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 01/10/2012

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

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W0000				
	This visit was for a post recertification revisit (PCR) to the PCR completed 8/4/11 to the investigation of complaint #IN00092167 conducted on 7/1/11. This visit was in conjunction with the full recertification and state licensure survey. This visit was in conjunction with the PCR to the PCR completed 8/4/11 to the investigation of complaint #IN00090212 and complaint #IN00089801 conducted on 5/6/11. Complaint #IN00092167: Not Corrected. Dates of Survey: January 3, 4, 5, 6, 9 and 10, 2012 Facility number: 005592 Provider number: 15G736 AIM number: 200859130 Surveyors: Tracy Brumbaugh, Medical Surveyor III-Team Leader Claudia Ramirez, Public Health Nurse Surveyor III These federal deficiencies also reflect state findings in accordance with 460 IAC	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	9. Quality Review completed 1/18/12 by Ruth Shackelford, Medical Surveyor III.			

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W0240	The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review, the facility failed for 1 of 3 sampled clients (client #2) to ensure the use of her adaptive equipment (lift) was included in her Individualized Support Plan (ISP). Findings include: Client #2 was observed at her home on 1-3-12 from 4:20 p.m. to 7:45 p.m. Client #2 was observed to sit in her recliner located in the living room. At 6:05 p.m. direct care staff (DCS) #6 brought the mechanical lift to the recliner and lifted client #2 out of her recliner and placed her in her wheelchair. Client #2 dangled in the sling as DCS #6 positioned the mechanical lift over the wheelchair and lowered client #2 into her wheelchair. DCS #6 then positioned the mechanical lift around client #2's wheelchair as she sat in her bedroom. DCS #6 lifted client #2 from her wheelchair, in her sling, with the mechanical lift, then lowered her to her bed. A record review was completed on 1-5-12 at 9:14 a.m. Client #2's Hoyer Lift Training instructions (no date available) indicated the mechanical lift should	W0240	In regard to W240, all staff were trained by the nurse and agency trainer in regard to the Hoyer Lift Protocol for the identified consumer. As part of the training, staff were required to demonstrate the skill. In addition, the Nurse and incoming QDDP are revising all High Risk Plans which will include specific instructions for adaptive equipment use. These will be referred to in the consumer's ISP. Plans will be reviewed with staff at the monthly group home meetings. In response to the question posed on 2/2/12 on this issue, on-going compliance with this monitored in several ways: * There is now a Lead DSP in place at Earl Group home who has the reposnsibility to ensure plans are followed. This person works shifts in the home. * There is now a GH Manager, the Program Manager for Tippecanoe County, who will also be in the home monitiring compliance. * The new QDDP and the agency nurse will also be regularly in the home and monitoring compliance. * During the monthly Earl staff trainings, protocols such as this will be reviewed and documented.	02/01/2012

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	"always" be used with 2 people. One staff should hold client #2 while the other staff operated the mechanical lift. Her Individualized Support Plan dated 5-23-11 did not indicate when staff were to use the mechanical lift to assist client #2 with her transfer needs. The physician's orders dated 12-30-11 did not indicate client #2 used a mechanical lift. On 1-5-12 at 1:25 p.m. an interview with the Qualified Mental Retardation Professional indicated guidelines for the use of her hoyer lift were not specified in her ISP. This deficiency was cited on 8-4-11. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			

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W0249	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.			
	Based on observation, record review, and interview, the facility failed to implement active treatment objectives and interventions during times of opportunity for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6). Findings include: 1. On 01/04/12 at 7:56 AM, staff #1 poured client #1's Listerine mouthwash into a cup and gave it to him to take to the bathroom. Client #1's records were reviewed on 01/05/12 at 9:15 AM. Client #1's ISP (Individual Support Plan) dated 12/12/11 contained a goal which indicated client #1 was to measure his mouthwash. 2. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Client #2's activity during the observation included the following: sitting in the recliner in the living room with the TV on; being taken to her room to change her adult brief; drinking an	W0249	In regard to W249, there is basically a need to overhaul active treatment at Earl Group Home. While the QDDP has created active treatment schedules, there has been a gap in training the staff to better understand how to meet those goals. Earl has been without a QDSP (the designated staff to help "run goals") for several months and more recently without a supervisor. A new QDDP, QDSP, and house manager have all been named and are in place as of this week. Active treatment and goals are a priority, as is training the staff on how to execute the consumer plans. There is a training on 2/9/12 with the agency nurse and dietician to begin this re-training process. However, it will not be fully completed by that date. \In response to the question posed on 2/2/12 on this issue, on-going compliance with this monitored in several ways: * There is now a Lead DSP in place at Earl Group home who has the reposnsibility to ensure plans are followed. This person works shifts in the home. * There is now a GH	02/01/2012

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	orange liquid with staff assistance and eating supper. During the observation period staff #6, #7 and #11 were on duty. Client #2 went to the table to eat supper at 6:50 PM and at 7:23 PM she received food to eat. Client #2's goals were not implemented during the evening observation. Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #2 was at the kitchen table sitting in her wheelchair at 7:00 AM. Client #2's activity during the observation included the following: eating breakfast, taking medications and leaving to go to dayservice program. During the observation period staff #1 and #3 were on duty. Staff #1 indicated there was to be 3 staff on duty, but someone called in ill. Staff #3 stated, "You should come back when we're staffed." On 01/04/12 at 8:11 AM, staff #1 prepared client #2's oral medications and fed them to her in applesauce and held on to the cup and gave her a drink of water after the medications. Client #2 did not hold the cup. Client #2's records were reviewed on 01/05/12 at 9:14 AM.. A review of client #2's 05/23/11 ISP (Individual Support Plan) indicated the active treatment schedule for client #2 was the following		Manager, the Program Manager for Tippecanoe County, who will also be in the home monitiring compliance. * The new QDDP and the agency nurse will also be regularly in the home and monitoring compliance. * There will be weekly staffing telephone calls with the Nurse, Programming Coordinator, QDDP, Lead and Behaviral Specialist to discuss active treatment, goals, medical issues, or concerns so that there is timely follow- up. * During the monthly Earl staff trainings, protocols such as this will be reviewed and documented.	

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	for the PM: 4:00 PM - arrive home from hab; 4:15 PM - picks a snack/eat/then clean up; 4:30 PM - fold towels - goal; 5:15 PM - wash hands/help set table; 5:45 PM - come to table for supper; 6:00 PM supper/goals; 6:45 PM - leisure activity; 7:15 PM - free time - mom usually visits and brings a snack and 8:00 PM - meds/goal. Client #2's active treatment schedule for the AM included the following: 7:00 AM - awakened by staff; 7:15 AM - picks clothes; 7:30 AM - showers; 8:00 AM - meds - complete med goal; 8:10 AM breakfast; 8:45 AM - clean-up and 9:00 AM - 3:00 PM - habilitation. Client #2's ISP dated 05/23/11 contained a goal which indicated client #2 was to hold onto her cup and take a drink of water after taking her medications. 3. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Client #3's activity during the observation included the following: sitting at the kitchen table working puzzles for 15 minutes, opening 2 cans of mandarin oranges and the remainder of the time was spent by herself in her room without staff checking on her or prompting her every 15 minutes to do an activity. Client #3 came out of her room at 7:13 PM to eat supper. During the observation period staff #6, #7 and #11			

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	were on duty. Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #3 was dressed and sitting on the couch at 7:00 AM. Client #3's activity during the observation included the following: taking off her shoes and scratching her feet, eating breakfast and leaving to go to dayservice program. Direct care staff #1 and #3 failed to provide training to client #3 by assisting her to bring her dishes to the sink, put her toys in her tote, and to wipe off the table per objectives in her ISP. During the observation period staff #1 and #3 were on duty. Staff #1 indicated there was to be 3 staff on duty, but someone called in ill. Staff #3 stated, "You should come back when we're staffed." Client #3's records were reviewed on 01/05/12 at 12:18 PM.. A review of client #3's 08/18/11 ISP indicated the active treatment schedule for client #2 was the following: 4:00 PM - arrive home from hab. Choose a snack, clean up from snack; 4:30 PM - leisure activity then free time; 5:00 PM - wash hands/assist with setting the table, meal prep, mix drink for the evening meal, etc; 6:00 PM - supper-meal clean-up; 7:00 PM - work on a puzzle or activity out of her room; 7:30 PM - pick out pajamas; 7:45			

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	to 8:00 PM - showered by staff, dress in the bathroom. Client #3's active treatment schedule for the AM included the following: 6:00 AM - awaken by staff - 6:15 AM - picks out clothes and takes to the bathroom, staff assists with shower; 6:30 AM - dresses in the bathroom/complete bra goal; 7:00 AM - breakfast, breakfast clean-up; 8:00 AM - meds - med goal; 8:15 AM make bed, pick up bedroom; 8:30 AM - leave for hab program and 9:00 AM - 3:30 PM - habilitation program. 4. Observations were conducted in the group home on 01/03/12 from 4:15 PM until 7:38 PM. Client #6's activity during the observation included the following: walking around the group home, scooting on the floor, stealing food from the pantry and taking it to his room to eat, taking a shower and eating supper. Client #6 ate supper at 7:20 PM. During the observation period staff #6, #7 and #11 were on duty and failed to provide training or to implement goals per his ISP. Observations were conducted in the group home on 01/04/12 from 7:00 AM until 9:00 AM. Client #6 was sitting in his room on his bed, bouncing up and down on the mattress. Client #6's activity during the observation included the following: walking around the home,			

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	eating breakfast and taking his medications. During the observation period staff #1 and #3 were on duty and failed to provide training or to implement goals per his ISP. Staff #1 indicated there was to be 3 staff on duty, but someone called in ill. Staff #3 stated, "You should come back when we're staffed." Client #6's records were reviewed on 01/05/12 at 12:45 PM. A review of client #6's 08/18/11 ISP indicated the active treatment schedule for client #6 was the following: 4:00 PM - arrive home/get off van; 4:45 PM picks out a drink and a low calorie snack (pickles, tomatoes, banana, apple, 100 calorie snack pack, etc); money goal; put cloths away goal; Leisure time (watch a movie, take a walk, swing, draw, write name, etc); 5:30 PM - wash hands/help with meal prep; 6:00 PM - eat dinner; 6:30 PM - dinner clean up; 6:45 PM - dancing, laps in the house, exercise tape; 7:15 PM - pick out P.J.'s/take a bath/brush teeth and 8:00 PM - meds (med goal). On 01/05/12 at 1:42 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated clients should be involved in active treatment all the time during waking hours and goals should be implemented at all opportunities.			

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	5. On 1-3-12 from 4:20 p.m. until 7:45 p.m. an observation at the home of clients #4 and #5 was conducted. At 7:10 p.m. clients #4 and #5 ate their supper meal with no adaptive silverware. On 1-4-12 from 6:45 a.m. until 9:10 a.m. an observation at the home of clients #4 and #5 was conducted. At 7:00 a.m. client #5 was observed to have a spoon and fork with a large round foam handle which he used to eat his breakfast. At 7:15 a.m. direct care staff #3 took the large round foam piece off of client #5's fork and put it on client #4's spoon for her to use to eat her breakfast. On 1-5-12 at 12:00 p.m. a record review for client #5 was conducted. The physician's orders dated 12-30-11 did not indicate client #5 had adaptive silverware at mealtimes. Client #5's dining plan dated 2-24-11 indicated client #5 used regular utensils. On 1-5-12 at 12:30 p.m. a record review for client #4 was conducted. The physician's orders dated 12-30-11 did not indicate client #4 used adaptive silverware at meal times. Client #4's dining plan (no date available) did not indicate what type of silverware client #4 was to use at meal times.			

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	On 1-5-12 at 1:20 p.m. an interview with the facility nurse indicated clients #4 and #5 did not use adaptive silverware and staff should implement the dining plans as written. 6. On 1-4-12 from 6:45 a.m. until 9:10 a.m. an observation at the home of client #1 was conducted. During this observation period client #1 was observed to look at a video box and take his medications. Client #1 sat at the kitchen table or on the couch during the observation except when he went to the medication closet to get his medications. Client #1's ISP indicated his goals were to mop the kitchen floor, wipe down the kitchen counters, use his check ledger, identify his soap and shampoo box, put the plates away, and to shave his face. On 1-5-12 at 1:40 p.m. an interview with the Qualified Mental Retardation Professional indicated clients #1 should be offered active treatment and his goals should be implemented. This deficiency was cited on 8-4-11. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			

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W0331	The facility must provide clients with nursing services in accordance with their needs.			
	Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3) and one additional client (client #5) by not ensuring the nurse monitored medical and nursing needs and medications. Findings include: Client #1's records were reviewed on 01/05/12 at 9:15 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 MAR. Client #2's records were reviewed on 01/05/12 at 9:14 AM. Client #2's record review indicated client #2 lacked the following examinations in the past year:	W0331	In regard to W331, there are a number of nursing related concerns at Earl Group Home. As of 2/1/12, all overdue medical appointments for each consumer have been scheduled. However, many of them will take place after February 9. The nurse has documentation of all the scheduled appointments for surveyor review.	02/01/2012

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	physical examination, nursing quarterlies, vision screening and dental examination. Client #2's record contained information which indicated she had a power wheelchair ordered but was not using it at the group home. Client #2'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. Client #2's record indicated client #2 was non-ambulatory, required a Hoyer lift, required a wheel-chair for her mobility and was unable to propel it herself. Client #3's records were reviewed on 01/05/12 at 9:15 AM. Client #3's record review indicated client #3 lacked the following examinations in the past year: physical examination, nursing quarterlies, vision screening and dental examination. Client #3's record indicated she had a psychiatric medication review on 10/06/11 with a new medication ordered. The medication was started on 11/01/11 and was written incorrectly on the MAR. The November 2011 MAR indicated client #3 took Paxil Elix 5 ml (milliliter) by mouth every day. The MAR did not indicated the milligram of the Paxil.			

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 01/10/2012
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
	Client #5's records were reviewed on 01/05/12 at 12:30 PM. Client #5's record indicated client #5 was non-ambulatory and required a wheel-chair for his mobility and depended upon staff to assist him in and out of it. On 1-5-12 at 1:42 p.m. the nurse indicated she had been with the company for 7 months and the examinations had not 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 indicated most of the medical examinations had not been completed on clients #1, #2 and #3. She also indicated the orders for client #3's Paxil and the order for client #2's Valium were incorrect. This deficiency was cited on 8-4-11. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			