

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 12/16/2011
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN46041
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W0000	<p>This visit was for a post certification revisit (PCR) to the recertification and state licensure survey completed on November 1, 2011.</p> <p>Dates of Survey: December 12, 13, 14 and 16, 2011</p> <p>Facility Number: 001116 Provider Number: 15G602 AIM Number: 100245620</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 12/22/2011 by Dotty Walton, Medical Surveyor III.</p>	W0000		
W0104	<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's health care/nursing services met the clients' health needs for 3 of 4 sampled clients</p>	W0104	<p>The governing body, as cited in W104, is made up of the Abilities Services Leadership Team (Executive Director, Director of Administration, Director of Day and Placement Services, and Director of Community Living). This group acts as the liasion with</p>	01/15/2012

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

TITLE

(X6) DATE

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

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	<p>(clients #1, #2 and 3).</p> <p>Based on interview and record review, the governing body failed to exercise general policy and operating direction over the facility to assure a full and complete accounting of clients' funds/expenditures for 1 sampled client (client #4) and 1 additional client (client #5).</p> <p>Findings include:</p> <p>1. The record review for client #1 was conducted on 12/13/11 at 12:55 PM. The governing body failed to ensure nursing services developed a risk plan to recognize symptoms of cerebral shunt malfunction (headaches, nausea, vomiting, double vision, and alterations in consciousness for client #1. The record review for client #2 was conducted on 12/13/11 at 1:44 PM. The governing body failed to ensure nursing services followed up, assessed and referred client #2 for timely evaluation of persistent symptoms of gastroenteritis. The record review for client #3 was conducted on 12/14/11 at 9:47 AM. The governing body failed to ensure nursing services developed and implemented a risk plan to prevent falls for client #3. Please see W331.</p> <p>2. The governing body failed to exercise</p>		<p>the agency's Board of Directors. There are several systematic changes proposed in regard to this set of issues. The Director of Community Living will be having bi-monthly supervision with the GH nurse to ensure assessments and follow-ups on consumer needs are being tracked and reported. All GH Managers, QDSP and the GH Nurse will be using a central tracking system to ensure that medical appointments, follow ups, and documentation is in place the Director will be auditing this central system at least once per month. The GH Nurse is revising all the High Risk and Care plans for all the consumers at Maplewood. These plans spell out specific concerns for consumers, possible signs/symptoms, and directions for staff action. All staff who work with these consumers will be trained and the nurse will implement a monthly training module for the home. The nurse has already implemented a number of cues for staff in regard to high risk needs, allergies, medication, etc. to assist the DSP in their daily functioning. The Director has also clarified for the DSP "who do you call/for what/when" so that concerns they may note will be addressed in a timely manner with the appropriate person. The Leadership Team has revised the investigation protion of the</p>		

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W0140	<p>operating direction over the facility to ensure the group home's financial ledgers were accurate. The group home's financial ledgers were reviewed on 12/13/11 at 3:30 PM. The financial ledger indicated client #4 had \$92.46 on hand. The cash on hand for client #4 was \$93.07. Client #4 had \$0.61 more than the ledger indicated he should have. The financial ledger indicated client #7 had \$73.85 on hand. The cash on hand for client #7 was \$76.85. Client #7 had \$3.00 more than the ledger indicated he should have. Please see W140.</p> <p>This deficiency was cited on 11/1/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed to assure an accurate accounting of clients' funds for 1 of 4 sampled client (client #4) and 1 additional client (client #7).</p>	W0140	<p>agency's Abuse/Neglect/Exploitation Policy to ensure consistent steps are taken. This will be trained with staff on a quarterly basis. The agency's dietary provider met with the GH Nurse and Managers to identify consumer specific dietary needs that can be documented and more easily followed by the DSP. All of these systematic changes will be monitored by the Leadership Team and it is the Executive Director's responsibility to ensure that all pieces of the plan are monitored on an on-going basis. This will occur in the one of the bi-monthly Leadership Meetings.</p> <p>The concerns noted in W140 have been corrected. The GH Manager has implemented the same financial tracking system at Maplewood that has been successful in another GH setting.</p>	01/15/2012

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	<p>Findings include:</p> <p>The group home financial ledgers were reviewed on 12/13/11 at 3:30 PM. Staff #2, Home Manager (HM), brought the clients' financial records and cash on hand to the facility business office and indicated each clients cash on hand was kept in separate zippered bags. Staff #2, House Manager (HM), counted the money in each of the zippered bags. The financial ledger had a breakdown of the cash that was spent for the month. The cash on hand for client #4 counted by staff #2, HM, was \$93.07. The financial ledger indicated client #4 should have \$92.46 cash on hand. The cash on hand for client #7 counted by staff #2, HM, was \$76.85. The financial ledger indicated client #7 should have \$73.85 cash on hand. Client #4 had \$0.61 more and client #7 had \$3.00 more than the financial ledgers indicated.</p> <p>Interview with Staff #2, HM, on 12/13/11 at 3:45 PM indicated she did not know why the cash on hand was more than the financial ledger showed. Staff #2, HM, indicated the money could be where staff put the change back into the clients' zippered bag after an outing and didn't add it back into the financial ledger. Staff #2, HM, indicated the process needed to</p>		<p>She will monitor the consumer's finances on a monthly basis and work with the internal auditor who will be doing monthly spot checks as well.</p>	
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W0323	<p>be changed.</p> <p>This deficiency was cited on 11/1/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 3 of 4 sampled clients (clients #1, #3 and #4), the facility failed to ensure annual physical examinations were completed.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 12/13/11 at 12:55 PM. There was no documentation indicating a physical examination had been conducted during the past year.</p> <p>The record review for client #3 was conducted on 12/14/11 at 9:47 AM. There was no documentation indicating a physical examination had been conducted during the past year.</p> <p>The record review for client #4 was conducted on 12/14/11 at 10:27 AM.</p>	W0323	<p>Of the four consumer's noted with deficiencies in W323, all are scheduled for physicals. One is set for January and the other three for February which is the soonest that their individual physicians could get them in. All four consumers are also on the waiting list for their doctor in case a sooner appointment becomes available. The GH Managers and Nurse are now using a centralized medical tracking system to ensure that appointments are scheduled, staffed, and documented. This is up-dated and distributed weekly. In addition to tracking appointments, the system also gives notice to the Nurse and Manager when an annual or needed appointment is coming due. The Director of Community Living will monitor the system on at least a monthly basis and will meet bi-monthly with the GH</p>	01/15/2012	

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W0331	<p>There was no documentation indicating a physical examination had been conducted during the past year.</p> <p>Interview with staff #4, Licensed Practical Nurse (LPN), on 12/14/11 at 11:00 AM indicated they had not been able to get all the physicals done. Interview with staff #2, Home Manager (HM), indicated they were going to have the physicals done in February, 2012. Staff #2, HM, indicated the physical examinations had not been done in the past year.</p> <p>This deficiency was cited on 11/1/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 3 of 4 sampled clients (clients #1, #2 and #3), the facility failed to ensure nursing services developed/revised health risk plans when needed.</p> <p>Findings include:</p>	W0331	<p>Nurse to ensure all consumers are getting services needed. In response to the January 12, 2012 letter that stated: These deficiencies were cited in October. Please explain why it was not possible to get a physical scheduled until January or after. January 13, 2012: * One consumer has his medical care overseen by his mother, his guardian. He was scheduled, and seen, for a physical on January 11, 2012 which was an appointment that had been scheduled prior to the surveys.</p> <p>* The other three consumers were seen by Dr. Eaton on December 8, 2011 but he would not complete a physical form at that time and requested they be rescheduled. According to the Continuity of Care forms for these appointments, Dr. Eaton completed a three-month check up. These three individuals are scheduled for physicals in February 2012 which was as soon as Dr. Eaton's office could set appointments for the physicals.</p> <p>There are a number so system-wide nursing issues to be addressed in W331. Specifically for the issues noted, the GH Nurse will be revising all risk assessments as well as high risk and care plans. These include but are not limited to: fall risk, seiquire assessments, skin</p>	01/15/2012	

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	<p>The record review for client #1 was conducted on 12/13/11 at 12:55 PM. Diagnoses included, but were not limited to, cerebral palsy, organic hallucinations, and cerebral shunt (used to prevent excess build up of cerebrospinal fluid in the brain). There was no documentation to indicate a health risk plan for the shunt had been developed.</p> <p>The record review for client #2 was conducted on 12/13/11 at 1:44 PM. Client #2's diagnoses included, but were not limited to, cerebral palsy and gastroenteritis. A "Case note," dated 10/3/11 at 10:00 AM indicated "Consumer (client #4) went to Urgent Care on Sunday due to (not) taking fluids, little output with dark urine...Sunday, 10/2/11, staff reports consumer still (not) taking fluids and (without) urine output. Afebrile (no fever)...As the night went on Sunday, consumer's BP (blood pressure) was decreasing...Instructed to send consumer to ER (emergency room)." Staff communication logs for October 2011 and November 2011 indicated client #4 refused one or more meal daily. There was no documentation to indicate a health risk plan for the meal refusals had been developed.</p> <p>The record review for client #3 was</p>		<p>breakdowns, and diagnostic considerations. The plans will spell out specific concerns for each consumer, possible signs/symptoms, and directions for staff action. All staff who work with these consumers will be trained and their will be on-going nursing training in the monthly staff meetings. Along with these up-dated plans, there are a number of additional cues that highlight issues such as allergies, medications, seizures, etc. to assist DSP in their daily activities. The agency's dietary services provider met with the GH Nurse and Managers to up-date dietary issues. They have been asked to further up-date the dietary plans so that they are more consumer-specific and address issues such as restrctions, preparation guidelines, and contraindicators. All of these changes will be monitored by the Leadership Team via its bi-monthly meetings. The reviews will be carried out on a more direct basis by the Director of Community Living who supervised the nursing and GH staff.</p>		

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	<p>conducted on 12/14/11 at 9:47 AM.</p> <p>Client #3's diagnoses included, but were not limited to, Scoliosis, Bilateral Cataracts, Periventricular Lekomalacia (white matter disease) and Parkinson's Disease. The record indicated client #3 had falls on 5/26/11, 5/28/11, 7/9/11, 7/10/11 and 9/17/11. There was no documentation to indicate a health risk plan for falls had been developed.</p> <p>Interview with staff #4, Licensed Practical Nurse (LPN) on 12/14/11 at 11:00 AM indicated she was in the process of writing health risk plans for all the clients in this home, but she had not had time to finish them.</p> <p>This deficiency was cited on 11/1/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				

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W0346	<p>If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to ensure a formal arrangement was in place with a registered nurse for verbal or onsite consultation to the licensed practical nurse.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 12/13/11 at 12:55 PM. There was no documentation to indicate a registered nurse was available for consultation to assist in management of client #1's health.</p> <p>The record review for client #2 was conducted on 12/13/11 at 1:44 PM. There was no documentation to indicate a registered nurse was available for consultation to assist in management of client #2's health.</p> <p>The record review for client #3 was conducted on 12/14/11 at 9:47 AM. There was no documentation to indicate a registered nurse was available for consultation to assist in management of</p>	W0346	<p>Abilities Services has identified a RN to provider oversight/consultation to the agency's LPN, however, there were some challenges in getting a written contract finalized. As of January 5, there has been a verbal resolution with the RN and a written contract is in process. The Executive Director is overseeing this process. The language of the contract indicates that the GH Nurse (LPN) will consult with the RN for complex situations as well as do quarterly face-to-face meetings. All communication with the RN will be documented. The Director of Community Living will oversee the RN consultation services once the contract is finalized.</p>	01/15/2012	

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W0369	<p>client #3's health.</p> <p>The record review for client #4 was conducted on 12/14/11 at 10:27 AM. There was no documentation to indicate a registered nurse was available for consultation to assist in management of client #4's health.</p> <p>Interview with staff #1, Director of Community Living, on 12/15/11 at 2:00 PM indicated a registered nurse had agreed to be the consultant, but they were still working on the contract and she had not started working.</p> <p>This deficiency was cited on 11/1/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</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, record review and interview for 1 of 20 doses of medication administered (client #2), the facility failed to ensure the medications were</p>	W0369	The staff noted for the medication error in W369 has received disciplinary action consistent with the agency's progressive disciplinary policy. The Director of Administration works with the GH Manager and Nurse in instances	01/15/2012	

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	<p>administered without error.</p> <p>Findings include:</p> <p>The morning medication administration was observed on 12/13/11 from 7:00 AM to 7:40 AM. Client #2 received her medication at 7:30 AM. Client #2 was observed to receive Divalproex, 250 mg (milligram) for seizures, Pravastatin, 40 mg for cholesterol, Clonazepam, 0.5 mg for seizures, Chlorhexidine Rinse for gingivitis. All the medications given to client #2 were in bubble packs except the Chlorhexidine Rinse. No pills from bottles were observed.</p> <p>The MAR (Medication Administration Record) was reviewed on 12/13/11 at 8:00 AM. The MAR indicated client #2 should have received Cranberry/Fruit, 4200 mg for UTI (urinary tract infection) as well as the above medications. The Cranberry/Fruit had not been marked as being given on the MAR.</p> <p>Interview with staff #6 on 12/13/11 at 8:15 AM indicated that she must have forgotten to show me the bottle of Cranberry/Fruit pills. Staff #6 indicated the Cranberry/Fruit came in a pill bottle and not in a bubble pack. Staff #6 indicated she just missed marking the MAR that she had given the</p>		<p>of medication errors to determine where that employee is with progressive action and re-training. While the responses are individualized, they are also consistent with the agency's policy.</p>		

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	<p>Cranberry/Fruit to Client #2. There was no evidence to substantiate the Cranberry/Fruit had been given.</p> <p>This deficiency was cited on 11/1/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				