

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 02/06/2012
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
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W0000	<p>This visit was for a post certification revisit (PCR) to the PCR completed 12/16/2011 to the recertification and state licensure survey completed on November 1, 2011.</p> <p>This visit was in conjunction with the investigation of complaint #IN00102180.</p> <p>Dates of Survey: January 31, February 1, 2, 3, and 6, 2012.</p> <p>Facility Number: 001116 Provider Number: 15G602 AIM number: 100245620</p> <p>Surveyor: Brenda Nunan, RN, CDDN, PHNS III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/13/12 by Ruth Shackelford, 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.

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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 care needs for 3 of 4 sampled clients (clients A, B, and C).</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client A's record was reviewed on 02/01/2012 at 10:40 a.m. The governing body failed to exercise operating direction over nursing services to ensure client A's yearly physical was completed. Please see W323. Client B's record was reviewed on 02/01/2012 at 11:00 a.m. The governing 	W0104	<p>The Director of Community Living receives weekly up-dates on all group home consumers' medical appointments. This is used a point of reference for bi-monthly supervision with the agency's nurse as well as the monthly meetings with the GH managers, QDDPs, nurse and lead staff. Also, each group home has set up weekly telephone staffings with the manager, nurse, lead DSP, QDDP, and behavioral consultant so emerging concerns are noted and addressed in a more timely manner.</p>	02/24/2012	

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	<p>body failed to exercise operating direction over nursing services to ensure nursing services developed a dining plan that included client B's diet order and restricted foods. Please see W331.</p> <p>3. Client C's record was reviewed on 02/01/2012 at 11:30 a.m. The governing body failed to exercise operating direction over nursing services to ensure nursing services developed a dining plan that included client C 's dietary/fluid requirements. Please see W331.</p> <p>This deficiency was cited on 11/01/11 and 12/16/2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>				

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W0323	<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, the facility failed to ensure an annual physical was completed for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 02/01/2012 at 10:40 a.m. There was no documentation in the client's record to indicate a physical evaluation had been completed during the past year.</p> <p>During an interview on 02/01/2012 at 12:40 p.m., the House Manager indicated an annual physical had not been completed for client A.</p> <p>During an interview on 02/01/2012 at 3:20 p.m., LPN #1 indicated she was aware client A had not had an annual physical.</p> <p>This deficiency was cited on 11/01/11 and 12/16/2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	W0323	All Maplewood consumers have had their annual appointments completed.	02/24/2012	

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	9-3-6(a)			

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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview, the facility failed to ensure nursing services developed dining plans for 2 of 4 sampled clients (clients B and C).</p> <p>Findings include:</p> <p>During meal observations on 01/31/2012 at 5:55 p.m., clients B and C received one serving of beef stew, one biscuit, one serving of spring vegetable salad, one piece of angel cake, one serving of strawberries and 12 ounces of whole milk. Client C was not offered additional fluids.</p> <p>The menu, dated, "Winter 2011," was reviewed on 01/31/2012 at 7 p.m. The menu indicated, "Beef stew, Biscuit GH, Spring Veg (vegetable) Salad, Angel</p>			W0331	<p>The menu and dining plans have been revised by ASI's dietary services provides to that between the two of them, they show all of the necessary information. However, ASI is looking into a different provider so that our needs can be addressed in one plan. The agency nurse will be training GH staff on these changes and how to correctly implement the plans/menus. These will be reviewed at the monthly trianings with staff as well.</p>		02/24/2012

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	<p>Cake/Strbrry (strawberries), Milk Whole." The menu did not include serving sizes.</p> <p>1. Client B's record was reviewed on 02/01/2012 at 11:00 a.m. The physician's orders, dated 01/01/2012-01/31/2012, indicated, "...Regular diet, no concentrated sweets, no seeds, nuts, or popcorn...." Client B's record did not include documentation to indicate a dining plan which included the diet order and restricted foods.</p> <p>2. Client C's record was reviewed on 02/01/2012 at 11:30 a.m. The physician's orders, dated 01/01/2012-01/31/2012, indicated, "...Increased fluid intake...regular diet...." Client C's record did not include documentation to indicate a dining plan that included fluid requirements.</p> <p>During an interview on 01/31/2012 at 7:00 p.m., DSP #1 indicated the menu was current. She indicated client B was allowed an extra serving of the entree. She indicated she was not aware of any dining needs for client C.</p> <p>During an interview on 02/01/2012 at 12:30 p.m., QDDP (Qualified Developmental Disabilities Professional) indicated the facility did not implement dining plans unless the client used</p>						

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	<p>adaptive equipment or required special instructions for eating. The QDDP indicated it was a nursing responsibility to ensure staff were trained on the diet.</p> <p>During an interview on 02/01/2012 at 12:40 p.m., the House Manager indicated the diets are listed on the MARS (Medication Administration Record). She indicated staff would not know the clients' diet orders unless the MAR was referenced.</p> <p>During an interview on 02/01/2012 at 3:15 p.m., the facility LPN stated, "The dietician is running behind in getting me a spreadsheet with all the different diets." She indicated there was not a dining plan to inform staff of clients B and C's specific dietary requirements or restrictions.</p> <p>This deficiency was cited on 11/01/11 and 12/16/2011. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			
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W0368	<p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to ensure the medications were administered without error for 1 of 4 sampled clients (client B).</p> <p>Findings include:</p> <p>An Indiana Division of Disability and Rehabilitative Services/Bureau of Developmental Disabilities Services incident report, dated 01/29/2012 at 7:30 a.m., indicated client B did not receive Lorazepam 0.5 mg at 7:30 a.m. on the day of the incident report.</p> <p>Client B's record was reviewed on 02/01/2012 at 11:00 a.m. The client's diagnoses included, but were not limited to, personality disorder and intermittent explosive disorder. Physician's orders, dated 01/01/2012-01/31/2012 indicated medications included, but were not limited to, Lorazepam (a medication used to relieve anxiety) 0.5 mg (milligram) twice daily.</p> <p>A "Medication Administration System Policy and Procedure," dated September 2011, was reviewed on 02/01/2012 at 9:20 a.m., The policy indicated. "...Manager is then responsible for filing a</p>	W0368	The staff noted in the incident tagged in W368 has gone through the required medication training. This incident resulted in a disciplinary action consistent with the agency's policy. The GH managers are going through an additional medication management training on March 1st so that they can do medication observation with staff while they are passing medications.	02/24/2012			

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	<p>BDDS (Bureau of Developmental Disabilities Services) report within 24 hours...Manager will contact HR (Human Resources) during the next business day to discuss appropriate disciplinary action...."</p> <p>During an interview on 01/31/2012 at 4:00 p.m., LPN #1 indicated medication errors were tracked and disciplinary action given based on the number of errors made by staff. She indicated there was not a process for nursing observation and training to ensure safe medication administration. LPN #1 indicated she was in the process of developing a system for nurse observation of medication administration.</p> <p>9-3-6(a)</p>				