

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
--	---

(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) to the PCR completed 1/10/12 to the PCR completed 8/4/11 to the investigation of complaints #IN00089801 and #IN00090212 completed on 5/6/11.</p> <p>This visit was in conjunction with the full recertification and state licensure survey.</p> <p>This visit was in conjunction with the PCR to the PCR to the investigation of complaint #IN00092167.</p> <p>Complaint #IN00090212: Not Corrected.</p> <p>Complaint #IN00089801: Not Corrected.</p> <p>Dates of Survey: February 13, 14 and 15, 2012</p> <p>Facility number: 005592 Provider number: 15G736 AIM number: 200859130</p> <p>Surveyor: Claudia Ramirez, RN, Public Health Nurse Surveyor III</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/23/12 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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			
W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review, the facility failed for 1 of 1 client (client #5) who required the use of a Hoyer lift, to ensure the use of her adaptive equipment (lift) was included in her Individualized Support Plan (ISP).</p> <p>Findings include:</p> <p>Client #5 was observed at her home on 02/13/12 from 4:15 PM to 6:15 PM. Client #5 was observed to sit in her recliner located in the living room. At 4:45 PM direct care staff (DCS) #1 brought the mechanical lift to the recliner and lifted client #2 out of her recliner with the assistance of DCS #2 and placed her in her wheelchair and took her to her bedroom. At 5:00 PM DCS #1 and #2 returned to the living room with client #5 in her wheelchair and lifted her using the mechanical lift from the wheelchair and placed her in the recliner.</p> <p>A review of client #5's record was completed on 02/14/12 at 12:30 PM. Client #5's record contained no Hoyer Lift Training instructions. Her Individualized Support Plan dated 05/23/11 did not</p>	W0240	The new QDDP has up-dated the ISP for this particular consumer as well as the other residents of Earl. Her revisions are comprehensive and address the deficiencies cited. In addition, the GH Nurse has trained all staff on the appropriate Hoyer Lift training. The IDT, which includes the QDDP, Nurse, GH Manager (job title is Programming Coordinator), Lead DSP, and Behavioral Specialist participate in weekly staffing meetings which will include plan up-dates as needed. These will be reviewed with staff in the monthly DSP Trainings.	03/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2012	
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905			
(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>indicate when staff were to use the mechanical lift to assist client #5 with her transfer needs. The physician's orders dated 02/2012 did not indicate client #5 used a mechanical lift.</p> <p>An interview with the Director of Community Living (DCL) was conducted on 02/15/12 at 10:45 AM. The DCL indicated guidelines for the use of her Hoyer lift were not specified in her ISP.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(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>483.460(c) NURSING SERVICES 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 for 1 of 3 sampled clients (client #1) and two additional clients (clients #4 and #5) by not ensuring the nurse monitored medical and nursing needs and medications.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 02/14/12 at 10:50 AM. Client #1's record review indicated client #1 lacked the following examinations in the past year: physical examination, nursing quarterlies and vision screening. Client #1's record contained a picture of the walker he was to use and information which indicated he was using the incorrect walker in the group home. Client #1's record indicated he had a psychiatric medication review on 11/03/11 with a medication increase for his Abilify to increase from 5 mg to 7.5 mg. The medication increase was not noted on the November, December 2011 MARs (Medication Administration Record) or on the January 2012 and February 2011 MAR.</p> <p>Client #4's records were reviewed on</p>	W0331	All medical, dental, vision, hearing, or speciality doctors appointments for Earl consumers have been completed or scheduled (some appointments could not be scheduled before the review date per the office availability). All medical appointments are recorded in the agency's GH tracking system which is up-dated weekly and distributed to the nurse, Lead DSP, Programming Coordinator and QDDP. This has a built-in trigger system to identify when appointments are coming due so that they do not lapse.	03/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>02/14/12 at 12:15 PM. Client #4's record review indicated client #4 lacked the following examinations in the past year: physical examination, nursing quarterlies and vision screening. Client #4's record indicated he was non-ambulatory and required a wheel-chair for his mobility and depended upon staff to assist him in and out of it. Client #4's record did not contain a repositioning schedule for client #4.</p> <p>Client #5's records were reviewed on 02/13/12 at 12:30 PM. Client #5's record review indicated client #5 lacked the following examinations in the past year: physical examination, nursing quarterlies, vision screening and dental examination. Client #5's record indicated she had a power wheelchair but was not using it herself at the group home. Client #5's record indicated she had seen her neurologist for her seizures control on 10/25/11. The MD had ordered a change in her Valium order and had ordered it increased. The November 2011, December 2011 and January 2012 MAR did not indicate the Valium order had been changed. The February 2012 MAR did not contain all of the physician's instructions for administration of the Valium order. Client #5's record indicated client #5 was non-ambulatory, required a Hoyer lift, required a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/15/2012
NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905		
(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>wheel-chair for her mobility and was unable to propel it herself. Client #5's record did not contain a repositioning schedule for client #5.</p> <p>An interview with the agency nurse was conducted on 02/15/12 at 10:45 AM. The nurse indicated she had been with the company for 8 months. She indicated all of the physical examinations, vision screening and hearing screenings had been scheduled but had not all been completed. She indicated she did not know the status of the medication increase on client #1 and why it had not happened yet. She also indicated the February 2012 MAR for the Valium order on client #5 did not contain the complete administration instructions. She indicated clients #4 and #5 needed to have a repositioning schedule but to date there was not any completed.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>				