

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065
--	---

(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 post certification revisit (PCR) survey to Complaint #IN00097766 Investigation completed on November 1, 2011.</p> <p>Complaint #IN00097766 - Not corrected.</p> <p>Survey Dates: December 12, 14, 15, and 16, 2011</p> <p>Facility Number: 001194 Provider Number: 15G628 AIM Number: 100245710</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		
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 for 4 of 4 sampled clients (clients #1, #2, #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 12/14/11 at 1:21 PM. There was no documentation indicating a physical examination had been conducted</p>	W0323	<p>As of January 5, there are still two outstanding physicals that need to be completed for Rossville Group Home consumers (of the four cited in W323). Both of these are scheduled for Janaury 2012 which was the soonest that their doctors could see them. To prevent lapses in the future, ASI has implemented a universtal tracking system for all group home consumers. This system tracks scheduled appoints and is up-dated and distributed weekly to the nurse, GH managers, and QDDP. This ensures that</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065		
(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>during the past year.</p> <p>The record review for client #2 was conducted on 12/15/11 at 12:01 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 5:30 PM. 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 12/15/11 at 2:15 PM. 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 12/15/11 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 had the physicals scheduled.</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</p>	W0331	<p>scheduled appointments are staffed (and therefore not cancelled) as well as triggers the nurse to schedule annual appointments as needed. The Director of Community Living monitors the tracking system on a monthly basis as well as meets with the nurse and GH manager on a bi-monthly basis for up-dates on consumer care.</p> <p>To address the issues noted in W331, the GH Nurse is working</p>	01/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065		
(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>3 of 4 sampled clients (clients #1, #2 and #3), the facility failed to ensure nursing personnel provided dining plans and ensured the staff were adequately trained in clients' dietary needs.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 12/14/11 at 1:21 PM. The record indicated client #1 was diagnosed with seizures and MCAD (Medium-chain acyl-CoA dehydrogenase deficiency) which included vomiting, lack of energy and low blood sugar. The only instructions provided to staff were client #1 was to have a low fat, low cholesterol diet. The record did not include a dining plan that addressed the dietary needs.</p> <p>The record review for client #2 was conducted on 12/15/11 at 12:01 PM. Diagnoses included, but were not limited to, Hypothyroidism, Gout, and High Cholesterol. The record indicated client #2 was to have a low saturated fat diet. The record did not include a dining plan.</p> <p>The record review for client #3 was conducted on 12/14/11 at 5:30 PM. Diagnoses included, but were not limited to, Spastic Quadriplegia, Hydrocephalus and Cerebral Palsy. The record indicated client #3 was on a</p>		<p>with the agency's dietary services provider to implement more detailed dining plans that address dietary needs, restrictions, and recommendations. When these are provided, all staff working with the Rossville consumers will be trained. It will be the resopnsibilitly of the Nurse and GH Manager to ensure that these plans are followed by staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065			
(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			
W0346	<p>regular diet and was to have yogurt daily. The record indicated client #3 was to drink out of a cup with a straw. The record did not include a dining plan.</p> <p>Interview with staff #4 on 12/14/11 at 3:00 PM indicated they only had one menu. Staff #4 indicated the only difference in menus is when there is a texture modification.</p> <p>Interview with staff #3, Licensed Practical Nurse (LPN) on 12/15/11 at 1:00 PM indicated she had met with the dietary provider and new diet plans would be provided.</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>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</p>	W0346	Abilities Services has identified a RN to provide oversight of LPN	01/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065		
(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>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 consultant 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 12/14/11 at 1:21 PM. There was no documentation to indicate a registered nurse was consulted to assist in management of client #1's health.</p> <p>The record review for client #2 was conducted on 12/15/11 at 12:01 PM. There was no documentation to indicate a registered nurse was consulted to assist in management of client #2's health.</p> <p>The record review for client #3 was conducted on 12/14/11 at 5:30 PM. There was no documentation to indicate a registered nurse was consulted to assist in management of client #3's health.</p> <p>The record review for client #4 was conducted on 12/15/11 at 1:30 PM. There was no documentation to indicate a registered nurse was consulted to assist in management of client #4's health.</p> <p>Interview with staff #1, Director of</p>		<p>services at the Group Home as cited in W346. However, there have been some challenges in finalizing a written contract. As of January 5, the details of the contract have been verbally resolved and the Executive Director is in the process of finalizing the written contract for the RN to sign. The contract outlines that the agency's LPN will have as needed contact with the RN for unusual or complicated situations. In addition, the two will have quarterly face-to-face meetings to review care. All communciations will be written to verify the nature of the consultation. The Director of Communtiy Living, as part of her oversight of nursing services, will monitor the RN consultation.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065		
(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	
W9999	<p>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 following Community Residential Facilities for persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>(4) Illness of any resident which requires hospitalization or which renders the</p>	W9999	<p>The two incidents cited in W9999 were reported to the BDDS office as a result of the survey process. Abilities Services has recently (as of January 1) implemented a new Incident Report form and process with the goal of reducing redundancy as well as improving efficiency. This includes ensuring that reports are made to the BDDS office within the appropriate time frames.</p>	01/15/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065		
(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>resident bedfast for more than seven (7) days.</p> <p>The state rule was not met as evidenced by:</p> <p>Based on record review for 1 of 4 sampled clients (client #3), the facility failed to report two incidents to the Bureau of Developmental Disabilities Services of client #3 having surgery to remove a Baclofen pump and catheter and returning to hospital for emergency repair of incision.</p> <p>Findings include:</p> <p>The record review for client #3 was conducted on 12/14/11 at 5:30 PM. The record indicated client #3 went to the hospital on 12/7/11 because the Baclofen pump was no longer working correctly. The record indicated the guardian requested to have the pump removed because of the problems client #3 had been having. The record indicated she was released from the hospital on 12/10/11, but had to return to the emergency room on 12/12/11. The record indicated client #3 had stretched and the incision on her abdomen had opened.</p> <p>Interview with staff #3, Licensed Practical Nurse (LPN), on 12/15/11 at 1:00 PM</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G628	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/16/2011
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN46065		
(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>indicated client #3 had surgery on 12/7/11, returned to the group home on 12/10/11 and had to go back to the emergency room on 12/12/11 because the incision had come apart. Staff #3, LPN, indicated client #3 returned to the group home on 12/12/11. Staff #3 indicated she had not reported the incident to BDDS (Bureau of Developmental Disability Services).</p> <p>Interview with staff #2, House Manager on 12/15/11 at 2:00 PM indicated the incidents had not been reported.</p> <p>9-3-1(b)(4)</p>				