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 11/05/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	This visit was for the investigation of complaint #IN00117936. COMPLAINT #IN00117936: SUBSTANTIATED, Federal and state deficiencies related to the allegation(s) are cited at W149, W194, and W249. Date of Survey: November 5, 2012 Facility number: 005592 Provider number: 15G736 AIM number: 200859310 Surveyor: Tracy Brumbaugh, Medical Surveyor III The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed 11/13/12 by Dotty Walton, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview the facility failed for 1 of 3 sampled clients (client A) to ensure the facility's Abuse/Neglect Policy was implemented for 3 of 3 Bureau of Developmental Disability Services reports. Findings include: On 11-5-12 at 11:00 a.m. a review of the facility's Bureau of Developmental Disability Services (BDDS) reports was conducted. A report dated 9-9-12 at 8:30 p.m. indicated client A had vacated his home with no staff supervision. A housemate's parent came to the home and saw him outside and reported to the staff he was out there. Staff went outside and found client A preparing to cross the street. A BDDS report dated 10-9-12 at 11:45 a.m. indicated client A had left the facility owned day program. An outside source notified the day program staff that client A was outside. The facility staff found client A outside, across the street, and on the back side of the body shop. A follow up report dated 10-10-12 indicated there were 5 staff involved and the incident was considered neglect since client A was unable to leave the facility	W0149	In regard to the incident identified in this investigation it is clear that the staff involved in each incident were not correctly following the consumer's protocol despite the fact that they had been trained on it. That issue was addressed using disciplinary measures for the specific staff involved. In addition, the following programmatic changes were made to prevent future incidents:* alarm bells were added to the front and rear doors of the hab area; * the consumer's BSP was up-dated to refect additonal activities staff can use to attempt to engage the consumer; * the watchful eye protocol was up-dated to improve clarity; * this consumer's active treatment schedule at hab was up-dated to address new treatment goals that were created to increase the opportunities for him to be engaged in activities; * new activities were added to this consumer's meaningful day activities; * staff at the GH and day services have been trained on the up-dated BSP and protocol; * incoming staff are trained on a consistent bi-weekly schedule; * the GH IDT meets weekly and identifies any new issues with this consumer and develops a plan; and* there are	11/26/2012

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	unattended. A BDDS report dated 10-25-12 at 2:15 p.m. indicated client A had left the facility owned day program without staff supervision. Client A left through 2 doors which had been propped open. The direct care staff responsible for propping the doors open was terminated for neglect for allowing client A to vacate. On 11-5-12 at 10:45 a.m. a record review for client A was conducted. The Behavior Support Plan (BSP) dated 9-15-12 indicated client A was an elopement risk and should be under a "watchful eye" during waking hours except for when he is in the bathroom (at home and day program) or his bedroom, then 5 minute checks should be completed. The BSP indicated if client A went towards the door, one staff should stand in front of the door giving verbal directions while the other staff should be ready to react and should say nothing. The door alarms should be on and functional for each shift. The "watchful eye protocol" dated 7-12-12 indicated a watchful eye was defined as being able to see client A when he was in any location except at home in his bedroom and bathroom and at day program in the bathroom. The "watchful eye protocol" indicated when client A was in any other room at day program, direct care staff would maintain a constant line of sight on		monthly staff meetings for the GH and day services staff which are opportunities for up-dated training and general reminders about high risk issues.These changes are the joint responsibility of the QDDP and Programming Coordinator to ensure implementation and follow-through. The IDT helps hold them responsible. Both staff are supervised by the Directors of Day and Placement Services and Community Living.	

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	client A. On 11-5-12 at 12:00 p.m., a record review of the facility's Abuse/Neglect Policy was conducted. The Abuse/Neglect policy dated 10-10 indicated all consumers should be free from neglect (any action which may place a consumer in a situation that may cause harm). On 11-5-12 at 12:30 p.m., an interview with the Qualified Mental Retardation Professional (QMRP) indicated the direct care staff working when client A vacated failed to implement the facility's policy on neglect by not properly supervising client A. The QMRP indicated the direct care staff working on 11-5-12 did not have a constant line of sight when client A went into the quiet room. The QMRP indicated staff should be in the room with client A or standing at the window watching him. The QMRP indicated staff should implement the BSP for client A and keep a "watchful eye" on him. This federal tag relates to complaint #IN00117936. 9-3-2(a)			

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W0194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. Based on record review and interview the facility failed for 1 of 3 clients (client A) to ensure staff could demonstrate the skills to implement client A's Behavior Support Plan for elopement. Findings include: On 11-5-12 from 10:30 a.m. until 1:00 p.m. an observation at the facility owned day program for client A was conducted. Client A walked around his day program, threw a bean bag, watched television in the "quiet room," had several snacks, and ate his lunch. When client A was in the quiet room direct care staff did not keep their eyes on him. Client A would go into the quiet room and shut the door. Direct care staff #1, #2, #3, #4, #5, and #6 did not keep a "watchful eye" on client A while he was in the quiet room (ensure he was within eye sight at all times while in the quiet room). On 11-5-12 at 11:00 a.m., a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted. A BDDS report dated 10-9-12 at 11:45 a.m. indicated client A had left	W0194	In regard to the incident identified in this investigation it is clear that the staff involved in each incident were not correctly following the consumer's protocol despite the fact that they had been trained on it. That issue was addressed using disciplinary measures for the specific staff involved. In addition, the following programmatic changes were made to prevent future incidents:* alarm bells were added to the front and rear doors of the hab area; * the consumer's BSP was up-dated to refect additonal activities staff can use to attempt to engage the consumer; * the watchful eye protocol was up-dated to improve clarity; * this consumer's active treatment schedule at hab was up-dated to address new treatment goals that were created to increase the opportunities for him to be engaged in activities; * new activities were added to this consumer's meaningful day activities; * staff at the GH and day services have been trained on the up-dated BSP and protocol; * incoming staff are trained on a consistent bi-weekly schedule; * the GH IDT meets weekly and identifies any new issues with this consumer and	11/26/2012

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	the facility owned day program. An outside source notified the day program staff that client A was outside. The facility staff found client A outside, across the street, and on the back side of the body shop. A BDDS report dated 10-25-12 at 2:15 p.m. indicated client A had left the facility owned day program without staff supervision. Client A left through 2 doors which had been propped open. On 11-5-12 at 10:45 a.m. a record review for client A was conducted. The Behavior Support Plan (BSP) dated 9-15-12 indicated client A was an elopement risk and should be under a "watchful eye" during waking hours except for when he was in the bathroom at day program and home or his bedroom, then 5 minute checks should be completed. The BSP indicated if client A went towards the door, one staff should stand in front of the door giving verbal directions while the other staff should be ready to react and should say nothing. The door alarms should be on and functional for each shift. The "watchful eye protocol" dated 7-12-12 indicated a watchful eye was defined as being able to see client A when he was in any location except at home in his bedroom and bathroom and at day program in the bathroom. The watchful eye protocol		develops a plan; and* there are monthly staff meetings for the GH and day services staff which are opportunities for up-dated training and general reminders about high risk issues.These changes are the joint responsibility of the QDDP and Programming Coordinator to ensure implementation and follow-through. The IDT helps hold them responsible. Both staff are supervised by the Directors of Day and Placement Services and Community Living.	

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	indicated when client A is in any other room at day program direct care staff would maintain a constant line of sight on client A. On 11-5-12 at 12:30 p.m. an interview with the Qualified Mental Retardation Professional indicated the direct care staff working with client A should show they are able to follow his plan as trained and have client A within their sight at all times except for when he was in the bathroom. This federal tag relates to complaint #IN00117936. 9-3-3(a)			

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W0249	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. Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client A) to ensure his Behavioral Support Plan (BSP) was implemented as written for elopement. Findings include: On 11-5-12 from 10:30 a.m. until 1:00 p.m. an observation at the facility owned day program for client A was conducted. Client A walked around his day program, threw a bean bag, watched television in the "quiet room," had several snacks, and ate his lunch. When client A was in the quiet room, direct care staff did not keep their eyes on him. Client A would go into the quiet room and shut the door. Direct care staff #1, #2, #3, #4, #5, and #6 did not keep a "watchful eye" on client A while he was in the quiet room. On 11-5-12 at 10:45 a.m. a record review for client A was conducted. The Behavior Support Plan (BSP) dated 9-15-12 indicated client A was an	W0249	In regard to the incident identified in this investigation it is clear that the staff involved in each incident were not correctly following the consumer's protocol despite the fact that they had been trained on it. That issue was addressed using disciplinary measures for the specific staff involved. In addition, the following programmatic changes were made to prevent future incidents:* alarm bells were added to the front and rear doors of the hab area; * the consumer's BSP was up-dated to refect additonal activities staff can use to attempt to engage the consumer; * the watchful eye protocol was up-dated to improve clarity; * this consumer's active treatment schedule at hab was up-dated to address new treatment goals that were created to increase the opportunities for him to be engaged in activities; * new activities were added to this consumer's meaningful day activities; * staff at the GH and day services have been trained on the up-dated BSP and protocol; * incoming staff are	11/26/2012

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	elopement risk and should be under a "watchful eye" during waking hours at day program and home except for when he is in the bathroom or his bedroom, then 5 minute checks should be completed. The BSP indicated if client A went towards the door one staff should stand in front of the door giving verbal directions while the other staff should be ready to react and should say nothing. The door alarms should be on and functional for each shift. The BSP indicated client A was to have direct care staff's eyes on him at all times (privacy in bathroom and bedroom with 5 minute checks). The "watchful eye protocol" dated 7-12-12 indicated a watchful eye was defined as being able to see client A when he was in any location except at home in his bedroom and bathroom and at day program in the bathroom. The watchful eye protocol indicated when client A is in any other room at day program direct care staff would maintain a constant line of sight on client A. On 11-5-12 at 12:30 p.m. an interview with the Qualified Mental Retardation Professional (QMRP) indicated the direct care staff working on 11-5-12 did not have a constant line of sight when client A went into the quiet room. The QMRP indicated staff should be in the room with client A or standing at the window		trained on a consistent bi-weekly schedule; * the GH IDT meets weekly and identifies any new issues with this consumer and develops a plan; and* there are monthly staff meetings for the GH and day services staff which are opportunities for up-dated training and general reminders about high risk issues.These changes are the joint responsibility of the QDDP and Programming Coordinator to ensure implementation and follow-through. The IDT helps hold them responsible. Both staff are supervised by the Directors of Day and Placement Services and Community Living.	

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	watching him. The QMRP indicated staff should implement the BSP for client A and keep a "watchful eye" on him. This federal tag relates to complaint #IN00117936. 9-3-4(a)			