

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2015
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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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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: December 16, 17, 18 and 22, 2015.</p> <p>Provider Number: 15G602 Aims Number: 100245620 Facility Number: 001116</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 12/28/15 by #09182.</p>	W 0000		
W 0249 Bldg. 00	<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 for 3 of 4 sampled clients (#1, #3, #4) to ensure the clients' training programs were implemented when opportunities were present.</p>	W 0249	In response to W249, the facility failed to ensure clients' training programs were implemented when opportunities were present, ASI has identified that staff need retrained on active treatment schedules, and each individuals goals and that staff require more monitoring to ensure they are	01/21/2016

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>Findings include:</p> <p>An observation was done on 12/16/15 from 3:56p.m. to 6:15p.m. at the facility group home. From 4:43p.m. to 5:26p.m., client #1 sat at the dining room table with no activity. Client #1 was not offered any activity choices during this time period and appeared to be waiting for supper to be served. At 6:12p.m. client #3 sat down at the dining room table for supper. Staff custodially prepared her plate of food and cut up her fish. Client #1 ate his supper at 6:12p.m. with no staff sitting next to him.</p> <p>An observation was done on 12/17/15 from 6:28a.m. to 7:58a.m. At 6:38a.m., client #3 received her medication, which included Lamictal for seizures. Staff #7 passed client #3 her medication and did not have client #3 identify any of her medication. At 6:50a.m. client #4 went for his medication. Client #4 received his medication which included Zoloft for depression. Staff did not have client #4 identify any of his medications.</p> <p>Record review for client #1 was done on 12/17/15 at 10:49a.m. Client #1 had an individual support plan (ISP) dated 10/13/15. The ISP indicated client #1 had a training program to be encouraged to participate in activity. The ISP indicated if client #1 appeared to be "just sitting</p>		<p>providing active treatment All active treatment schedules and goals will be reviewed monthly with staff. QIDP will review meaningful day activities and tracking daily to ensure plans are being followed. Any change needed will be made immediately. QIDP will assist staff in following plans and be available for questions regarding the plans daily. On site monitoring will consist of both the QIDP and the PC splitting a schedule of being at the group home daily to ensure that staff knows how to follow the active treatment schedules. The QIDP and PC will meet weekly with the PD to discuss progress with active treatment schedules. The schedule will include rotating between morning and evening shifts.</p>		

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	<p>there," staff should redirect client #1 with a choice of activities which included: card games, preparing food, dancing, music and assistance with chores. Client #1's ISP also indicated he was to receive a pureed diet with staff sitting by him.</p> <p>Record review for client #3 was done on 12/17/15 at 12:54p.m. Client #3 had an ISP dated 9/10/15. The ISP indicated client #3 had a training program to identify her seizure medication, Lamictal. Staff were to ask client #3 to state the color of the medication and then point to the Lamictal in her medication cup.</p> <p>Record review for client #4 was done on 12/17/15 at 11:38a.m. Client #4 had an ISP dated 6/30/15. The ISP indicated client #4 had a training program to look at his Invega and Zolofit medication and name each medication.</p> <p>Staff #1 was interviewed on 12/22/15 at 1:24p.m. Staff #1 indicated facility staff should have been involved with providing client #1 with activity choices. Staff #1 indicated clients #3 and #4's medication training programs should have been implemented at all opportunities.</p> <p>9-3-4(a)</p>			

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W 0262 Bldg. 00	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 1 of 4 sampled clients (#3) with restrictive programs, to ensure the client's individual support plan (ISP), including behavior interventions for use of a wheel chair and bed alarm, were reviewed/monitored within the past year.</p> <p>Findings include:</p> <p>An observation was done on 12/17/15 from 6:28a.m. to 7:58a.m. At 6:38a.m. client #3 went to the medication room for her medication. While in the medication room, staff #6, checked client #3's wheel chair alarm to ensure it was working. Staff #6 indicated client #3 had the alarm on her wheel chair and bed due to her behavior of getting up without assistance and she had a history of falls.</p>	W 0262	In response to W262, the facility failed to ensure that clients with restrictive programs, including behavior interventions for use of a wheel chair and bed alarm, were reviewed/monitored within their ISP each year ASI reviewed all ISP's to ensure completion of review/monitoring annually for any restrictive programs HRC listed all restrictive programs to have an annual review These reviews will be done monthly in HRC and will be brought for review by the agency nurse Weekly paperwork review will assist in identifying any restrictive programs ready for review	01/21/2016

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	<p>The record of client #3 was reviewed on 12/17/15 at 12:54p.m. Client #3's 9/10/15 ISP indicated client #3 had alarms placed on her bed and wheel chair due to a history of falls. There was no documentation client #3's ISP had been reviewed by the facility's HRC.</p> <p>Staff #1 was interviewed on 12/17/15 at 1:24p.m. Staff #1 indicated there was no documentation the facility's HRC had reviewed the restrictive intervention (use of alarms) for client #3 during the past year.</p> <p>9-3-4(a)</p>			