

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  08/06/2012
NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2 FREEMAN ST ROSSVILLE, IN 46065		
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: July 30, 31, August 1, 6, 2012</p> <p>Provider Number: 15G628 Aims Number: 100245710 Facility Number: 001194</p> <p>Surveyors: Mark Ficklin, Medical Surveyor III Brenda Nunan, RN, CDDN, PHNS III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 8/13/12 by Tim Shebel, 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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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 its policy and procedures to prevent client to client abuse (physical aggression) and thoroughly investigate 1 of 1 incident reviewed for allegations of abuse (clients #1 and #2).</p> <p>Findings include:</p> <p>The facility's policy and procedures were reviewed on 07/31/2012 at 10:10 a.m. The facility's "ABUSE, NEGLECT, AND EXPLOITATION POLICY AND PROCEDURE," dated September 2010 and identified as current, indicated, "...It is the policy of Abilities Services, Inc. to protect and advocate for the protection and safety of all consumers in accordance with all applicable federal, state, and local laws ...The appropriate Department Director or designees as appointed by the Executive Director or designee will conduct an internal investigation. A written investigation report that includes, but is not limited, description of events, persons interviewed, opinions of results, recommendations to prevent similar incidents in the future, will be followed within five (5) working days to the Executive Director or designee."</p> <p>The facility's reportable incidents were reviewed on 07/31/2012 at 9:59 a.m. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 04/24/2012 at 3:09 p.m., indicated, "... [Client #2] was getting onto the van to be transported home from workshop ...[Client #2] picked up a clip board to move it and threw it, (sic) the clip board hit [client #1] on his right knee</p>	W0149	Regarding W149, the documentation and system were in place, however, staff did not follow the system. To address this, all Programming Coordinators, QDDPs, and Nurses have been re-trained on the consumer-consumer investigation process by the Director of Community Living. Each IDT has identified who will complete the investigations and where the documentation will be kept for review by HRC if it is a significant incident or meets the agency's threshold for review. The Director of Community Living oversees the HRC process which meets at least one time per month if not more often so that will be one way to monitor the system in the future. In addition, the Safety Committee will review the investigation binders on a quarterly basis.	09/05/2012			

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	<p>.... " The record did not indicate the allegation of (physical aggression) client to client abuse had been investigated.</p> <p>During an interview on 07/31/2012 at 10:15 a.m.,staff #1 (House Manager) indicated she was not able to produce documentation to indicate an investigation had been completed. 9-3-2(a)</p>			

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W0154	<p><b>483.420(d)(3) STAFF TREATMENT OF CLIENTS</b> The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 1 of 1 incident reviewed for allegations of (physical aggression) client to client abuse (clients #1 and #2).</p> <p>Findings include:</p> <p>The facility's reportable incidents were reviewed on 07/31/2012 at 9:59 a.m. An Indiana Division of Disability and Rehabilitative Services Incident Report, dated, 04/24/2012 at 3:09 p.m., indicated, "... [Client #2] was getting onto the van to be transported home from workshop ...[Client #2] picked up a clip board to move it and threw it, (sic) the clip board hit [client #1] on his right knee .... " The record did not indicate the allegation of (physical aggression) client to client abuse had been investigated.</p> <p>During an interview on 07/31/2012 at 10:15 a.m., staff #1 (House Manager) indicated she was not able to produce documentation to indicate an investigation had been completed. 9-3-2(a)</p>	W0154	<p>Regarding W154, the documentation and system were in place, however, staff did not follow the system. To address this, all Programming Coordinators, QDDPs, and Nurses have been re-trained on the consumer-consumer investigation process by the Director of Community Living. Each IDT has identified who will complete the investigations and where the documentation will be kept for review by HRC if it is a significant incident or meets the agency's threshold for review. The Director of Community Living oversees the HRC process which meets at least one time per month if not more often so that will be one way to monitor the system in the future. In addition, the Safety Committee will review the investigation binders on a quarterly basis.</p>	09/05/2012			

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W0159	<p><b>483.430(a)</b> <b>QUALIFIED MENTAL RETARDATION PROFESSIONAL</b> Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the QDDP (Qualified Developmental Disabilities Professional) failed to monitor/revise clients' training objectives for 4 of 4 sampled clients (clients #1, #2, #3 and #4).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #1's record was reviewed on 07/31/2012 at 10:36 a.m. The ISP (Individual Support Plan), dated, 04/02/2012, indicated training objectives included, but were not limited to, brushing teeth, depositing a check into his checking account, checking out books from the library, and walking in community alone with staff following 10 feet behind him. The record indicated, " ...No tracking at time of report " for all June 2012 training objectives. The record did not include summarization of data to determine client #1's skills acquisition, retention, or regression from April 2012-June 2012.</li> <li>Client #2's record was reviewed on 07/31/2012 at 11:48 a.m. The ISP, dated 1/18/12, indicated training objectives included, but were not limited to, putting activities on a calendar , make list of what to shop for and then shop for the items on the list, and cash a check and count the money received. The record did not include summarization of data to determine client #2's skills acquisition, retention, or regression from April 2012-June 2012.</li> <li>Client #3's record was reviewed on 07/31/2012 at 1:29p.m. The ISP, dated 12/14/11, indicated</li> </ol>	W0159	In regard to W159, the summaries for April-June had been completed by the QDDP but were in her office and not filed in the consumer chart in the home. That has been corrected and the items are filed up to date. In the future, all filing will be handed from QDDP to Lead DSP in person at the weekly staff meetings rather than left in mailboxes.	09/05/2012			

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	<p>training objectives included, but were not limited to, identify Risperdal, write his work address and phone number, exercise, make toast, identify coins and participate in a group activity. The record did not include summarization of data to determine client #3's skills acquisition, retention, or regression from April 2012-June 2012.</p> <p>4. Client #4's record was reviewed on 07/31/2012 at 11:41a.m. The ISP, dated 9/23/11, indicated training objectives included, but were not limited to, count money, make brownies, clean her wheel chair, write her name, clean her eyeglasses and read aloud to a staff member. The record did not include summarization of data to determine client #4's skills acquisition, retention, or regression from April 2012-June 2012.</p> <p>During an interview on 07/31/2012 at 3:45 p.m., staff #1 (House Manager) indicated data for training objectives for clients #1, #2, #3 and #4 had not been collected accurately during June 2012. 9-3-3(a)</p>				

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W0210	<p><b>483.440(c)(3)</b> <b>INDIVIDUAL PROGRAM PLAN</b> Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, the facility failed to complete assessments within 30 days of admission for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 07/31/2012 at 10:36 a.m. The record indicated client #1 was admitted to the facility on 03/01/2012. The record lacked documentation to indicate client #1 was screened for tuberculosis and did not include an initial dietary assessment. The record did not indicate a Comprehensive Functional Assessment (CFA) had been completed.</p> <p>During an interview on 07/31/2012 at 12:20 p.m., staff #2 (LPN) indicated tuberculosis screening had not been completed for client #1. At 3:10 p.m., the LPN indicated she was not able to locate documentation to indicate an initial dietary assessment had been completed.</p> <p>During an interview on 07/31/2012 at 3:10 p.m., staff #1 (House Manager) indicated she was unable to locate documentation to indicate a CFA had been completed.</p> <p>9-3-4(a)</p>	W0210	In regard to W210, the items that were noted as missing were located/completed. They were addressed with teh staff responsible for failure to complete. All GH charts have been re-structured to more clearly outline where items should be located. The agency is in the process of initiating a chart audit process to identify concerns for immediate correction as well as to evaluate the quality of documentation.	09/05/2012	

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W0249	<p><b>483.440(d)(1) PROGRAM IMPLEMENTATION</b></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 (#2, #3, #4) to ensure the client's leisure skills training programs were implemented when opportunities were present at the facility owned workshop.</p> <p>Findings include:</p> <p>An observation was done on 7/31/12 from 10:15a.m. to 11:07a.m. at the facility owned workshop. Clients #2, #3 and #4 were in the production area of the workshop. There was no work available from 10:15a.m. to 11:00a.m. Clients #2, #3 and #4 sat without activity and were not prompted to any activities from 10:15am through 11:00a.m. Client #3 walked into another program area and later returned to his area without any staff intervention.</p> <p>The record of client #2 was reviewed on 7/31/12 at 11:48a.m. Client #2's 1/18/12 individual support plan (ISP) had the following training programs: count money; participate in a meaningful activity at the workshop.</p> <p>The record of client #3 was reviewed on 7/31/12 at 1:29p.m. Client #3's 12/4/11 (ISP) indicated client #3 had the following training programs: write his work address; write his work phone</p>	W0249	Regarding W249, the down time in the prevocational area was due to the work not yet being delivered to the site. While this is an anomaly, the Director of Day and Placement Services has trained the staff working in the prevocational area that in future situations, consumers need to be directed to a prosocial activity that is consistent with their goals. This can be done in the prevocational or hab area. The Director and Programming Coordinator will monitor compliance by observing the prevocational area at various times to make sure appropriate activities are taking place. The Lead DSP for this area will email the Director anytime the deliveries are delayed so that any patterns are noted and corrected with the company.	09/05/2012			

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	<p>number; identify coins; exercise; match words with pictures of food items.</p> <p>The record of client #4 was reviewed on 7/31/12 at 11:41a.m. Client #4's 9/23/11 (ISP) indicated client #4 had the following training programs: count money; write her first name and middle initial; clean her wheelchair; clean her eyeglasses; read aloud to a staff member.</p> <p>Interview of staff #1 (House manager) on 7/31/12 at 3:17p.m. indicated clients (#2, #3, #4) had identified training programs that could be done during leisure time at the workshop. 9-3-4(a)</p>			

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W0325	<p><b>483.460(a)(3)(iii) PHYSICIAN SERVICES</b></p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician.</p> <p>Based on record review and interview, the facility failed to ensure physician recommendations for routine laboratory and health screening tests were implemented for 2 of 4 sampled clients (#2, #4).</p> <p>Findings include:</p> <p>1. Client #2's record was reviewed on 07/31/2012 at 11:48 a.m. A Laboratory result form, dated 01/05/2012, indicated, " ...Vit (vitamin) D low @ (at) 18 (range is 30-74 nannograms per milliliter) ...800 IU *International Units) Vit D3/ (per) day x (times) 3 mo (months) then do vitamin D level ... "</p> <p>The record did not include documentation to indicate the physician's recommendations had been implemented.</p> <p>The physician's orders dated 07/01/2012-07/31/2012, indicated, "...APLISOL (injection used to detect tuberculosis (TB) exposure) 0.1 ml (milliliter) INTRADERMALLY (under the skin) YEARLY .... " The record did not include documentation to indicate the physician's recommendations had been implemented during the past year.</p> <p>2. Client #4's record was reviewed on 7/31/12 at 11:41a.m. The physician's orders dated 07/01/2012-07/31/2012, indicated, "...APLISOL (injection used to detect tuberculosis (TB) exposure) 0.1 ml (milliliter) INTRADERMALLY (under the skin) YEARLY .... " The record did not include documentation to indicate the physician's recommendations had been implemented during</p>	W0325	Regarding W325, the missing items were corrected. ASI has implemented a second nursing position to help address the medical needs of consumers in group homes and waiver programming. The division of the caseload should help ensure that all annual requirements are met and that there is timely follow through on labs/follow ups.All GH medical appointments are tracked on a spreadsheet to identify when annual items are due. This will be monitored by the house lead, nurse, and programming coordinator.	09/05/2012			

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	<p>the past year.</p> <p>During an interview on 07/31/2012 at 12:20 p.m., staff #2 (LPN) indicated the TB screening had not been completed during the past year as recommended by the physician for clients #2 and #4.</p> <p>During an interview on 07/31/2012 at 3:45 p.m., the LPN indicated she was not able to locate documentation to indicate the vitamin D level had been obtained as recommended by the physician for client #2.</p> <p>9-3-6(a)</p>			

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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, interview and record review, the facility failed to ensure nursing services monitored/assessed nutritional requirements for 1 of 4 sampled clients (client #2). The facility failed to ensure nursing services followed physician orders and followed up on physician recommendations for 1 of 4 sampled clients (#2).</p> <p>Findings include:</p> <p>During observations at the group home on 07/31/2012 between 6:02a.m. and 7:50a.m. client #2 did not eat breakfast. She received a container of yogurt with her 7:30 a.m. medications.</p> <p>1. Client #2's record was reviewed on 07/31/2012 at 11:48 a.m. Diagnosis included, but was not limited to, MCAD (Medium Chain Acyl-CoA Dehydrogenase Deficiency - disorder that affects the way the body breaks down fats) that, when left untreated, can cause life-threatening illness.</p> <p>A Nutritional Services Progress Note, dated 06/28/2012, indicated client #2 was on a 2200 calorie per day/44 grams of fat.</p> <p>The physician's orders, dated 07/01/2012-07/31/2012, indicated, "...2200 CAL/DAY 44 GRAMS FAT IN 3 MEALS/ 3 SNACKS/ 2 SERVINGS OF SKIM MILK .... "</p> <p>A Laboratory result form, dated 01/05/2012, indicated, "...Vit (vitamin) D low @ (at) 18 (range is 30-74 nannograms per milliliter) ...800 IU *International Units) Vit D3/ (per) day x (times) 3 mo (months) then do vitamin D level ... "</p>	W0331	Regarding W331, the missing items were corrected. ASI has implemented a second nursing position to help address the medical needs of consumers in group homes and waiver programming. The division of the caseload should help ensure that all annual requirements are met and that there is timely follow through on labs/follow ups. All GH medical appointments are tracked on a spreadsheet to identify when annual items are due. This will be monitored by the house lead, nurse, and programming coordinator.	09/05/2012			

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	<p>The record did not include documentation to indicate the physician's recommendations had been implemented.</p> <p>The physician's orders dated 07/01/2012-07/31/2012, indicated, "...APLISOL (injection used to detect tuberculosis (TB) exposure) 0.1 ml (milliliter) INTRADERMALLY (under the skin) YEARLY .... " The record did not include documentation to indicate the physician's recommendations had been implemented during the past year.</p> <p>During an interview on 07/31/2012 at 12:20 p.m., staff #2 (LPN) indicated the TB screening had not been completed during the past year as recommended by the physician for client #2.</p> <p>During an interview on 07/31/2012 at 3:45 p.m., staff #1 (House Manager) stated, " [Client #2] never eats breakfast. Staff #1 (House Manager) indicated the menu items from breakfast were not replaced to ensure client #2 received the recommended dietary intake for management of MCAD.</p> <p>During an interview on 07/31/2012 at 3:45 p.m., staff #2 (LPN) indicated she was unaware of client #2 's refusal to eat breakfast. The LPN indicated there was no system to ensure client #2 received the daily dietary recommendations for management of MCAD. The LPN indicated she was not able to locate documentation to indicate the vitamin D level had been obtained as recommended by the physician for client #2.</p> <p>9-3-6(a)</p>				

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(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			
W0441	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. 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 and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed for clients #1, #2, #3, #4, #5, #6, #7 and #8 on 07/31/2012 at 9:30 a.m. The record did not include documentation of a fire drill on the day shift (5 a.m-10 a.m.) for the quarter covering October, November, and December, 2011. The record did not include documentation of a fire drill during the night shift (10 p.m. - 6 a.m.) for the quarter covering April, May, June 2012.</p> <p>During an interview on 07/31/2012 at 9:50 a.m., staff #1 (House Manager) indicated the facility did not conduct a fire drill on the day shift during the quarter covering October, November, and December 2011. The House Manager indicated the facility did not conduct a fire drill on the night shift for the quarter covering April, May, June 2012.</p> <p>9-3-7(a)</p>	W0441	In regard to W441, the GH Manager had scheduled the drills and staff failed to carry them out. The Manager will be checking the drill logs within the week that the drills were scheduled to ensure the correct paperwork was done. If the drill was not completed at the scheduled time, disciplinary action may be used and the drill will be done. The fire safety binders, which include the documentaiton for all drills and/or real events, will be reviewed by the Safety Committee on a quarterly basis.	09/05/2012			

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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 for 4 of 4 sampled clients (#1, #2, #3, #4) and 3 additional clients (#5, #7, #8), the facility failed to encourage clients to participate in meal preparation and family style dining to the extent they were capable.</p> <p>Findings include:</p> <p>During the 7/31/12 observation period between 6:02a.m. to 7:50a.m. at the group home, facility staff did not encourage clients, who were available to assist (#1, #2, #3, #4, #5, 7, #8), to participate in all aspects of the meal preparation and family style dining. At 6:02a.m. the dining room table had been set for clients #1, #2, #3, #4, #5, #7 and #8. The clients had their plates/bowls, utensils, napkins and cups on the table. At 6:45a.m., staff #5 put cereal, milk and juice on the table. Staff #5 got frozen sausage out of the freezer, put some on a plate and microwaved the sausage. Staff #5 put the unused sausage back into the freezer. Staff #5 got out butter. Staff #5 served sausage, one pattie on each clients plate. Staff #5 put forks on the table for each client. Staff #5 poured drinks for client #4. Staff #5 put the butter away and rinsed the plate used to cook the sausage and placed it in the dishwasher. At 7:20a.m. staff cleared off the dining room table and put breakfast items away. Staff #5 wiped off dining room chairs and put them back around the dining room table. Staff #5 was interviewed at 6:55a.m. and indicated</p>	W0488	Regarding W488, the GH staff were retrained to ensure they understood the concept of encouraging consumers to complete personal self care to their individual full capacity. This will be a topic of training wth GH staff during future DSP trainings.	09/05/2012			

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	<p>they had set the breakfast table this morning.</p> <p>Interview of professional staff #1 on 7/31/12 at 3:17p.m. indicated all the clients were capable of assisting with the preparation of breakfast and serving themselves with some staff assistance. Staff #1 indicated the clients should have been more involved with breakfast preparation.</p> <p>9-3-8(a)</p>						