disconnect and start over.</p> <p>A review of client C's record was conducted on 12/5/14 at 12:16 P.M.. A review of client C's 'G-tube High Risk Plan' dated 8/7/13 indicated: "[Client C] has a Mickey-tube that his medications are crushed and administered through as well as his daily nutrient/formula. [Client C] does not consumer (sic) anything through his mouth. He does not receive any feeding while at Day Services but staff does administer his formula when he has respite. The following are the instructions to administer formula through his g-Mickey tube:</p> <p>[Client C] is to be laying down.</p> <p>1. Connect the plunger to the tube before attaching to [client C]. 2. Line up black (line) on the button</p>			
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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	<p>attached to [client C] and the tube.</p> <p>3. Turn clockwise 1/2 to 3/4 of the way around.</p> <p>4. Pull on tube lightly to ensure it is in. You will see stomach acid in tubing if done correctly. If the stomach acid is not seen the staff needs to disconnect tube and start at step 2 again.</p> <p>5. Put the correct number of ounces in the syringe. Once the formula is almost gone add the predetermined amount of water.</p> <p>6. Turn to match black lines up on button and tube then remove."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated staff should follow client C's G-tube protocol at all times. The QIDP further indicated all staff who work at the group home had been trained by the agency's nurse on client C's G-tube protocol.</p> <p>3. A review of the facility's records was conducted at the facility owned day program on 12/5/14 at 10:30 A.M.. At 1:30 P.M., client F entered into the office where this surveyor reviewed records, and closed the door behind him. Client F walked around the room and sat in the office for 15 minutes with no staff supervision. At 1:48 P.M., facility</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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	<p>owned day program staff entered into the office and prompted client F to the day program area.</p> <p>A review of client F's record was conducted on 12/5/14 at 1:45 P.M.. Review of his Behavior Support Plan dated 9/17/13 indicated: "Changes made: Updated plan and addition of Watchful Eye Protocol with increased restrictions due to recent incidents of elopement...Watchful Eye Protocol: Due to an increase in recent, successful elopement behaviors, [Facility name] has placed [client F] on a more restrictive Watchful Eye Protocol. [Client F] should be in staff's LINE OF SIGHT AT ALL TIMES. The only exception to this is when [client F] is in the bathroom or bedroom; staff should ensure that he is in one of these locations initially and then do 2-3 minute checks to ensure he has remained in that location. Staff should be in the common area to ensure that he has not slipped out of the bathroom or bedroom and out the main doors of the home or habilitation program. This protocol remains in place during sleeping hours as well. In addition, when [client F] is in the backyard, staff should be outside with him to ensure that he has not left the area through the fence."</p> <p>An interview with the Qualified</p>			

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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W000249	<p>Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated staff should follow client F's line of sight protocol at all times. The QIDP further indicated all staff working at the group home have been trained on F's protocol.</p> <p>9-3-3(a)</p> <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 3 of 3 sampled clients and 3 additional clients (clients A, B, C, D, E and F), 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>	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	01/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014	
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	<p>A morning observation was conducted at the group home on 12/2/14 from 6:15 A.M. until 8:15 A.M.. During the entire observation period clients A, B and E stayed in their bedrooms with no interaction and/or meaningful activity. Client F walked back and forth throughout the group home with no supervision. Clients C and D sat in the kitchen with no meaningful activity. Direct Support Professionals (DSP) #1, #2 and #3 would walk into the rooms and occasionally check on clients A, B, C, D, E and F, but did not offer any meaningful activity. At 6:30 A.M., DSP #2 began administering clients A, B, C, D, E and F's prescribed medications. DSP #2 popped out each of the clients' medications and fed them to each client. No medication objectives were implemented during the medication administration period.</p> <p>A review of client A's record was conducted on 12/5/14 at 12:45 P.M.. The ISP (Individual Support Plan) dated 8/28/14 indicated the following objectives that could have been implemented during both observations: "Will pick the coins out of staff's hands that he needs to pay for a vending machine...Will put his pills in the applesauce after staff have handed him</p>		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				

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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	<p>his pills...Will participate in a group activity...Will assist staff preparing one aspect of a meal."</p> <p>A review of client B's record was conducted on 12/5/14 at 11:00 A.M.. The ISP dated 9/20/13 indicated the following objectives that could have been implemented during both observations: "Will measure out her Bene-fiber into a med cup...Will participate in a group exercise...Will complete one task with a peer...Will choose an activity."</p> <p>A review of client C's record was conducted on 12/5/14 at 11:30 A.M.. The ISP dated 8/28/13 indicated the following objectives that could have been implemented during both observations: "Will identify his medications...Will understand the concept of money with three examples...Will write his brother's address...Will address the envelope to his brother for the letter he will help write...Will help write a one page letter to his brother with staff...Staff will give him an example that he has \$5.00 can he buy a candy bar, tv, he has \$1000.00 dollars now can he buy a tv. Staff will do three examples with him."</p> <p>A review of client D's record was conducted on 12/5/14 at 11:45 A.M.. A review of client D's Individual Support</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
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	<p>Plan (ISP) dated 8/27/14 indicated the following objectives that could have been implemented during both observations: "Will hold onto her cup and take a drink of Gatorade after taking her medication...Will stir a food item...Will participate in fine motor activities...Will identify a quarter, dime, nickel and penny by sight...Will participate in group exercise...Will be given a choice of two community outings."</p> <p>A review of client E's record was conducted on 12/5/14 at 12:00 P.M.. A review of client E's Individual Support Plan (ISP) dated 6/24/14 indicated the following objectives that could have been implemented during both observations: "Will choose an activity to complete...Will express his choice between items...Will make eye contact...Will make eye contact with staff before they administer medications."</p> <p>A review of client F's record was conducted on 12/5/14 at 12:25 P.M.. The ISP dated 8/28/13 indicated the following objectives that could have been implemented during both observations: "Will go shopping with the group home staff...Will pick out his clothes for the next day...Will understand the concept of money when given examples...Will be shown two of his medications when</p>						

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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
--	---

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W000336	<p>medications are being administered... Will engage in group activity... Will complete two individual activities on his own... Will put his pills in applesauce after the staff hands him his pills."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/13 at 3:20 P.M.. The QIDP indicated facility staff should implement training objectives at all times of opportunity.</p> <p>9-3-4(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 for 1 of 3 sampled clients and 1 additional (clients C and D), the facility's nursing services failed to conduct quarterly nursing assessments of each client's health status and medical needs.</p> <p>Findings include:</p>	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	01/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
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	<p>A review of client C's record was conducted on 12/5/14 at 12:45 P.M.. Client C's record indicated no nursing quarterlies were completed for 12/13. Client C's most current annual physical was dated 2/18/14. Client C's 8/28/14 Individual Support Plan (ISP) indicated client C's diagnoses included, but were not limited to, epilepsy, cerebral palsy, aggressive unsocialized oppositional disorder and spinal scoliosis. Client C's 12/14 physician orders indicated client C received routine medications.</p> <p>A review of client D's record was conducted on 12/5/14 at 11:20 A.M.. Client D's record indicated no nursing quarterly completed for 11/14. Client D's annual physical was dated 7/17/14. Client D's 8/27/14 Individual Support Plan (ISP) indicated client D's diagnoses included, but were not limited to, cerebral palsy, osteoporosis, bone disease and nervous disorder. Client D's 12/14 physician orders indicated client D received routine medications.</p> <p>An interview with the Nurse was conducted on 12/5/14 at 1:30 P.M.. The Nurse indicated nursing quarterlies are to be completed every three months. The Nurse further indicated the nursing quarterlies were not completed every three months.</p>		<p>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 ensure they are to the RN within 24 hours of any notification that she has not received them on time.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2014
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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W000368	<p>9-3-6(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION 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 drugs administered to 2 of 3 sampled clients (clients A and C) were administered in compliance with the physician's orders.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports, Internal Reports (IR) and investigation records was conducted on 12/2/14 at 12:30 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 1/12/14 involving client A indicated: "[Client A] went home for the night with his father. He returned home on Sunday afternoon and did not receive his 12 P.M. dose of Depakote (seizures/bipolar). The importance of all medications being given and at the proper time was explained the (sic) [client A]'s father.</p>	W000368	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	01/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
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W000369	<p>[Facility] will explain the importance of all medications to [client A]'s father each time he takes him out of the house during a time that medications are to be given."</p> <p>-Investigation record dated 1/31/14 involving client C indicated: "Missing one Nadolol (high blood pressure) in 5 P.M. pack. Date of missing pill unknown."</p> <p>An interview with the facility's nurse was conducted on 12/5/14 at 1:30 P.M.. The nurse indicated client A did not receive his prescribed medication. The nurse indicated client A should have received his medication as ordered. The nurse further indicated the facility should have ensured client A's medications were available for administration at the prescribed time. The nurse indicated the facility could not determine when the medication became missing.</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</p>		<p>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</p>		

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	<p>are self-administered, are administered without error.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients and 2 additional clients (clients A, B, C, D and F), to ensure proper administration of medications as ordered</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 12/2/14 from 6:15 A.M. until 8:15 A.M.. At 6:30 A.M., Direct Support Professional (DSP) #2 began administering client F's prescribed medications. At 6:35 A.M., a review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Abilify (schizophrenia) 15 mg (milligram) tablet, 1 tablet at 8:00 A.M....Folic Acid 1 mg (supplement), 1 tablet at 8:00 A.M....Loratadine 10 mg tablet (allergies), 1 tablet at 8:00 A.M....Propranolol 20 mg (high blood pressure), 1 tablet at 8:00 A.M." Client F's medications were not administered at 8:00 A.M. as ordered.</p> <p>At 6:40 A.M., DSP #2 began administering client B's prescribed medications. At 6:45 A.M., review of the medication packet, Physician's Order and Medication Administration Record</p>	W000369	In response to W369, the facility failed to ensure that staff 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 weely 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 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,	01/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2014	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
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	<p>(MAR) dated 12/1/14 indicated DSP #2 administered "Folic Acid 1 mg (supplement), 1 tablet at 8:00 A.M....Intuniv 2 mg (low blood pressure), 1 tablet at 8:00 A.M....Intuniv 4 mg, 1 tablet at 8:00 A.M." Client B's medications were not administered at 8:00 A.M. as ordered.</p> <p>At 6:50 A.M., DSP #2 began administering client A's prescribed medications. At 6:55 A.M., review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Divalproex ER (extended release) (seizures) 250 mg, 1 tablet at 8:00 A.M....Furosemide 20 mg (fluid retention), 1 tablet at 8:00 A.M., Levothyroxine 25 mcg (micrograms) (hypothyroidism), 1 tablet at 8:00 A.M....Risperidone 2 mg (bipolar), 1 tablet at 8:00 A.M." Client A's medications were not administered at 8:00 A.M. as ordered.</p> <p>At 7:04 A.M., DSP #2 began administering client D's prescribed medications. At 7:08 A.M., review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Calcium and Vitamin D 500 mg/400 mg (supplement), 1 tablet at</p>		<p>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. Documentation of the observation will be submitted to the Director of Programming for review.</p>				

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	<p>8:00 A.M.." Client D's medications were not administered at 8:00 A.M. as ordered.</p> <p>At 7:18 A.M., DSP #2 began administering client C's prescribed medications. At 7:22 A.M., review of the medication packet, Physician's Order and Medication Administration Record (MAR) dated 12/1/14 indicated DSP #2 administered "Ranitidine 150 mg (Gastroesophageal reflux disease), 1 tablet at 8:00 A.M....Tizanidine 4 mg (muscle spasms), 1 tablet at 8:00 A.M....Carbamazepine 20 mg (bipolar), 1 tablet at 8:00 A.M....Citalopram 20 mg (antidepressant), 1 tablet at 8:00 A.M., Invega 6 mg (schizophrenia), 1 tablet at 8:00 A.M., Levetiracetam 1000 mg (seizures), 1 tablet at 8:00 A.M., Losartan 100 mg (hypertension), 1 tablet at 8:00 A.M.." Client C's medications were not administered at 8:00 A.M. as ordered.</p> <p>A review of the facility's "Medication Administration System" Dated 12/12 was conducted on 12/4/14 at 7:30 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,</p>						

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	<p>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 Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated staff are trained on the facility's medication administration upon hire and then annually. The QIDP indicated staff should pass medications as ordered by the physician and further indicated staff should follow the policy at all times. The QIDP indicated medications should be administered within 30 minutes before or 30 minutes after the prescribed time. The QIDP indicated staff should have checked the label three times prior to dispensing the medications to prevent medication errors. The QIDP further indicated the agency's nurse retrains staff after medication errors occur.</p> <p>9-3-6(a)</p>						

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 6 of 6 clients (clients A, B, C, D, E and F) who lived in the group home, the facility failed to maintain proper medication security.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/2/14 from 6:15 A.M. until 8:15 A.M.. At 6:30 A.M., Direct Support Professional (DSP) #2 began administering client F's prescribed medications. DSP #2 poured each of client F's medications into a medication cup, walked away from the medication cart located in the closet in the open living room area near the front door, and administered client F's medication in the bathroom.</p> <p>At 6:40 A.M., DSP #2 began administering client B's prescribed medications. DSP #2 poured each of client B's medications into a medication cup, walked away from the medication cart located in the closet in the open living room area near the front door, and administered client B's medication in</p>	W000382	In regard to W382, facility failed to maintain proper medication security, procedure for medication administration has been changed to the area beside the med cart, not to pass meds in the bathroom or the bedrooms. This also ensures proper lighting and ability to watch consumer closely to ensure meds are taken. Staff has been trained to lock med cart in any event that they need to move from the med cart and med administration area. Nurse will observe med passes of all staff to ensure the procedure is followed. Nurse will also do weekly med pass evaluations as normal. QIDP and PC will also observe a med pass weekly.	01/15/2015			

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	<p>their bedroom.</p> <p>At 6:50 A.M., DSP #2 began administering client A's prescribed medications. DSP #2 poured each of client A's medications into a medication cup, walked away from the medication cart located in the closet in the open living room area near the front door, and administered client A's medication in their bedroom.</p> <p>At 7:04 A.M., DSP #2 began administering client D's prescribed medications. DSP #2 poured each of client D's medications into a medication cup, walked away from the medication cart located in the closet in the open living room area near the front door, and administered client D's medication in the kitchen.</p> <p>At 7:18 A.M., DSP #2 began administering client C's prescribed medications. DSP #2 poured each of client C's medications into a medication cup, walked away from the medication cart located in the closet in the open living room area near the front door, and administered client C's medication in the kitchen.</p> <p>The medication cart, which contained all of clients A, B, C, D, E and F's</p>			
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W000436	<p>prescribed medications was left unlocked and unattended during the entire medication administration.</p> <p>An interview with the facility's nurse was conducted on 12/5/14 at 1:30 P.M.. The nurse indicated the medications should be locked at all times except when being administered and if staff needed to leave the area they needed to lock the medication cabinet.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients and 2 additional clients who used adaptive aids and devices (clients C, D and E), the facility failed to encourage and teach the use of their eyeglasses, water shoes and leg braces.</p> <p>Findings include:</p> <p>1. A morning observation was conducted</p>	W000436	<p>In response to W436, the facility failed to encourage and teach the use of wearing eyeglasses. Consumer protocol for wearing eyeglasses has been updated and staff has been retrained. Additionally, the Nurse, QIDP and PC will ensure at weekly site checks that protocol is being followed. There was confusion for staff between training and guardian instruction. This has been resolved. In response the shower shoes, staff failed to</p>	01/15/2015

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	<p>at the group home on 12/2/14 from 6:15 A.M. until 8:15 A.M.. During the entire observation, client #5 sat in his wheelchair. Client E did not wear his eyeglasses. Direct Support Professional (DSP) #1, #2, #3 and #4 did not prompt client E to wear his eyeglasses. At 6:25 A.M., client D was escorted into the bathroom barefooted. DSP #4 undressed client D and escorted her into the shower barefooted and began showering client D. On the wall located next to the bathroom door above the light switch was a orange and black sign which indicated: "[Client D] is to wear the water shoes in the shower. She is to have them on prior to going into the restroom. Take them off to wash her feet and put them right back on her. This is to prevent falls." Client D did not, was not prompted and was not assisted in wearing water shoes to prevent her from falling during showering.</p> <p>An interview with the facility nurse was conducted on 12/2/14 at 2:30 P.M.. The nurse indicated client A should wear water shoes at all times while in the bathroom and while showering to prevent her from falling, due to her unsteady gait. The nurse indicated DSP #4 should have ensured client D had shower shoes when entering the bathroom and while in the shower.</p>		follow protocol Staff have been retrained In regard to leg braces, staff encourage consumer and consumer refuses This will be documented and a plan for continual prompts will be implemented				

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	<p>A facility owned day program observation was conducted on 12/2/14 between 1:20 P.M. and 2:30 P.M.. During the entire observation, client C sat in his wheelchair. Client C did not wear his eyeglasses. DSP #5 and #6 did not prompt client C to wear his eyeglasses.</p> <p>An evening observation was conducted at the group home on 12/3/14 between 5:30 P.M. and 6:20 P.M.. During the entire observation, client E did not wear his eyeglasses. DSP #4, #7, #8 and #9 did not prompt client E to wear his eyeglasses.</p> <p>A review of client E's record was conducted on 12/3/14 at 3:30 P.M.. A review of client E's Individual Support Plan (ISP) dated 6/24/2014 indicated: "[Client E] wears glasses during the day. He has astigmatism. He is not able to clean them himself, he requires someone to clean them. He needs to have them placed on him but, he can take them off by himself."</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigations was conducted on 12/5/14 at 11:30 A.M.. Review of the reports indicated:</p>			

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	<p>"Abuse, neglect, Exploitation Investigation Form...Date of Investigation begins: 1/30/14...Name of Alleged Victim: [Client C]...Program/Service Location: Day Service program (facility owned)...[Client C] alleged that [Qualified Intellectual Disabilities Professional (QIDP)] yelled at him at hab (day program)...[Client C] was not wearing his leg brace. [QIDP] prompted him to do so...I [QIDP] walked into hab and saw [client C] did not have his leg brace on. I asked why he did not have his brace on; he stated 'it was broken.' I asked what was wrong with his (sic) and he said 'it couldn't unlock or lock.' I stated that [Staff #25] called his PT (Physical Therapist) and [Orthopedic Company] and it was not broken and that he should be wearing it. I told him it was important that he wears it to help his leg. I stated that he needed to be wearing it everyday...." Further review of the record indicated the group home staff did not ensure client C wore his leg brace.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 12/5/14 at 3:20 P.M.. The QIDP indicated staff should be teaching clients to wear their adaptive equipment at all times. The QIDP further indicated staff should have prompted client E to wear</p>						

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W000440	<p>his eyeglasses and ensured client C had his leg braces on.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills for shifts of personal which affected 6 of 6 clients living in the facility (clients A, B, C, D, E and F.)</p> <p>Findings include:</p> <p>The facility's records were reviewed on 12/5/14 at 1:00 P.M.. The review failed to indicate the facility held an evacuation drill for clients A, B, C, D, E and F on the morning shift (8:00 A.M. to 4:00 P.M.), evening shift (4:00 P.M. to 12:00 A.M.) and overnight shift (12:00 A.M. to 8:00 A.M.) during the last quarter (October 1st through December 31st) of 2013 and during the morning shift (8:00 A.M. to 4:00 P.M.) and overnight shift (12:00 A.m. to 8:00 A.m.) for the first quarter (January 1st through March 31st) and second quarter (April 1st through June 30th) and third quarter (July 1st</p>	W000440	<p>In response to W440, facility failed to conduct evacuation drills according to requirements. ASI will conduct evacuation drills according to requirements. Staff have been trained to follow a calendar of required drills. PC will oversee the timeliness of the drills. The group home failed to document drills and provide copies of the drills to the agency Safety Committee. Safety Committee will ensure that if documentation of completed drills are not turned in, follow up will occur and the drill documentation will be required within 24 hours. Director of Programming will review the drills logs bi-weekly to ensure no drills are missed.</p>	01/15/2015
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W000455	<p>through September 30th) of 2014.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated evacuation drills are to be conducted during each quarter for each shift of staff.</p> <p>9-3-7(a)</p> <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 3 of 3 sampled clients and 2 additional client (clients A, B, C, D and F).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 12/2/14 from 6:15 A.M. until 8:15 A.M.. At 6:30 P.M., client F sat on the toilet with the light off and the bathroom door open. Direct Support Professionals (DSP) #2 walked</p>	W000455	In response to W455, the facility failed to maintain proper hygiene practices and prevent cross contamination during medication administration and meal preparation 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	01/15/2015

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W000460	<p>up to the opened bathroom door and stood outside the door with client F's prescribed medications as he wiped himself, flushed the toilet, exited the bathroom and was administered his medications by DSP #2. Client F did not and was not prompted to wash his hands. At 7:30 A.M., DSP #3 prompted client B to set the dining table. Client B did not and was not prompted to wash her hands. At 7:45, DSP #1 grabbed muffins off a serving plate with her bare hands and placed a muffin on clients A, B, C, D and F's plates.</p> <p>An interview with the facility's nurse was conducted on 12/5/14 at 1:30 P.M.. The nurse indicated staff should have prompted client F to wash his hands before administering his medications. The nurse indicated staff should have prompted client B to wash her hands. The nurse further indicated staff should not handle the client's food with their bare hands.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p>		<p>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. To ensure proper hygiene, meals and med passes will be monitored daily until no issues need addressed.</p>		

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	<p>Based on observation, record review and interview for 1 additional client (client D), the facility failed to assure the staff provided food in accordance with the client's diet order.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group on 12/3/14 from 5:30 P.M. until 6:20 P.M.. At 5:40 P.M., DSP #7 was observed feeding client D her evening meal which consisted of ground chicken stir fry, whole grain rice, whole kernel corn and broccoli florets. Client D's meal was not of a mechanical soft consistency.</p> <p>A review of client D's record was conducted on 12/5/14 at 10:30 A.M.. Review of client D's Individual Support Plan (ISP) dated 8/27/14 indicated: Dining Difficulties: Foods need to be chopped, ground or blenderized to avoid swallowing difficulties. Consumer cannot have foods that are hard to chew or swallow. These foods are raw vegetables and fruits, chewy breads and meats. Review of client D's 12/1/14 Physician's Order indicated: "Diet Order: Mechanical Soft Diet with ground meat and thin liquids."</p> <p>An interview with the facility's nurse was</p>	W000460	In response to W460, the facility failed to ensure the staff provided food in accordance with the clients diet order, staff have been retrained on the diet order. Staff will be monitored at meal time daily until all staff has been observed and there are no issue with following the diet order. Additionally, PC and QIDP and Nurse will each be in the home weekly during a meal to observe for continued monitoring.	01/15/2015			

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W000484	<p>conducted on 12/5/14 at 1:30 P.M.. The nurse indicated staff should have followed the client's prescribed diet. The nurse indicated client D's meal should have been of a mechanical soft consistency.</p> <p>9-3-8(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 5 of 6 clients (clients A, B, C, D and F) residing in the group home to provide sugar/sugar substitute, ketchup and butter/margarine at the dining table.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 12/2/14 from 6:15 A.M. until 8:15 A.M.. At 7:35 A.M., Direct Support Professional #1 (DSP) cooked and served the clients' meal which consisted of cold unsweetened cereal, sausage links, baked blueberry muffins,</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 condiment and a condiment basket has been created to assist Program Coordinators will do weekly checks of a meal time to ensure condiments are being made available. Staff will be monitored at meal time daily until all staff has been observed and there are no issue with condiments being offered. Additionally, PC and QIDP and Nurse will each be in the home weekly during a meal to observe, as continued	01/15/2015

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W000488	<p>milk and juice. No sugar/sugar substitute, ketchup and butter/margarine was observed on the table for clients A, B, C, D and F's use.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated sugar/sugar substitute, ketchup and butter/margarine should be put on the table for the clients to use.</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, record review and interview, the facility failed to assure 5 of 6 clients residing at the group home (clients A, B, C, D and F) were involved in meal preparation and served themselves at meal times as independently as possible.</p> <p>Findings include: A morning observation was conducted at</p>	W000488	<p>monitoring.</p> <p>In response to W488, the facility failed to assure clients were involved in meal preparation and served themselves at meal times as independently as possible, the facility has retrained the staff on assisting clients at meal time Staff will be monitored at meal time daily until all staff has been observed and there are no issue with clients assisting. Additionally, PC and QIDP and Nurse will each be in the home weekly during a meal to</p>	01/15/2015

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	<p>the group on 12/2/14 from 6:15 A.M. until 8:15 A.M.. From 6:15 A.M. until 7:35 A.M., client B sat in her bedroom with no interaction and no activity. Client D sat in the kitchen with no interaction and no activity. Client F walked around the group home with no interaction or activity. Direct Support Professional #1 (DSP) cooked and served the clients' meal which consisted of cold unsweetened cereal, sausage links, baked blueberry muffins, milk and juice. At 7:45 A.M., DSP #1 placed the already prepared plates on the dining table and poured the clients juice and milk into each cup. At 7:30 A.M., clients A, B, C, D and F were prompted to the table to eat their breakfast. Clients A, B, C, D and F did not assist in preparing their meal and did not serve themselves. Client D did not feed herself.</p> <p>A review of client A's record was conducted on 12/5/14 at 11:00 A.M.. The Individual Support Plan (ISP) dated 8/28/14 indicated: "Will assist with cooking a food item."</p> <p>A review of client B's record was conducted on 12/5/14 at 10:40 A.M.. The ISP dated 9/20/13 indicated: "Will assist staff preparing one aspect of a meal."</p>		observe, as continued monitoring.				

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W009999	<p>A review of client D's record was conducted on 12/5/14 at 11:20 A.M.. The ISP dated 8/27/14 indicated: "Will hold a spoon in her hand while eating and feed herself."</p> <p>A review of client F's record was conducted on 12/5/14 at 11:45 A.M.. The ISP dated 8/22/13 indicated: "Will assist staff preparing one aspect of a meal."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 12/5/14 at 3:20 P.M.. The QIDP indicated clients were capable of assisting in meal preparation and of serving themselves with assistance and further indicated they should be assisting in preparation and serving themselves with assistance at meal time.</p> <p>9-3-8(a)</p> <p>State Findings:</p>	W009999	In response to W9999, the facility failed to report a med error to	01/15/2015			

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	<p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>1. 460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime.</p> <p>The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 3 of 7 staff (staff #13, #14 and #15) personnel files reviewed, the facility failed to ensure three references were obtained prior to employment.</p>		<p>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</p>		

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	<p>Findings include:</p> <p>The facility's administrative records were reviewed on 12/3/14 at 4:00 P.M.. Review of the personnel files for staff #13, #14 and #15 indicated three references were not obtained. The personnel files indicated only two references were obtained for staff #13, no references were obtained for staff #14 and only two references were obtained for staff #15.</p> <p>An interview with the Human Resource Director (HRD) was conducted on 12/3/14 at 4:15 P.M.. The HRD indicated the facility's policy is that each employee should have three references, completed prior to employment with the facility. The HRD further indicated staff #13, #14 and #15 did not have 3 references in their personnel record prior to employment.</p> <p>9-3-2(c)(3)</p>						