

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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	<p>This visit was for a recertification and state licensure survey. This visit was included the investigation of complaint #IN00116944.</p> <p>Complaint #IN00116944: Substantiated, no deficiencies related to the allegation(s) cited.</p> <p>Dates of Survey: October 1, 2, 3, and 4, 2012.</p> <p>Facility number: 001116 Provider number: 15G602 AIM number: 100245620</p> <p>Surveyor: Brenda Nunan, RN, Public Health Nurse Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 10, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure the facility immediately reported and thoroughly investigated all allegations of abuse/neglect and/or injuries of unknown origin for 3 of 4 sampled clients (clients B, C, and D) and 3 additional clients (E, G, and H).</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to implement their policy and procedures to ensure all allegations of abuse/neglect and/or injuries of unknown origin were reported to the administrator and/or to state officials and to ensure all allegations of abuse/neglect were thoroughly investigated for 25 of 37 incidents reviewed for abuse/neglect/injuries of unknown origin clients B, C, D, E, G, and H, Please see W149. The governing body failed to immediately report allegations of client abuse and/or injuries of unknown origin for 6 of 37 incidents reviewed for abuse/neglect/injuries of unknown origin for clients B, C, D, G and H to the 	W0104	In regard to W104, the Human Rights/Risk Management Committee will be monitoring all allegations of consumer-to-consumer abuse as well as injuries of unknown origin. These investigations are done by Programming Coordinators, Nurses, or QDDP on a formal written investigation form. These forms have been inconsistently reviewed by the IDT but will now be consistently reviewed by the HRC/RMC which means it will be reviewed at two times per month. Monitoring within the HRC/RMC format means that individual consumer (or site or staff) up-dates can be made and will be monitored for follow up. In response to a follow up letter: Every month, each program and county has staff meetings. Every month, the agenda includes reviewing the agency's Abuse/Neglect/Exploitation policy so it is always reinforced with staff. In the GH setting, there are always at least two staff on the schedule so there are multiple staff monitoring consumer behaviors and staff-consumer interactions. All staff receive training on completing Incident Reporting which includes but is not limited to indicators of A/N/E, consumer-consumer aggression,	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>administrator and/or to the Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services and/or Adult Protective Services as required by state law. Please see W153.</p> <p>3. The governing body failed to investigate allegations of client abuse and or injuries of unknown origin for 23 of 37 incidents reviewed for abuse/neglect/injuries of unknown origin for clients B, C, D, E, G and H. Please see W154.</p> <p>9-3-1(a)</p>		<p>and all injuries. These are completed prior to the end of the shift so that appropriate individuals are notified (depending on the issue it could be the QDDP, Nurse, or Programming Coordinator). All Incident Reports are reviewed by Programming Coordinators and QDDPs within 24 hours (usually less). This two-person review process is to ensure that all concerns are noted and addressed. The PC completes any investigations of consumer-consumer abuse allegations as well as injuries of unknown origins. There is a standardized form used within the agency for this. The completed investigations are reviewed by the QDDP. Any consumer-specific concerns are reviewed in the weekly GH IDT meetings. In addition, these categories of incidents are reviewed bi-monthly at HRC. HRC requires documented follow up on consumers. The Directors of Community Living and Day and Placement Services participate in the HRC process as well as represent the Leadership Team. Documentation within individual consumer files as well as the HRC record evidence consistent follow up and documentation of such follow-up.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed to implement their policy and procedures to ensure all allegations of abuse/neglect/mistreatment/injury of unknown origin were immediately reported to the administrator and/or reported to state officials and thoroughly investigated for 25 of 37 incidents/investigations reviewed for 3 of 4 sampled clients (clients B, C, and D) and 3 additional clients (clients E, G, and H).</p> <p>Findings include:</p> <p>Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (DDRS/BDDS) incident reports and/or investigations from 03/01/2012 through 09/30/2012 and one additional internal report, dated 08/29/2012 were reviewed on 10/01/2011 at 11:50 a.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 03/21/2012 at 10:17 a.m., indicated, "...consumers were having a tornado drill...[client G] hit 2 male</p>	W0149	In regard to W149, the Human Rights/Risk Management Committee will be monitoring all allegations of consumer-to-consumer abuse as well as injuries of unknown origin. These investigations are done by Programming Coordinators, Nurses, or QDDP on a formal written investigation form. These forms have been inconsistently reviewed by the IDT but will now be consistently reviewed by the HRC/RMC which means it will be reviewed at two times per month. Monitoring within the HRC/RMC format means that individual consumer (or site or staff) up-dates can be made and will be monitored for follow up. In response to a follow up letter: Every month, each program and county has staff meetings. Every month, the agenda includes reviewing the agency's Abuse/Neglect/Exploitation policy so it is always reinforced with staff. In the GH setting, there are always at least two staff on the schedule so there are multiple staff monitoring consumer behaviors and staff-consumer interactions. All staff receive training on completing Incident Reporting which includes but is not limited to indicators of A/N/E, consumer-consumer aggression,	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>consumers and threw her water bottle...."</p> <p>The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 03/29/2012 at 6:50 p.m., indicated client G hit client E in the chest. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/11/2012 at 12:53 p.m., indicated a female consumer (not identified) pulled client H's hair. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/11/2012 at 3:56 p.m., indicated client G hit client B on the right shoulder resulting in a scratch on client B's shoulder blade. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of</p>		<p>and all injuries. These are completed prior to the end of the shift so that appropriate individuals are notified (depending on the issue it could be the QDDP, Nurse, or Programming Coordinator). All Incident Reports are reviewed by Programming Coordinators and QDDPs within 24 hours (usually less). This two-person review process is to ensure that all concerns are noted and addressed. The PC completes any investigations of consumer-consumer abuse allegations as well as injuries of unknown origins. There is a standardized form used within the agency for this. The completed investigations are reviewed by the QDDP. Any consumer-specific concerns are reviewed in the weekly GH IDT meetings. In addition, these categories of incidents are reviewed bi-monthly at HRC. HRC requires documented follow up on consumers. The Directors of Community Living and Day and Placement Services participate in the HRC process as well as represent the Leadership Team. Documentation within individual consumer files as well as the HRC record evidence consistent follow up and documentation of such follow-up.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Developmental Disabilities Services incident report, dated 04/17/2012 at 4:38 p.m., indicated client G hit client C on the left shoulder. The record indicated late reporting of the incident (04/19/2012) and did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/25/12 at 8:05 a.m., indicated, "...staff asking if anyone said anything about a scratch on the top of [client D's] head..." The record did not indicate the facility investigated the injury of unknown origin.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/10/2012 at 2:30 p.m., indicated client C hit client D on the right upper leg. The record did not indicated the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/21/2012 at 3:00 p.m., indicated client G smacked a peer (not identified) in the back when she exited day services. The record did not</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/25/2012 at 8:00 a.m., indicated client G slapped client H in the face who in turn struck client G on her upper right arm and caused client G to lose her balance and fall. The record indicated late reporting (5/29/2012) and did not indicate the facility investigated the allegations of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/31/2012 at 2:00 p.m., indicated a female consumer (client H) grabbed client D's arm, leaving a scratch mark on his left forearm. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/04/2012 at 2:30 p.m., indicated a male consumer (client C) at day services hit client B in the middle of the back. The record indicated late reporting of the incident (06/06/2012) and did not indicate the facility</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/05/2012 at 12:50 p.m., indicated a male consumer (not identified) slapped client H's right arm with an open palm. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/06/2012 at 4:30 p.m., indicated, "...staff [DSP #9] noticed a bruise on right cheek of [client B's] buttock." The record indicated late reporting of the incident (06/11/2012) and did not indicate the facility investigated the injury of unknown origin.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/26/2012 at 8:35 a.m., indicated client H hit a female consumer (not identified) in the arm. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Developmental Disabilities Services incident report, dated 07/13/2012 at 8:00 a.m., indicated client H struck client G on her arm 3 times and spit at her. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 07/13/2012 at 8:45 a.m., indicated client H grabbed and hit a female consumer (not identified) in the arm. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 07/17/2012 at 9:00 a.m. indicated client B slapped a female (not identified) peer at day services. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 08/09/2012 at 1:40 p.m., indicated client D urinated on the arm of another consumer in day services (not identified). The record did not indicate the facility investigated the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 08/22/12 at 8:15 a.m., indicated client D hit client H on her arm. The record indicated an investigation was completed on 08/23/2012. The record did not indicate the facility notified the administrator of the investigation results within 5 working days.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 08/27/12 at 10:00 a.m., indicated client D grabbed a male consumer's (not a group home resident) wrist and would not let go. The record indicated the facility investigated the incident and increased monitoring of client D to prevent additional opportunities for client D to grab other consumers. The record did not indicate the facility notified the administrator of the investigation results.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 08/27/2012 at 10:05 a.m., indicated client D grabbed a female</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>consumer's (client H) arm who in turn scratched client D. The record indicated the facility investigated the incident and increased monitoring of client D to prevent additional opportunities for client D to grab other consumers. The record did not indicate the facility notified the administrator of the investigation results.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 09/11/2012 at 6:45 a.m., indicated client G and client H sat on the sofa at the same time and began slapping each other. The record did not indicate the facility investigated the allegations of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 09/27/2012 at 2:45 p.m., indicated a female consumer (not a group home resident) bumped into client H, who in turn, hit the female consumer. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>Client D's record was reviewed on 10/02/2012 at 11:05 a.m. A facility incident report, dated 08/29/2012 at 5:15 p.m. indicated, "...Staff called [client D] to the office for his 5P (5:00 p.m.) meds</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(medications). he (sic) brought w/ (with) him a broken record. he (sic) stated repeatedly "it hurts" when staff searched him a 2 1/2 inch scrape on his L (left) forearm...." The record indicated an Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report was not completed and did not indicate the facility investigated the injury of unknown origin.</p> <p>A "Bruising Documentation" record indicated scratches on client D's right hip on 8/31/2012. The record indicated an Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report had not been completed and did not indicate the facility investigated the injury of unknown origin.</p> <p>An "Investigation Protocol," dated December 2011, was reviewed on 10/01/2012 at 12:01 p.m. The policy indicated, "...Allegations of Consumer to Consumer Abuse/Neglect/Exploitation:</p> <ol style="list-style-type: none"> 1. All staff have the responsibility to report concerns via the Incident Report system and referred (sic) to the appropriate supervisor. Investigations of consumer to consumer mistreatment can be investigated by any of the following: Group Home Manager, Programming 			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Coordinator, QDDP (Qualified Developmental Disabilities Professional), or Nurse. 2. Upon notification of the allegation, the investigator must first determine if any immediate steps are taken to ensure the safety of all parties...3. The investigating staff is also responsible for completing the BDDS (Bureau of Developmental Disabilities) report in a timely manner...all relevant information (including a timeline) will be organized by the staff along with a summary of the findings and a recommendation of action. These will be forwarded to the Reviewing Director (Director of Day and Placement Services or Director of Community Living) for review and approval of the recommendations...Injuries of Unknown Origin: 1. All staff have the responsibility to report concerns via the Incident Report system and referred (sic) to the appropriate supervisor. Investigations of consumer to consumer mistreatment can be investigated by any of the following: Group Home Manager, Programming Coordinator, QDDP (Qualified Developmental Disabilities Professional), or Nurse. 2. Upon notification of the allegation, the investigator must first determine if any immediate steps are taken to ensure the safety of all parties...3. The investigating staff is also responsible for completing the BDDS (Bureau of Developmental</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Disabilities) report in a timely manner...all relevant information (including a timeline) will be organized by the staff along with a summary of the findings and a recommendation of action. These will be forwarded to the Reviewing Director (Director of Day and Placement Services or Director of Community Living) for review and approval of the recommendations...."</p> <p>During an interview on 10/03/2012 at 12:30 p.m., QDDP #1 indicated allegations of abuse/neglect/injuries of unknown origin should have been reported immediately to the Director. She indicated incident reports should have been submitted to BDDS within 24 hours of knowledge of the incident. QDDP #1 indicated all allegations of abuse/neglect/mistreatment/injuries of unknown origin should have been investigated. She indicated the investigation results/recommendations should have been provided to the Director within 5 working days.</p> <p>1. The facility failed to implement their policy and procedures to ensure all allegations of neglect/abuse/injury of unknown origin were immediately reported to the administrator and/or reported to state officials for 6 of 37 incidents reviewed for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>abuse/neglect/injuries of unknown origin for 3 of 4 sampled clients (clients B, C, and D) and 2 additional clients (clients G and H). Please see W153.</p> <p>2. The facility failed to implement their policy and procedures to ensure all allegations of neglect/abuse/injury of unknown origin were thoroughly investigated for 23 of 37 incidents reviewed for abuse/neglect/injuries of unknown origin for 3 of 4 sampled clients (clients B, C, and D) and 3 additional clients (clients E, G, and H). Please see W154.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(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	
W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility failed to ensure all allegations of abuse/neglect/mistreatment/injury of unknown origin were immediately reported to the administrator and/or reported to state officials in accordance with State law for 6 of 37 incidents reviewed for abuse/neglect/injuries of unknown origin for 3 of 4 sampled clients (clients B, C, and D) and 2 additional clients (clients G and H).</p> <p>Findings include:</p> <p>Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (DDRS/BDDS) incident reports and/or investigations from 03/01/2012 through 09/30/2012 and one additional internal report, dated 08/29/2012 were reviewed on 10/01/2011 at 11:50 a.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/17/2012 at 4:38</p>	W0153	In regard to W153, the Human Rights/Risk Management Committee will be monitoring all allegations of consumer-to-consumer abuse as well as injuries of unknown origin. These investigations are done by Programming Coordinators, Nurses, or QDDP on a formal written investigation form. These forms have been inconsistently reviewed by the IDT but will now be consistently reviewed by the HRC/RMC which means it will be reviewed at two times per month. Monitoring within the HRC/RMC format means that individual consumer (or site or staff) up-dates can be made and will be monitored for follow up. In response to a follow up letter: Every month, each program and county has staff meetings. Every month, the agenda includes reviewing the agency's Abuse/Neglect/Exploitation policy so it is always reinforced with staff. In the GH setting, there are always at least two staff on the schedule so there are multiple staff monitoring consumer behaviors and staff-consumer interactions. All staff receive training on completing Incident	11/02/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>p.m., indicated client G hit client C on the left shoulder. The record indicated late reporting (04/19/2012) of the incident.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/25/2012 at 8:00 a.m., indicated client G slapped client H in the face who in turn struck client G on her upper right arm and caused client G to lose her balance and fall. The record indicated late reporting (5/29/2012) of the incident.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/04/2012 at 2:30 p.m., indicated a male consumer (client C) at day services hit client B in the middle of the back. The record indicated late reporting (06/06/2012) of the incident.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/06/2012 at 4:30 p.m., indicated, "...staff [DSP #9] noticed a bruise on right cheek of [client B's] buttock. The record indicated late reporting (06/11/2012) of the incident.</p>		<p>Reporting which includes but is not limited to indicators of A/N/E, consumer-consumer aggression, and all injuries. These are completed prior to the end of the shift so that appropriate individuals are notified (depending on the issue it could be the QDDP, Nurse, or Programming Coordinator). All Incident Reports are reviewed by Programming Coordinators and QDDPs within 24 hours (usually less). This two-person review process is to ensure that all concerns are noted and addressed. The PC completes any investigations of consumer-consumer abuse allegations as well as injuries of unknown origins. There is a standardized form used within the agency for this. The completed investigations are reviewed by the QDDP. Any consumer-specific concerns are reviewed in the weekly GH IDT meetings. In addition, these categories of incidents are reviewed bi-monthly at HRC. HRC requires documented follow up on consumers. The Directors of Community Living and Day and Placement Services participate in the HRC process as well as represent the Leadership Team. Documentation within individual consumer files as well as the HRC record evidence consistent follow up and documentation of such follow-up.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Client D's record was reviewed on 10/02/2012 at 11:05 a.m. A facility incident report, dated 08/29/2012 at 5:15 p.m. indicated, "...Staff called [client D] to the office for his 5P (5:00 p.m.) meds (medications). he (sic) brought w/ (with) him a broken record. he (sic) stated repeatedly "it hurts" when staff searched him a 2 1/2 inch scrape on his L (left) forearm...." The record did not indicate an Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report was completed and did not indicate the facility immediately notified the administrator of the injury of unknown origin.</p> <p>A "Bruising Documentation" record indicated scratches on client D's right hip on 8/31/2012. The record did not indicate an Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report had been completed and did not indicate the facility immediately notified the administrator of the injury of unknown origin.</p> <p>An "Investigation Protocol," dated December 2011, was reviewed on 10/01/2012 at 12:01 p.m. The policy indicated, "...Allegations of Consumer to Consumer Abuse/Neglect/Exploitation:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>1. All staff have the responsibility to report concerns via the Incident Report system and referred (sic) to the appropriate supervisor...3. The investigating staff is also responsible for completing the BDDS (Bureau of Developmental Disabilities) report in a timely manner...Injuries of Unknown Origin: 1. All staff have the responsibility to report concerns via the Incident Report system and referred (sic) to the appropriate supervisor...3. The investigating staff is also responsible for completing the BDDS (Bureau of Developmental Disabilities) report in a timely manner...."</p> <p>During an interview on 10/03/2012 at 12:30 p.m., QDDP #1 indicated allegations of abuse/neglect/injuries of unknown origin should have been reported immediately to the Director. She indicated incident reports should have been submitted to BDDS within 24 hours of knowledge of the incident.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0154	<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 ensure all allegations of abuse/neglect/mistreatment/injury of unknown origin were thoroughly investigated for 23 of 37 incidents reviewed for abuse/neglect/injuries of unknown origin for 3 of 4 sampled clients (clients B, C, and D) and 3 additional clients (clients E, G, and H).</p> <p>Findings include:</p> <p>Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services (BDDS/DDRS) incident reports and/or investigations from 03/01/2012 through 09/30/2012 and one additional internal report, dated 08/29/2012 were reviewed on 10/01/2011 at 11:50 a.m.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 03/21/2012 at 10:17 a.m., indicated, "...consumers were having a tornado drill...[client G] hit 2 male consumers and threw her water bottle...." The record did not indicate the facility investigated the allegation of client abuse.</p>	W0154	In regard to W154, the Human Rights/Risk Management Committee will be monitoring all allegations of consumer-to-consumer abuse as well as injuries of unknown origin. These investigations are done by Programming Coordinators, Nurses, or QDDP on a formal written investigation form. These forms have been inconsistently reviewed by the IDT but will now be consistently reviewed by the HRC/RMC which means it will be reviewed at two times per month. Monitoring within the HRC/RMC format means that individual consumer (or site or staff) up-dates can be made and will be monitored for follow up. In response to a follow up letter: Every month, each program and county has staff meetings. Every month, the agenda includes reviewing the agency's Abuse/Neglect/Exploitation policy so it is always reinforced with staff. In the GH setting, there are always at least two staff on the schedule so there are multiple staff monitoring consumer behaviors and staff-consumer interactions. All staff receive training on completing Incident Reporting which includes but is not limited to indicators of A/N/E, consumer-consumer aggression,	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 03/29/2012 at 6:50 p.m., indicated client G hit client E in the chest. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/11/2012 at 12:53 p.m., indicated a female consumer (not identified) pulled client H's hair. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/11/2012 at 3:56 p.m., indicated client G hit client B on the right shoulder resulting in a scratch on client B's shoulder blade. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/17/2012 at 4:38 p.m., indicated client G hit client C on the</p>		<p>and all injuries. These are completed prior to the end of the shift so that appropriate individuals are notified (depending on the issue it could be the QDDP, Nurse, or Programming Coordinator). All Incident Reports are reviewed by Programming Coordinators and QDDPs within 24 hours (usually less). This two-person review process is to ensure that all concerns are noted and addressed. The PC completes any investigations of consumer-consumer abuse allegations as well as injuries of unknown origins. There is a standardized form used within the agency for this. The completed investigations are reviewed by the QDDP. Any consumer-specific concerns are reviewed in the weekly GH IDT meetings. In addition, these categories of incidents are reviewed bi-monthly at HRC. HRC requires documented follow up on consumers. The Directors of Community Living and Day and Placement Services participate in the HRC process as well as represent the Leadership Team. Documentation within individual consumer files as well as the HRC record evidence consistent follow up and documentation of such follow-up.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>left shoulder. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 04/25/12 at 8:05 a.m., indicated, "...staff asking if anyone said anything about a scratch on the top of [client D's] head..." The record did not indicate the facility investigated the injury of unknown origin.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/10/2012 at 2:30 p.m., indicated client C hit client D on the right upper leg. The record did not indicated the facility investigated the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/21/2012 at 3:00 p.m., indicated client G smacked a peer (not identified) in the back when she exited day services. The record did not indicate the facility investigated the allegation of client abuse.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/25/2012 at 8:00 a.m., indicated client G slapped client H in the face who in turn struck client G on her upper right arm and caused client G to lose her balance and fall. The record did not indicate the facility investigated the allegations of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 05/31/2012 at 2:00 p.m., indicated a female consumer (client H) grabbed client D's arm, leaving a scratch mark on his left forearm. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/04/2012 at 2:30 p.m., indicated a male consumer (client C) at day services hit client B in the middle of the back. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>incident report, dated 06/05/2012 at 12:50 p.m., indicated a male consumer (not identified) slapped client H's right arm with an open palm. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/06/2012 at 4:30 p.m., indicated, "...staff [DSP #9] noticed a bruise on right cheek of [client B's] buttock." The record did not indicate the facility investigated the injury of unknown origin.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 06/26/2012 at 8:35 a.m., indicated client H hit a female consumer (not identified) in the arm. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 07/13/2012 at 8:00 a.m., indicated client H struck client G on her arm 3 times and spit at her. The record did not indicate the facility investigated the allegation of client abuse.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 07/13/2012 at 8:45 a.m., indicated client H grabbed and hit a female consumer (not identified) in the arm. The record did not indicate the facility investigated the allegation of abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 07/17/2012 at 9:00 a.m. indicated client B slapped a female (not identified) peer at day services. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 08/09/2012 at 1:40 p.m., indicated client D urinated on the arm of another consumer in day services (not identified). The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 08/27/2012 at 10:05</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a.m., indicated client D grabbed a female consumer's (client H) arm who in turn scratched client D. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 09/11/2012 at 6:45 a.m., indicated client G and client H sat on the sofa at the same time and began slapping each other. The record did not indicate the facility investigated the allegations of client abuse.</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 09/27/2012 at 2:45 p.m., indicated a female consumer (not a group home resident) bumped into client H, who in turn, hit the female consumer. The record did not indicate the facility investigated the allegation of client abuse.</p> <p>Client D's record was reviewed on 10/02/2012 at 11:05 a.m. A facility incident report, dated 08/29/2012 at 5:15 p.m. indicated, "...Staff called [client D] to the office for his 5P (5:00 p.m.) meds (medications). he (sic) brought w/ (with) him a broken record. he (sic) stated repeatedly "it hurts" when staff searched</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>him (sic) a 2 1/2 inch scrape on his L (left) forearm...." The record indicated an Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report was not completed and the facility did not investigate the injury of unknown origin.</p> <p>A "Bruising Documentation" record indicated scratches on client D's right hip on 8/31/2012. The record indicated an Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report had not been completed and the facility did not investigate the injury of unknown origin.</p> <p>An "Investigation Protocol," dated December 2011, was reviewed on 10/01/2012 at 12:01 p.m. The policy indicated, "...Allegations of Consumer to Consumer Abuse/Neglect/Exploitation: 1. All staff have the responsibility to report concerns via the Incident Report system and referred (sic) to the appropriate supervisor. Investigations of consumer to consumer mistreatment can be investigated by any of the following: Group Home Manager, Programming Coordinator, QDDP (Qualified Developmental Disabilities Professional), or Nurse. 2. Upon notification of the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>allegation, the investigator must first determine if any immediate steps are taken to ensure the safety of all parties...3. The investigating staff is also responsible for completing the BDDS (Bureau of Developmental Disabilities) report in a timely manner...all relevant information (including a timeline) will be organized by the staff along with a summary of the findings and a recommendation of action...Injuries of Unknown Origin: 1. All staff have the responsibility to report concerns via the Incident Report system and referred (sic) to the appropriate supervisor. Investigations of consumer to consumer mistreatment can be investigated by any of the following: Group Home Manager, Programming Coordinator, QDDP (Qualified Developmental Disabilities Professional), or Nurse. 2. Upon notification of the allegation, the investigator must first determine if any immediate steps are taken to ensure the safety of all parties...3. The investigating staff is also responsible for completing the BDDS (Bureau of Developmental Disabilities) report in a timely manner...all relevant information (including a timeline) will be organized by the staff along with a summary of the findings and a recommendation of action...."</p> <p>During an interview on 10/03/2012 at</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>12:30 p.m., QDDP #1 indicated all allegations of abuse/neglect/mistreatment/injuries of unknown origin should have been investigated.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
W0189	<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 duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview, the facility failed to adequately train staff to follow menus and fluid consistency for 4 of 4 sampled clients (clients A, B, C, and D) and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p> <p>During observations at the group home on 10/01/2012 between 3:50 p.m., and 6:30 p.m., client D was out of the facility with his mother.</p> <p>During observation on 10/01/2012 at 5:10 p.m. Direct Support Professional (DSP) #4 blended client E's and F's food to pureed texture. She pre-plated each client's food. Clients E and F received 1 slice of pureed pizza, 1 pureed breadstick, 1/2 cup of pureed California blend vegetables and 1 cup of pureed salad with 2 tablespoons of French dressing. Clients E and F did not receive 2 additional pieces of pizza or a second breadstick.</p> <p>During observations on 10/01/2012 at 5:30 p.m., DSP #3 filled and gave clients</p>	W0189	<p>In response to W189, DSP are trained in regard to dietary expectations for consumers. This includes the different kind of meal preparations, portion sizes, menus, etc. These issues are also reviewed during the staff's "On the Job" training at each site as well as the monthly GH staff meetings. This will continue to be a focus of the intial and on-going trainings. In addition, the agency's nutritonal services provider has been contacted to do an on-site training with staff which will be done on a quarterly basis. ASI is in the process of over-hauling the staff evalaution process to include more competency-based ratings. This will include more opportunities for staff to demonstrate understanding and use of skills, including dietary services, as part of evaluation process.</p>	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

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

	<p>A, B, C, F, G, and H an 8 ounce glass of skim milk. DSP #5 thickened client E's milk to pudding consistency. DSP #4 carried a pan of pizza around the table and instructed clients A, B, C, G, and H to take one slice of pizza. DSP #4 carried a pan of breadsticks around the table and instructed clients A, B, C, G, and H to serve themselves one bread stick. Each client served themselves the quantity of pizza and bread sticks directed by DSP #4. DSP #3 carried the salad bowl around the table and assisted clients B, G, and H to serve themselves 1 cup of salad using hand over hand assistance. DSP #3 held the salad bowl while clients A and C served themselves 1 cup of salad. DSP #3 took the salad bowl to the kitchen and placed it on the counter after all clients were served. DSP #5 carried a dish of steamed vegetables around the table and assisted client B, G, and H to serve themselves 1/2 cup of vegetables using hand over hand assistance. DSP #5 took the vegetables to the kitchen and placed them on the counter. Clients A and C were not offered steamed vegetables. Client A asked for and received 1/2 cup of vegetables. Client C did not receive the menu item. Client G asked for and received a second piece of pizza. Clients A, B, C, D and H did not receive the additional 2 slices of pizza listed on the menu. Client G did not receive the 3rd</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>slice of pizza on the menu. Clients A, B, C, D, G and H did not receive the second breadstick.</p> <p>During observations on 10/02/2012 at 5:55 a.m., clients D, E, F, and H were seated at the dining table. Client E had finished breakfast and his divided plate was empty. Client E was drinking 4 ounces of nectar thick orange juice. Clients D, F, and H each had a bowl of oatmeal, a plate with 1 sausage patty, and a glass with 4 ounces of orange juice in front of them and had not begun eating. Client F's oatmeal and sausage patty were pureed. Clients D, E, F, and H did not have an 8 ounce glass of milk. Four dining chairs were unoccupied. A bowl of oatmeal, a plate with 1 sausage patty, and a glass containing 4 ounces of orange juice were on the table in front of the empty chairs. There were no glasses of milk on the table. Clients A, C and G came to the dining table at 6:00 a.m. and each client sat in one of the empty chairs and began consuming the pre-plated food and drink. At 6:20 a.m., client H asked for milk. DSP #8 informed client H that the facility was out of milk. Client B came to the table at 6:35 a.m. DSP #8 warmed client B's food in the microwave. DSP #2 and client E went to the store and returned with a gallon of skim milk at 6:40 a.m. DSP #2 poured 4 ounces of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>milk in a glass and handed it to Client H. Client H did not receive the menu quantity of 8 ounces of milk. Clients, A, B, C, D, E, F, and G did not receive the menu item of 8 ounces of skim or whole milk (depending on diet orders).</p> <p>The menu, dated Summer 2012, week 2, was reviewed on 10/02/2012 at 8:15 a.m. The regular diet menu indicated, "...Monday...Evening: Pepperoni Pizza 3 slices, California Blend Veg (vegetables)1/2 Cup, Breadsticks 2 each, Tossed Salad w/ (with) Tomato 1 Cup, Choice LF (low fat) Dressing 4 fl oz (fluid ounces), Milk Whole 1/2 c (cup)..." The pureed menu indicated. "...Monday...Pizza -pur (pureed) 1 cup, California Veg Blend - pur 1/2 cup, Tossed Salad-pur 1/2 cup, Choice LF Dressing 2 TBS (Tablespoons) Milk, Whole 1/2 cup..." The 2000 Calorie, no concentrated sweets/low cholesterol/double portion protein indicated, "...Evening: Pepperoni Pizza 3 slices, Shredded Cheese 1 oz, California Blend Veg (vegetables) 1/2 Cup, Breadsticks 2 each, Tossed Salad w/ (with) Tomato 1 Cup, Choice LF (low fat) Dressing 4 fl oz (fluid ounces), Milk, skim 4 oz (ounces)..." The regular and pureed menu indicated, "...Tuesday...Breakfast: Vitamin C Juice 4 oz, Hot or Cold Cereal 1 cup, Sausage</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Patty, 1 ea (each) Milk, Whole 8 oz (ounces)...." The 2000 Calorie, no concentrated sweets/low cholesterol/double portion protein menu indicated, "...Tuesday...Breakfast: Vitamin C Juice 4 oz, Hot or Cold Cereal 1 cup, Sausage Patty, 1 ea (each) Milk, Skim, 8 oz (ounces)...."</p> <p>Client E's record was reviewed on 10/03/2012 at 11:00 a.m. The record indicated client E should have received nectar thick liquids.</p> <p>During an interview on 10/01/2012 at 4:30 p.m., DSP #3 indicated she did not know where to look to determine the portion sizes of food to be served.</p> <p>During an interview on 10/01/2012 at 4:30 p.m., DSP #5 indicated she did not know where to look to determine the portion sizes of food to be served. DSP #5 stated, "I don't really know how thick the liquid is supposed to be (for client E)."</p> <p>During an interview on 10/01/2012 at 4:30 p.m., DSP #6 indicated she did not know where to look to determine the portion sizes of food to be served.</p> <p>During an interview on 10/01/2012 at 6:20 p.m., DSP #4 stated, "I rely on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>memory from my old job" for determining portion sizes.</p> <p>During an interview on 10/02/2012 at 6:15 a.m., DSP #8 indicated she was aware that clients should have received milk for breakfast. DSP #8 stated, "I didn't know anyone received whole milk."</p> <p>During an interview on 10/03/2012 at 11 a.m., LPN #1 indicated she had trained staff in the dining programs and fluid consistencies. She indicated staff should have followed the menus for portion sizes.</p> <p>During an interview on 10/03/2012 at 12:30 p.m., Qualified Developmental Disabilities Professional (QDDP) #1 indicated staff had been trained in portion sizes and fluid consistency. She indicated staff should have followed the menu for portion sizes.</p> <p>9-3-3(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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, the facility failed to implement Individual Support Plan (ISP) objectives when training opportunities existed formally and informally for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p> <p>During observations at the group home on 10/01/2012 between 3:50 p.m., and 6:30 p.m., client D was out of the facility with his mother.</p> <p>During observation on 10/01/2012 at 5:10 p.m. Direct Support Professional (DSP) #4 placed 4 frozen pizzas on pans. She placed frozen breadsticks on a pan. DSP #4 put 2 pizzas and the pan of breadsticks in the oven to bake. She did not encourage any clients to assist with the food preparation. DSP #4 opened a bag of frozen California blend vegetables and poured the vegetables into a pan of</p>	W0249	<p>In response to W189, DSP are trained in regard to dietary expectations for consumers. This includes the different kind of meal preparations, portion sizes, menus, etc. These issues are also reviewed during the staff's "On the Job" training at each site as well as the monthly GH staff meetings. This will continue to be a focus of the intial and on-going trainings. In addition, the agency's nutritonal services provider has been contacted to do an on-site training with staff which will be done on a quarterly basis. ASI is in the process of over-hauling the staff evaluation process to include more competency-based ratings. This will include more opportunities for staff to demonstrate understanding and use of skills, including dietary services, as part of evaluation process.</p>	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>boiling water. She did not encourage any clients to assist with preparing the food item. DSP #4 removed the baked pizzas and breadsticks from the oven and cut the pizza into slices. No clients were offered an opportunity to cut the pizzas. DSP #4 blended client E and F's food to pureed consistency. She did not encourage either client to participate in processing their food.</p> <p>During observations on 10/01/2012 at 5:30 p.m., DSP #3 filled 8 glasses (8 ounces) with milk and carried the glasses to the table. Clients A, B, C, F, G, and H were each given a glass of milk and were not provided opportunities to pour their own beverages. DSP #5 added thickener to client E's milk and placed the glass in front of him. Client E was not provided an opportunity to stir his beverage.</p> <p>Client A's record was reviewed on 10/02/2012 at 9:59 a.m. An Adaptive Behavior Scale-Residential and Community assessment, dated 09/30/2012 indicated client A was able to prepare simple foods that don't require mixing.</p> <p>Client B's record was reviewed on 10/02/2012 at 12:12 p.m. An Individual Support Plan (ISP), dated 09/13/2012, indicated client B had a cooking goal of making a sandwich.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Client C's record was reviewed on 10/02/2012 at 1:51 p.m. An ISP, dated 06/14/2012, indicated client C had a goal for making a sandwich and a pitcher of tea.</p> <p>Client D's record was reviewed on 10/02/2012 at 11:05 a.m. An ISP, dated 08/16/2012, indicated client D had a goal for making a sandwich, setting the table and pouring a glass of water.</p> <p>Client E's record was reviewed on 10/03/2012 at 11:00 a.m. The record indicated client E had a goal for stirring "thick it" in his supper beverage.</p> <p>Client F's record was reviewed on 10/03/2012 at 11:30 a.m. The record indicated client F had a goal for pouring water into the coffee maker.</p> <p>During an interview on 10/02/2012 at 6:15 p.m., DSP #4 indicated client G helped make the salad prior to the observation process. She indicated clients B and F were able to open containers and stir. DSP #4 stated, "[Client D] was supposed to help with dinner, but he was gone."</p> <p>During an interview on 10/03/2012, Qualified Developmental Disabilities</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Professional (QDDP) #1 stated, "All clients are capable of assisting with food preparation in some capacity. Most of them have a cooking goal." QDDP #1 indicated clients should have participated in meal preparation.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observations and interview, the facility failed to ensure clients dignity in regards to associating individuals with the type of diet they received for 2 additional clients (clients E and F).</p> <p>Findings include:</p> <p>1. During observations on 10/01/2012 at 5:30 p.m., client A asked why chicken broth was on the counter. Direct Support Professional (DSP) #4 stated, " I used it to make the pureeds' food" and pointed to clients E and F.</p> <p>During an interview on 10/02/2012 at 8:45 a.m., Qualified Developmental Disabilities Professional (QDDP) #1 stated, "Staff should never label a client by the type of diet he receives."</p> <p>9-3-5(a)</p>	W0268	In regard to W268, the finding is a good opportunity for coaching. This will be done individually with the staff person involved but also with all staff during regularly scheduled meetings. In addition, this example will related to the agency trainer to be included in lessons for incoming staff.	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility nursing services failed to ensure staff were trained in regards to medication administration, fluid consistencies and menus and failed to clarify/obtain physician orders for diet and medication changes for 3 of 4 sampled clients (clients A, B, and D) and 3 additional clients (clients E, F and H). The facility nursing services failed to schedule/obtain a diagnostic test when recommended by the physician for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>During observations on 10/01/2012 at 5:00 p.m. Direct Support Professional #3 gave client B Lorazepam (antianxiety medication) 0.5 mg (milligrams).The medication label indicated the time for administration was "bedtime."</p> <p>During observation on 10/01/2012 at 5:30 p.m., DSP #3 filled client E's glass with 8 ounces of skim milk. DSP #5 thickened the milk to pudding consistency</p> <p>During observations on 10/02/2012 at 7:00 a.m., DSP #8 gave client E liquids medications (Calcium 500 milligrams (5</p>	W0331	<p>In regard to W331, there are several action steps related to nursing that the agency has or will be putting in place to improve the consistency/quality of nursing care. These include: * A second nurse added to distribute case loads to ensure more hands-on evaluation/care. * Medication administration monitoring will be a regular component of nursing function in the home. * Programmign Coordinators and GH Lead DSP will receive additional training in medication administration monitoring.* PC have assumed more responsibility with working with the pharmacy to review MAR prior to medications entering the home. The consumer with the specific concerns with liquids is being addressed with his treatment team. He has inconsistent orders from doctors and speech therapists.</p>	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>milliliters) and Colace 200 mg (20 milliliters) that were not thickened to nectar consistency. DSP #8 gave client H Peridex 15 milliliters and instructed her to swallow the medication.</p> <p>Client B's record was reviewed on 10/02/2012 at 12:12 p.m. The Medication Administration Record, dated 10/01/2012-10/31/2012 indicated. "...LORAZEPAM 0.5 MG GIVE 1 TAB BY MOUTH AT BEDTIME...." The physician's recapitulation, dated 10/01/2012-10/31/2012 indicated. "...LORAZEPAM 0.5 MG GIVE 1 TAB BY MOUTH AT BEDTIME...."</p> <p>Client A's record was reviewed on 10/02/2012 at 9:59 a.m. A physical, dated 09/10/2012, indicated, "...Swallow study...." The record did not indicate the diagnostic test had been completed.</p> <p>Client D's record was reviewed on 10/02/2012 at 11:05 a.m. A physician's prescription order, dated 1/11/2012 indicated, "...2200 cal (calorie) ADA (American Diabetic Association) c (with) double protein portions...." A nutritional note, dated 06/30/2012, indicated client D was on a regular, no concentrated sweets diet. A physician's appointment form, dated 09/28/2012 indicated, "...High fiber diet...." A physician's recapitulation</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>order, dated 10/01/2012-10/31/2012, indicated, "...2200 CALORIE DIET WITH DOUBLE PROTEIN PORTIONS LACTOSE INTOLERANT..."</p> <p>Client E's record was reviewed on 10/03/2012 at 11:00 a.m. The record indicated client E should have received nectar thick liquids.</p> <p>Client H's record was reviewed on 10/03/2012 at 11:05 a.m. The physician's recapitulation, dated 10/02/2012-10/31/2012, indicated, "...CHLOREX SOL (solutions) 0.12 % RINSE MOUTH WITH 15 ML DAILY..."</p> <p>During an interview on 10/01/2012 at 4:30 p.m., DSP #5 stated, "I don't really know how thick the liquid is supposed to be (for client E)."</p> <p>During an interview on 10/01/2012 at 5:15 p.m., DSP #3 stated, "The time was changed for [client B's] medication (Lorazepam)."</p> <p>During an interview on 10/02/2012 at 7:30 a.m., DSP #8 stated, "[Client H] can't swish and spit the mouth rinse so I have her swallow it instead."</p> <p>During an interview on 10/03/2012 at 11</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>a.m., LPN #1 indicated she did not obtain a physician's order to change the time client B's Lorazepam was administered. LPN #1 indicated staff were trained to fluid consistencies and should have given liquid medications at the same consistency as the diet order. LPN #1 indicated client H should not have swallowed the Peridex. LPN #1 indicated she did not have accessible documentation to provide evidence of training staff in regards to fluid consistencies and medication administration. LPN #1 indicated she had not scheduled client A's swallow study. LPN #1 indicated she had not clarified client D's diet order.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, interview and record review, the facility failed to ensure clients' medications were administered without error for 2 of 17 medications observed for 1 of 4 sampled clients (client B) and 1 additional client (client H).</p> <p>Findings include:</p> <p>During observations on 10/01/2012 at 5:00 p.m. Direct Support Professional #3 gave client B Lorazepam (antianxiety medication) 0.5 mg (milligrams). The medication label indicated the time for administration was "bedtime."</p> <p>During observations on 10/02/2012 at 7:00 a.m., DSP #8 gave client E liquids medications (Calcium 500 milligrams (5 milliliters) and Colace 200 mg (20 milligrams) that were not thickened to nectar consistency. DSP #8 gave client H Peridex 15 milliliters and instructed her to swallow the medication.</p> <p>Client B's record was reviewed on 10/02/2012 at 12:12 p.m. The Medication Administration Record, dated 10/01/2012-10/31/2012 indicated.</p>	W0369	<p>In regard to W369, there are several action steps related to nursing that the agency has or will be putting in place to improve the consistency/quality of nursing care. These include: * A second nurse added to distribute case loads to ensure more hands-on evaluation/care. * Medication administration monitoring will be a regular component of nursing function in the home. * Programmnign Coordinators and GH Lead DSP will receive additional training in medication administration monitoring.* PC have assumed more responsibility with working with the pharmacy to review MAR prior to medications entering the home.</p>	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>"...LORAZEPAM 0.5 MG GIVE 1 TAB BY MOUTH AT BEDTIME..." The physician's recapitulation, dated 10/01/2012-10/31/2012 indicated.</p> <p>"...LORAZEPAM 0.5 MG GIVE 1 TAB BY MOUTH AT BEDTIME..."</p> <p>Client H's record was reviewed on 10/03/2012 at 11:05 a.m. The physician's recapitulation, dated 10/02/2012-10/31/2012, indicated, "...CHLOREX SOL (solutions) 0.12 % RINSE MOUTH WITH 15 ML DAILY..."</p> <p>During an interview on 10/01/2012 at 5:15 p.m., DSP #3 stated, "The time was changed for [client B's] medication.</p> <p>During an interview on 10/02/2012 at 7:30 a.m., DSP #8 stated, "[Client H] can't swish the medicine and spit it so I have her swallow it instead."</p> <p>During an interview on 10/03/2012 at 11 a.m., LPN #1 indicated client H should not have swallowed the Peridex. LPN #1 stated, "I noticed she [client B] was having more seizures in the evenings so I asked about changing the time we gave the Lorazepam." LPN #1 indicated she did not obtain a physician's order to change the time client B's Lorazepam was administered.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
	9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0440	<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 ensure an evacuation drill was conducted quarterly for each shift for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p> <p>The facility's evacuation drills for clients A, B, C, D, E, F, G and H were reviewed on 10/02/2012 at 10:00 a.m. Records indicated a drill was not completed during the night shift (10:00 p.m.-6:00 a.m.) during the quarter covering October, November, December, 2011.</p> <p>During an interview on 10/02/2012 at 10:30 a.m. the House Manager indicated a drill had not been completed on the night shift during the quarter covering October, November, December, 2011.</p> <p>During an interview on 10/03/2012 at 12:30 p.m., the Qualified Developmental Disabilities Professional indicated a fire drill should have been completed on all shifts quarterly.</p> <p>9-3-7(a)</p>	W0440	In regard to W440, the 2012 and 2013 schedule for drills has been created and are followed. In addition, the drill binders for each GH are reviewed at each month's Safety Committee meeting.	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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
W0460	<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>Based on observation, interview and record review, the facility failed to ensure the planned menus were followed for dinner and breakfast for 4 of 4 sampled clients (clients A, B, C and D) and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p> <p>During observations at the group home on 10/01/2012 between 3:50 p.m., and 6:30 p.m., client D was out of the facility with his mother.</p> <p>During observation on 10/01/2012 at 5:10 p.m. Direct Support Professional (DSP) #4 blended client E's and F's food to pureed texture. She pre-plated each client's food. Clients E and F received 1 slice of pureed pizza, 1 pureed breadstick, 1/2 cup of pureed California blend vegetables and 1 cup of pureed salad with 2 tablespoons of French dressing. Clients E and F did not receive 2 additional pieces of pizza or a second breadstick.</p> <p>During observations on 10/01/2012 at 5:30 p.m., DSP #3 filled and gave clients A, B, C, F, G, and H an 8 ounce glass of skim milk. DSP #5 added thickener to</p>	W0460	<p>In response to W460, DSP are trained in regard to dietary expectations for consumers. This includes the different kind of meal preparations, portion sizes, menus, etc. These issues are also reviewed during the staff's "On the Job" training at each site as well as the monthly GH staff meetings. This will continue to be a focus of the intial and on-going trainings. In addition, the agency's nutritonal services provider has been contacted to do an on-site training with staff which will be done on a quarterly basis. ASI is in the process of over-hauling the staff evalaution process to include more competency-based ratings. This will include more opportunities for staff to demonstrate understanding and use of skills, including dietary services, as part of evaluation process.</p>	11/02/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client E's milk and placed the glass in front of him. DSP #4 carried a pan of pizza around the table and instructed clients A, B, C, G, and H to take one slice of pizza. DSP #4 carried a pan of breadsticks around the table and instructed clients A, B, C, G, and H to serve themselves one bread stick. Each client served themselves the quantity of pizza and bread sticks directed by DSP #4. DSP #3 carried the salad bowl around the table and assisted clients B, G, and H to serve themselves 1 cup of salad using hand over hand assistance. DSP #3 held the salad bowl while clients A and C served themselves 1 cup of salad. DSP #3 took the salad bowl to the kitchen and placed it on the counter after all clients were served. DSP #5 carried a dish of steamed vegetables around the table and assisted client B, G, and H to serve themselves 1/2 cup of vegetables using hand over hand assistance. DSP #5 took the vegetables to the kitchen and placed them on the counter. Clients A and C were not offered steamed vegetables. Client A asked for and received 1/2 cup of vegetables. Client C did not receive the menu item. Client G asked for and received a second piece of pizza. Clients A, B, C, D and H did not receive the additional 2 slices of pizza listed on the menu. Client G did not receive the 3rd slice of pizza on the menu. Clients A, B,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>C, D, G and H did not receive the second breadstick.</p> <p>During observations on 10/02/2012 between 5:55 a.m. and 8:00 a.m., clients D, E, F, and H were seated at the dining table. Client E had finished breakfast and his divided plate was empty. Client E was drinking 4 ounces of nectar thick orange juice. Clients D, F, and H each had a bowl of oatmeal, a plate with 1 sausage patty, and a glass with 4 ounces of orange juice in front of them and had not begun eating. Client F's oatmeal and sausage patty were pureed. Clients D, E, F, and H did not have an 8 ounce glass of milk. Four dining chairs were unoccupied. A bowl of oatmeal, a plate with 1 sausage patty, and a glass containing 4 ounces of orange juice were on the table in front of the empty chairs. There were no glasses of milk on the table. Clients A, C and G came to the dining table at 6:00 a.m. and each client sat in one of the empty chairs and began consuming the pre-plated food and drink. At 6:20 a.m., client H asked for milk. DSP #8 informed client H that the facility was out of milk. Client B came to the table at 6:35 a.m. DSP #8 warmed client B's food in the microwave. DSP #2 and client E went to the store and returned with a gallon of skim milk at 6:40 a.m. DSP #2 poured 4 ounces of milk in a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>glass and handed it to Client H. Client H did not receive the menu quantity of 8 ounces of milk. Clients, A, B, C, D, E, F, and G did not receive the menu item of 8 ounces of skim or whole milk (depending on diet orders).</p> <p>The menu, dated Summer 2012, week 2, was reviewed on 10/02/2012 at 8:15 a.m. The regular diet menu indicated, "...Monday...Evening: Pepperoni Pizza 3 slices, California Blend Veg (vegetables)1/2 Cup, Breadsticks 2 each, Tossed Salad w/ (with) Tomato 1 Cup, Choice LF (low fat) Dressing 4 fl oz (fluid ounces), Milk Whole 1/2 c (cup)..." The pureed menu indicated. "...Monday...Pizza -pur (pureed) 1 cup, California Veg Blend - pur 1/2 cup, Tossed Salad-pur 1/2 cup, Choice LF Dressing 2 TBS (Tablespoons) Milk, Whole 1/2 cup..." The 2000 Calorie, no concentrated sweets/low cholesterol/double portion protein indicated, "...Evening: Pepperoni Pizza 3 slices, Shredded Cheese 1 oz, California Blend Veg (vegetables) 1/2 Cup, Breadsticks 2 each, Tossed Salad w/ (with) Tomato 1 Cup, Choice LF (low fat) Dressing 4 fl oz (fluid ounces), Milk, skim 4 oz (ounces)..." The regular and pureed menu indicated, "...Tuesday...Breakfast: Vitamin C Juice 4 oz, Hot or Cold Cereal 1 cup, Sausage</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Patty, 1 ea (each) Milk, Whole 8 oz (ounces)...." The 2000 Calorie, no concentrated sweets/low cholesterol/double portion protein menu indicated, "...Tuesday...Breakfast: Vitamin C Juice 4 oz, Hot or Cold Cereal 1 cup, Sausage Patty, 1 ea (each) Milk, Skim, 8 oz (ounces)...."</p> <p>During an interview on 10/01/2012 at 4:30 p.m., DSP #3 indicated she did not know where to look to determine the portion sizes of food to be served.</p> <p>During an interview on 10/01/2012 at 4:30 p.m., DSP #5 indicated she did not know where to look to determine the portion sizes of food to be served.</p> <p>During an interview on 10/01/2012 at 4:30 p.m., DSP #6 indicated she did not know where to look to determine the portion sizes of food to be served.</p> <p>During an interview on 10/01/2012 at 6:20 p.m., DSP #4 stated, "I rely on memory from my old job" for determining portion sizes.</p> <p>During an interview on 10/02/2012 at 6:15 a.m., DSP #8 indicated she was aware that clients should have received milk for breakfast. DSP #8 stated, "I didn't know anyone received whole milk."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>During an interview on 10/03/2012 at 11 a.m., LPN #1 indicated she had trained staff in the dining programs. She indicated staff should have followed the menus for portion sizes.</p> <p>During an interview on 10/03/2012 at 12:30 p.m., Qualified Developmental Disabilities Professional (QDDP) #1 indicated staff should have followed the menu for portion sizes.</p> <p>9-3-8(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(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			
W0488	<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.</p> <p>Based on observation and interview, the facility failed to encourage clients to participate in dining procedures to the extent they were capable for 3 of 4 sampled clients (clients A, B and C) and 4 additional clients (clients E, F, G and H).</p> <p>Findings include:</p> <p>During observations at the group home on 10/01/2012 between 3:50 p.m., and 6:30 p.m., client D was out of the facility with his mother.</p> <p>During observation on 10/01/2012 at 5:10 p.m. Direct Support Professional (DSP) #4 placed 4 frozen pizzas on pans. She placed frozen breadsticks on a pan. DSP #4 put 2 pizzas and the pan of breadsticks in the oven to bake. She did not encourage any clients to assist with the food preparation. DSP #4 opened a bag of frozen California blend vegetables and poured the vegetables into a pan of boiling water. She did not encourage any clients to assist with preparing the food item. DSP #4 removed the baked pizzas and breadsticks from the oven and cut the pizza into slices. No clients were offered an opportunity to cut the pizzas. DSP #4</p>	W0488	<p>In response to W189, DSP are trained in regard to dietary expectations for consumers. This includes the different kind of meal preparations, portion sizes, menus, etc. These issues are also reviewed during the staff's "On the Job" training at each site as well as the monthly GH staff meetings. This will continue to be a focus of the intial and on-going trainings. In addition, the agency's nutritonal services provider has been contacted to do an on-site training with staff which will be done on a quarterly basis. ASI is in the process of over-hauling the staff evalaution process to include more competency-based ratings. This will include more opportunities for staff to demonstrate understanding and use of skills, including dietary services, as part of evaluation process.</p>	11/02/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>blended client E and F's food to pureed consistency. She did not encourage either client to participate in processing their food.</p> <p>During observations on 10/01/2012 at 5:30 p.m., DSP #3 filled 8 glasses (8 ounces) with milk and carried the glasses to the table. Clients A, B, C, F, G, and H were each given a glass of milk and were not provided opportunities to pour their own beverages. DSP #5 added thickener to client E's milk and placed the glass in front of him. Client E was not provided an opportunity to stir his beverage.</p> <p>Client A's record was reviewed on 10/02/2012 at 9:59 a.m. An Adaptive Behavior Scale-Residential and Community assessment, dated 09/30/2012 indicated client A was able to prepare simple foods that don't require mixing.</p> <p>Client B's record was reviewed on 10/02/2012 at 12:12 p.m. An Individual Support Plan (ISP), dated 09/13/2012, indicated client B had a cooking goal of making a sandwich.</p> <p>Client C's record was reviewed on 10/02/2012 at 1:51 p.m. An ISP, dated 06/14/2012, indicated client C had a goal for making a sandwich and a pitcher of tea.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/04/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Client E's record was reviewed on 10/03/2012 at 11:00 a.m. The record indicated client E had a goal for stirring "thick it" in his supper beverage.</p> <p>Client F's record was reviewed on 10/03/2012 at 11:30 a.m. The record indicated client F had a goal for pouring water into the coffee maker.</p> <p>During an interview on 10/02/2012 at 6:15 p.m., DSP #4 indicated client G helped make the salad prior to the observation process. She indicated clients B and F were able to open containers and stir. DSP #4 stated, "[Client D] was supposed to help with dinner, but he was gone."</p> <p>During an interview on 10/03/2012, Qualified Developmental Disabilities Professional (QDDP) #1 stated, "All clients are capable of assisting with food preparation in some capacity. Most of them have a cooking goal." QDDP #1 indicated clients should have participated in meal preparation.</p> <p>9-3-8(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/04/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
--	--

(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