

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
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NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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W0000	<p>This visit was a post-certification revisit (PCR) to the full recertification and state licensure survey conducted on January 10, 2012.</p> <p>This visit was in conjunction with the PCR to the PCR completed on 01/10/12, to the PCR completed 08/04/11, to the investigation of complaint #IN00092167 completed on 7/1/11.</p> <p>This visit was in conjunction with the PCR to the PCR completed on 01/10/12, to the PCR completed 08/04/11, to the investigation of complaints #IN00089801 and #IN00090212 completed on 5/6/11.</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.</p> <p>Quality Review completed 2/23/12 by</p>	W0000		
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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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	Ruth Shackelford, Medical Surveyor III.			

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise general direction in a manner that resulted in the facility being well maintained for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the group home.</p> <p>Findings include:</p> <p>On 02/13/12 from 4:14 PM until 6:15 PM an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 4:45 PM the kitchen walls had 22 small holes the size of a pencil top and 1 large hole golf ball size. The doorway from the kitchen to the living room had a 1 foot long area going up the wall, on both sides of the doorway, which had broken drywall with exposed wire mesh. The living room had a 3 inch by 3 inch hole by the television in the wall. The bathroom beside clients #1 and #4's room had a broken towel rack, broken toilet paper holder, and an area by the tub 1 foot by 3 inches which was bubbles drywall with an orange and black substance which covered it. The dresser in the hallway had a broken bottom drawer. Client #3's bedroom door and frame had paint which</p>	W0104	<p>The majority of the repairs cited in W104 have been corrected or are in the process of being repaired. The house will be getting an interior coat of paint once all of the wall repairs are finished. ASI has had two repair companies back out at the last minute to replace the doors and do some of the more substantial repairs. The agency will be using the company that has successfully done the repairs for our Clinton County facilities. All of these issues have caused a delay in completing the repairs. Congruent to these repairs getting completed, ASI is still going to look for a local contractor that can be used to provide on-going maintenance. The Earl Group Home will use the same maintenance request process that has been implemented in the Clinton County homes and has been successful in maintaining the homes in better overall condition. The new GH Manager (titled as Programming Coordinator) will also be monitoring the house on at least a weekly basis for potential damage/need for repairs. Representatives from the Safety Committee will also be touring the home on a quarterly basis to identify issues.</p>	03/16/2012			

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	<p>was scratched and chipped off over the entire door. Client #5's bedroom had an area under her window which had dents and chipped paint with black marks which covered a 3 foot by 10 inch area. The wall leading into the hall by the medication closet had 3 holes in it 2 inches by 2 inches in size. The window and door in the living room had unfinished drywall and wood around it.</p> <p>On 02/14/12 from 7:50 AM until 8:45 AM an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 8:00 AM client #1 and #4's closet door had no handle and the paint was chipped and scratched.</p> <p>On 02/14/12 at 8:00 AM an interview with direct care staff (DCS) #3 indicated the window and door in the living room had been installed in August 2011.</p> <p>On 02/14/12 at 1:40 PM an interview with the Director of Community Living indicated the maintenance issues in the home of clients #1, #2, #3, #4, #5, and #6 should be addressed and none of the work had been started.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #1) to obtain a legally sanctioned representative for a client with an assessed need.</p> <p>Findings include:</p> <p>On 02/14/12 at 10:50 AM a record review for client #1 was conducted. The Individualized Support Plan (ISP) dated 12-9-10 indicated he was an emancipated adult. His ISP indicated his goal/objectives were: Client #1 would write his name 3 times a week, measure out his mouth wash, wash his hands prior to a meal, take his dirty clothes to the laundry room, cook an item in the microwave, wash a serving dish, identify coins, go to the bank to cash his check, order his food, clean his walker, write his phone number, and mop the kitchen floor. Client #1's Behavior Management Plan (BMP) dated 11-10 indicated he took Abilify for behaviors/aggression and Risperdal for aggression. The BMP</p>	W0125	<p>The family members of the consumer identified in W125 are not interested in becoming guardians. However, the GH's QDDP is working with his mother to determine if she is willing to be his medical advocate. This has not been finalized as of today (3/7/12), however, the conversations are still in progress.</p>	03/16/2012

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	<p>indicated the client's targeted behaviors included: refusing to take a bath and medications, physical aggression, verbal aggression, and giving false information. Client 1's Comprehensive Functional Assessment dated 12-6-11 indicated client #1 needed assistance with community safety, finances, meal preparation, and medical/health needs.</p> <p>On 02/15/12 at 10:45 AM an interview with the Director of Community Living indicated client #1 needed assistance with his medical and financial needs and he needed 24/7 supervision.</p> <p>On 02/15/12 at 10:45 AM an interview with the facility nurse indicated client #1 needed someone to assist him with his medical/health needs.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W0140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, for 3 of 3 sample clients (clients #1, #2 and #3) for whom the facility managed their personal funds accounts, the facility failed to maintain an accurate accounting system for each client's individual personal funds accounts.</p> <p>Findings include:</p> <p>1. Client #1's records were reviewed on 02/14/12 at 10:50 AM. Client #1's ISP (Individual Support Plan) dated 12/12/11 indicated client #1 was not able to independently handle his money and required assistance.</p> <p>On 02/14/12 at 12:30 PM client #1's personal funds accounts were reviewed according to an accounting conducted by an agency audit on 01/26/12. The audit sheet indicated client #1's funds contained no ledger and he had \$9.06.</p> <p>An interview with the Director of Community Living (DCL) was conducted on 02/15/12 at 10:45 AM. The DCL indicated the agency was unsure if the</p>	W0140	<p>The financial accounting system for all Earl consumers has been revised. There is now a safe at the home to hold the consumers' money and only the manager and Lead DSP have access. Consumers can get money at any time as the two identified staff understand they must be available to release funds as requested. Each consumer has a separate tracking system for incoming/outgoing money and receipts. The agency's protocol regarding consumer funds in GH (and waiver) has been revised and is currently waiting for Board approval. A representative from the fiscal department will conduct monthly unaccounted audits of consumer funds.</p>	03/16/2012	

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	<p>balance was still correct as the cash box could not be opened at the current time because they could not find the key.</p> <p>2. Client #2's records were reviewed on 02/14/12 at 11:10 AM. Client #2's ISP dated 08/18/11 indicated client #2 was not able to independently handle his money and required assistance.</p> <p>An interview with the DCL was conducted on 02/15/12 at 10:45 AM. The DCL indicated the agency was unsure if the balance was still correct as the cash box could not be opened at the current time because they could not find the key.</p> <p>3. Client #3's records were reviewed on 02/14/12 at 11:30 AM. Client #3's ISP dated 08/18/11 indicated client #3 was not able to independently handle her money and required assistance.</p> <p>An interview with the DCL was conducted on 02/15/12 at 10:45 AM. The DCL indicated the agency was unsure if the balance was still correct as the cash box could not be opened at the current time because they could not find the key.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>						

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview, the QMRP (Qualified Mental Retardation Professional) failed for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6) to ensure a legally sanctioned representative for client #1 was obtained, to ensure an accurate accounting system for clients #1, #2 and #3 was developed and implemented, to ensure assessments were completed for clients #1, #4, #5 and #6, to ensure specific Crisis Physical Intervention (CPI) holds were specified in Behavior Management Plans for clients #1 and #2, to ensure the Human Rights Committee (HRC) reviewed and approved restrictive measures for clients #1 and #2, to ensure the correct walker was used for client #1, and to ensure prescribed diets were followed for clients #4 and #6.</p> <p>Findings include:</p> <p>Please refer to W125. The QMRP failed to provide a legally sanctioned representative for 1 of 3 sampled clients (client #1).</p>	W0159	<p>A new QDDP was hired for Earl GH on January 30. She has now completed orientation and other trainings and has assumed the responsibility for the needs of Earl GH consumers. She is working closely with the new Behavioral Specialist as well to ensure plans are up-to-date and include all the issues that have been deficient. The QDDP has also been working closely with the GH Nurse who is responsible for up-dating all consumer high risk, care plans, and dining plans. The staff have participated in several trainings to ensure they are well-versed in these aspects of GH functioning. The Treatment Team, which includes the QDDP, Nurse, GH Manager, Lead DSP, and Behavioral Specialist participate in weekly staff meetings to more quickly identify problems and ensure they are addressed in a timely manner.</p>	03/16/2012	

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	<p>Please refer to W140. The QMRP failed to maintain an accurate accounting system for each client's (clients #1, #2 and #3) individual personal funds accounts.</p> <p>Please refer to W218. The QMRP failed for 1 of 3 sampled clients (client #1) and 2 additional clients (client #4 and #5) who required equipment for mobility, to have a sensorimotor assessment.</p> <p>Please refer to W227. The QMRP failed for 2 of 2 non-verbal clients (clients #5 and #6), to address the clients' identified communication needs.</p> <p>Please refer to W295. The QMRP failed for 2 of 2 clients (clients #1 and #2) who had physical aggression in their Behavior Management Plan to ensure the specific techniques were incorporated in the plan.</p> <p>Please refer to W262. The QMRP failed to ensure the facility's Human Rights Committee (HRC) for 2 of 3 sampled clients (clients #1, and #2) who required Behavior Support Plans (BSP) due to behaviors, to review, approve, and monitor restrictive practices.</p> <p>Please refer to W436. The QMRP failed to ensure the correct walker was used for 1 of 3 clients (client #1) who used</p>				

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	<p>adaptive equipment to assist them with mobility.</p> <p>Please refer to W460. The QMRP failed for 2 of 6 clients (clients #4 and #6) to ensure their diets were followed.</p> <p>On 02/15/12 at 10:45 AM an interview with the Director of Community Living (DCL) was conducted. The DCL indicated the agency had hired a QMRP (Qualified Mental Retardation Professional) and a new Residential Manager (RM). She indicated the QMRP had started 01/30/12 a day prior to the POC (Plan of Correction) date. She indicated the RM had returned from maternity leave early and had taken over that home on 02/06/12. The DCL indicated there was a new team in place for this home, but there were still many things they needed to do and several of the issues had not been corrected yet.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-3(a)</p>						

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W0218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1) and 2 additional clients (clients #4 and #5) who required equipment for mobility, to have a sensorimotor assessment.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 02/13/12 from 4:15 PM until 6:15 PM and on 02/14/12 from 7:50 AM until 8:45 AM. During the observation times, client #1 used a walker when he ambulated. Client #1 picked up the walker and set it down with each step he took. Clients #4 and #5 used wheelchairs and required staff for mobility.</p> <p>Client #1's records were reviewed on 02/14/12 at 10:50 AM. Client #1's Individual Support Plan (ISP) dated 12/12/11 indicated client #1 was to ambulate with a walker. Client #1's record did not contain a Physical Therapy (PT) evaluation.</p> <p>Client #4's records were reviewed on 02/14/12 at 12:15 PM. Client #4's ISP</p>	W0218	<p>The repairs for the walker for consumer #1 have been authorized and the GH is just waiting on the repair company to schedule the improvements. This is expected to be completed by March 16, however, it is somewhat out of ASI's control. He has been referred for a PT evaluation as well. In regard to consumer #4, he has also been referred for a PT evaluation and the repairs to his wheelchair have been authorized. The guardian of consumer #5 has refused a referral for a PT evaluation as well as a swallow study. ASI has asked her to put her refusal, and reasons for it, in writing so that it may be reviewed by the agency's HRC.</p>	03/16/2012			

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	<p>dated 07/18/11 indicated client #4's condition required a wheelchair and he was nonambulatory. Client #4's record did not contain a PT evaluation.</p> <p>Client #5's records were reviewed on 02/14/12 at 12:30 PM. Client #5's ISP dated 05/23/11 indicated client #5's condition required a wheelchair and she was nonambulatory. Client #5's record did not contain a PT evaluation.</p> <p>On 02/14/12 at 1:40 PM an interview with the agency nurse indicated there were no physical therapy evaluations for clients #1, #4 or #5 and she did not know when the last one had been conducted. She indicated clients #1, #4 and #5 needed to have an updated PT evaluations.</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>						

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W0220	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development.</p> <p>Based on observation, record review and interview for 2 of 2 non-verbal clients (clients #5 and #6) who lived in the group home, the facility failed to ensure speech assessments were completed for clients with identified communication needs.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 02/13/12 from 4:15 PM until 6:15 PM and on 02/14/12 from 7:50 AM until 8:45 AM. During the observation times clients #5 and #6 were nonverbal and did not speak.</p> <p>Client #5's records were reviewed on 02/14/12 at 12:30 PM. Client #5's Individual Support Plan (ISP) dated 05/23/11 indicated she was nonverbal. Client #5's record did not contain a speech evaluation.</p> <p>Client #6's records were reviewed on 02/14/12 at 12:45 PM. Client #6's ISP dated 05/17/11 indicated she was nonverbal. Client #6's record did not contain a speech evaluation.</p>	W0220	Regarding W220, a referral has been made for a speech evaluation for consumer #5. However, the guardian of consumer #6 has refused this request. ASI has asked her to put her refusal and reasons for it in writing so that it may be reviewed by the HRC.	03/16/2012			

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	<p>On 02/14/12 at 1:40 PM an interview with the agency nurse indicated there were not speech evaluations on clients #5 and #6 and she did not know when the last evaluations had been conducted. She indicated clients #5 and #6 needed to have updated speech evaluations.</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>				

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 2 of 2 non-verbal clients (clients #5 and #6) who lived in the group home, the facility failed to ensure the Individualized Support Plan (ISP) addressed the clients' identified communication needs.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 02/13/12 from 4:15 PM until 6:15 PM and on 02/14/12 from 7:50 AM until 8:45 AM. During the observation times clients #5 and #6 were nonverbal and did not speak.</p> <p>Client #5's records were reviewed on 02/14/12 at 12:30 PM. Client #5's Individual Support Plan (ISP) dated 05/23/11 indicated she was nonverbal. Client #5's ISP did not contain a communication goal or objective.</p> <p>Client #6's records were reviewed on 02/14/12 at 12:45 PM. Client #6's ISP dated 05/17/11 indicated she was</p>	W0227	The new QDDP is revising the ISP for all Earl consumers to ensure that they adequately address their needs. This will include providing up-dated goas as needed. The QDDP, Behavioal Specialist, Nurse, GH Manager, and Lead DSP will meet weekly to identify any issues/concerns that can be corrected in a timely manner.	03/16/2012	

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	<p>nonverbal. Client #6's did not contain a communication goal/objective.</p> <p>An interview with the Director of Community Living (DCL) was conducted on 02/15/12 at 10:45 AM. The DCL indicated clients #5 and #6 did not have a goal or objective to tell staff what they should do in order to assist the clients with their identified communication needs.</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>				

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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 GH Nurse will ensure that the correct order is in place for use of the Hoyer. She is the one responsible for training staff on the correct use of the lift as well. The QDDP has rewritten the ISP to ensure use of the Hoyer is correctly reflected in there as well.	03/16/2012			

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	<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>				

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W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE 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 record review and interview, the facility's Human Rights Committee (HRC) failed for 2 of 3 sampled clients (clients #1 and #2) who lived in the home and required Behavior Support Plans (BSP) due to behaviors, to approve restrictive practices (psychotropic medications).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 02/14/12 at 10:50 AM. Client #1's Individual Support Plan (ISP) was dated 12/12/11. Client #1's BSP was dated 11/2011 and indicated client #1 was on the behavioral medication Abilify 5 mgs (milligrams) for the following behaviors: verbal/physical aggression and refusal to bathe. The BSP did not contain signatures of the HRC to indicate the committee had reviewed and approved the plan.</p> <p>Client #2's records were reviewed on 02/14/12 at 11:10 AM. Client #2's ISP</p>	W0262	The new Behavioral Specialist has up-dated the plans to ensure that all restrictive measures are spelled out. These will be reviewed by the HRC at her agency as well as at ASI. The new QDDP will act as the liasion with the Behavioral Speciliast and HRC to ensure that any up-dates or new plans in the future are reviewed/approved.	03/16/2012	

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	<p>was dated 08/18/11. Client #3's BSP was dated 05/06/11 and indicated client #2 was on the behavioral medication Invega 6 mg, Abilify 10 mg, and Thorazine 50 mg prn (as needed) for the following behaviors: physical aggression, SIB (self injurious behaviors), elopement, stealing food, shredding and non-compliance. The BSP did not contain signatures of the HRC to indicate the committee had reviewed and approved the plan.</p> <p>An interview with the Director of Community Living (DCL) was conducted on 02/15/12 at 10:45 AM. The DCL indicated the HRC had not approved the BSPs.</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>				

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W0295	<p>483.450(d)(1)(i) PHYSICAL RESTRAINTS</p> <p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on record review and interview, the facility failed for 2 of 2 sample clients (clients #1 and #2), who had a targeted behavior of physical aggression, to ensure the specific Crisis Physical Intervention (CPI) hold/restraint was included in the Behavior Support Plan.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>On 02/14/12 at 10:50 AM a record review for client #1 was conducted. His BMP dated 11-10 indicated he had the targeted behavior of physical aggression. The BMP indicated if client #1 had physical aggression CPI could be used. The BMP did not specify what kind of CPI hold/restraint to use on client #1 if he became physically aggressive.</li> <li>On 02/14/12 at 11:10 AM a record review for client #2 was conducted. His Behavior Management Plan (BMP) dated 05/06/11 indicated he had a target behavior of physical aggression. The BMP indicated if client #2 had physical aggression CPI could be used. The BMP</li> </ol>	W0295	<p>The new Behavioral Specialist has up-dated the plans to ensure that all restrictive measures are spelled out. This includes the correct CPI Two measures that can safely be employed. These will be reviewed by the HRC at her agency as well as at ASI. The new QDDP will act as the liasion with the Behavioral Speciliast and HRC to ensure that any up-dates or new plans in the future are reviewed/approved. All staff working at Earl have had an up-dated CPI Two training conducted by the agency's trainer. These are up-dated annually, or more often if needed.</p>	03/16/2012			

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	<p>did not specify what kind of CPI hold/restraint to use for the targeted behavior of physical aggression.</p> <p>On 02/14/12 at 11:10 AM a review of client #6's Bureau of Developmental Disability Services (BDDS) reports was conducted. A BDDS report dated 7-22-11 indicated a CPI hold was used on client #2 due to a behavior. The report did not indicate what hold was utilized.</p> <p>An interview with the Director of Community Living (DCL) was conducted on 02/15/12 at 10:45 AM. The DCL indicated client #1 and #2's BMPs did not specify what hold to use for the targeted behavior of physical aggression. She also indicated a 2 person control hold was used on 7-22-11 to restrain client #2.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-5(a)</p>				

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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	The medical, dental, vision, hearing or speciality appointments have either been scheduled or taken place. In some cases, the appointment could not be scheduled prior to the deadline due to the availability at the physician's office. All medical appointments are recorded in the agency's GH tracking system which is up-dated on weekly basis and distributed to the GH Manager, Nurse, Lead DSP, and QDDP. This has a built-in trigger system to identify when appointments are coming due so that they will not lapse.	03/16/2012			

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	<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>			

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	<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>				

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W0336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) with medical conditions not requiring a medical care plan, to have quarterly nursing assessments completed in a timely fashion.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client #1's records were reviewed on 02/14/12 at 10:50 AM. Client #1's record did not contain evidence of a need for a medical care plan. The record review indicated the quarterly nursing assessments had not been completed in 2011. There were no quarterly nursing assessments in the record.</li> <li>Client #2's records were reviewed on 02/14/12 at 11:10 AM. Client #2's record did not contain evidence of a need for a medical care plan. The record review indicated the quarterly nursing assessments had not been completed in 2011. There were no quarterly nursing assessments in the record.</li> </ol>	W0336	The Nurse has up-dated all High Risk and Care Plans for Earl consumers and staff have been trained on these changes. This also includes the dietary/menu plan up-dates. All quarterly nursing notes have also been completed. ASI is in the process of hiring a second nurse which will be responsible for Earl GH.	03/16/2012			

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	<p>3. Client #3's records were reviewed on 02/14/12 at 11:30 AM. Client #3's record did not contain evidence of a need for a medical care plan. The record review indicated the quarterly nursing assessments had not been completed in 2011. There were no quarterly nursing assessments in the record.</p> <p>On 02/15/12 at 10:45 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated there were no quarterly nursing assessments for 2011 and had not completed any yet to date.</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>			

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W0352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients #2 and #3) to provide annual dental examinations.</p> <p>Findings include:</p> <p>1. Client #2's records were reviewed on 02/14/12 at 11:10 AM. Client #2's records did not indicate when client #2 had her last dental examination.</p> <p>On 02/15/12 at 10:45 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she could not locate any records to indicate client #2 was current with her dental examination. The LPN indicated she did not have any dental examination available for review. She indicated an appointment needed to be made for client #2.</p> <p>2. Client #3's records were reviewed on 02/14/12 at 11:30 AM. Client #3's records did not indicate when client #3 had his last dental examination.</p> <p>On 02/15/12 at 10:45 AM an interview</p>	W0352	All dental appointments have either been scheduled or already taken place. These appointments are entered into a centralized tracking system which is distributed weekly to the nurse, manager, Lead DSP and QDDP so that future appointments will not lapse.	03/16/2012			

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	<p>with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated she could not locate any records to indicate client #3 was current with her dental examination. The LPN indicated she did not have any dental examination available for review. She indicated an appointment needed to be made for client #3.</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>				

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview, the facility failed to ensure the correct walker was used for 1 of 3 clients (client #1) who used adaptive equipment to assist them with mobility.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 02/13/12 from 4:15 PM until 6:15 PM and on 02/14/12 from 7:50 AM until 8:45 AM. During the observation times, client #1 used a walker when he ambulated. The walker had 2 wheels and 2 tennis balls on it. Client #1 picked up the walker and set it down when walking. Client #1 was bent over as he used the walker throughout the entire observation.</p> <p>Record review on 02/14/12 at 10:50 AM for client #1 was conducted. A medicaid form dated 4-11 indicated client #1 received a walker with 4 wheels, a hand brake, and a seat.</p>	W0436	The repairs for the walker for consumer #1 have been authorized and ASI is just waitingn on the repair company to get the parts and make the repairs. He has been referred for a PT evaluation as well.	03/16/2012			

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	<p>On 02/15/12 at 10:45 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #1 was not using the correct walker and staff should ensure the walker which was ordered for him was available for his use. She indicated she was unsure why he was using the walker with the wheels and tennis balls. She further indicated she needed to get back with PT (Physical Therapy) for an updated evaluation and to determine exactly which walker he was to use and to obtain assistance to use it properly.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-7(a)</p>						

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review, and interview, for 2 of 6 clients (clients #4 and #6) who lived in the home, the facility failed to ensure their foods were prepared according to their prescribed diet.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 02/13/12 from 4:15 PM until 6:15 PM. At 4:15 PM client #6 was sitting at the kitchen table with 3 hard chocolate chip cookies in front of her. Staff #1 assisted client #6 to eat the cookies. The cookies were not moistened or softened. At 6:03 PM client #4's burrito was cut up into pieces larger than 1 inch on his plate by staff #2. At 6:07 PM client #4 started gagging and appeared to be choking. He started spitting food out onto his plate and stated, "I took too big of a bite." Staff #3 asked him if he wanted his food cut into smaller pieces, he indicated he did and staff #3 cut each of the previous pieces into smaller sizes.</p> <p>Client #4's record was reviewed on</p>	W0460	The GH Nurse has worked with the dietary services provider to obtain new menu and dining plans. The staff at Earl have been trained on these changes.	03/16/2012			

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	<p>02/14/12 at 12:15 PM. Client #4's 02-24-11 Dining Plan indicated his food, "needs to be cut into bite size pieces for him to consume (the visual size would be that of a quarter)."</p> <p>On 02/14/12 at 12:45 PM a record review for client #6 was conducted. Her dining plan (no date available) indicated her food was to be "chopped, ground, or blenderized and prepared with added liquids to make them easier to eat." Client #6's dining protocol indicated she was on a mechanical soft diet and foods which were hard to chew should be avoided.</p> <p>On 02/15/12 at 10:45 AM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the dining protocols for clients #4 and #6 should be implemented by direct care staff at all meals.</p> <p>This deficiency was cited 01/10/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-8(a)</p>			