STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G602	A. BUILDING 00 B. WING	02/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ABILITIES SERVICES INC	850 MAPLELEAF DR FRANKFORT, IN 46041

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit was in conjunction with the post-certification revisit (PCR) to the investigation of complaint #IN00282942 completed on 1/7/2019. Dates of Survey: 2/19, 2/20, 2/21, 2/22, and 2/25/2019. Provider Number: 15G602 AIM Number: 100245620 Facility Number: 001116 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/11/19.	W 0000		
W 0227 Bldg. 00	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. Based on observation, record review, and interview for 1 of 3 sampled clients (client #1), the facility failed to develop a written training program to address client #1's dental recommendations for a dental spin brush and a timer used for the care of his teeth. Findings include: On 2/20/19 at 5:30am until 8:00am, client #1 was observed at the group home. At 7:40am, client #1	W 0227	Staff will prompt the consumers to use their adaptive equipment; such as: glasses, dentures, braces, timers, electric toothbrushes, etc. If a consumer refuses, staff will educate the consumer on the importance of using the equipment. Staff will document the teaching, training, and refusal in CareTracker. The QIDP will monitor the training	02/26/2019

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	brushed his teeth with a regular manual toothbrush and did not use a timer in the hallway bathroom. On 2/21/19 at 9:50am, an interview was conducted with client #1 and the QIDP (Qualified Intellectual Disabilities Professional) at the facility owned day services. At 9:50am, client #1 indicated he had brushed his teeth at the group home during the morning and did not use a timer or an electric toothbrush. Client #1's record was reviewed on 2/20/19 at 11:00am. Client #1's 7/26/18 dental visit indicated the recommendations to "clean his teeth, needs better hygiene...Gave timer to help w/ (with) brushing." Client #1's 1/9/18 dental visit indicated the recommendation to use an "electric toothbrush twice daily" for his dental health and hygiene. Client #1's 7/5/18 ISP (Individual Support Plan) indicated a dental goal to brush his own teeth. Client #1's ISP did not include a written training program regarding client #1's dental recommendations. On 2/21/19 at 9:00am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the Registered Nurse (RN). The QIDP and RN indicated client #1 did have an electric spin toothbrush available at the group home for his use. The QIDP indicated she was unsure of client #1's dental goal and if the goal included the use of an electric toothbrush. The QIDP indicated she was unaware of the dental recommendation regarding the use of a timer to brush his teeth. On 2/22/19 at 9:00am, an interview was conducted with the QIDP. The QIDP provided an updated dental goal for client #1's dental hygiene revised		opportunities monthly to determine if a formal goal is needed.	

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	on 2/21/19 that included the dental recommendations for the use of an electric toothbrush and times. The QIDP indicated client #1's dental training program did not have the recommendations incorporated before 2/21/19. 9-3-4(a)			
W 0262 Bldg. 00	483.440(f)(3)(i) PROGRAM MONITORING & 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.			
	Based on record review and interview for 1 of 3 sampled clients (client #2), the facility failed to ensure the Human Rights Committee (HRC) reviewed and approved the use of client #2's Seroquel medication used for behaviors. Findings include: Client #2's record was reviewed on 2/20/19 at 11:50am. Client #2's record indicated he was admitted to the facility on 11/15/2018. Client #2's 12/15/18 ISP (Individual Support Plan) did not indicate the use of Seroquel medication for behaviors. Client #2's record did not indicate a Behavior Support Plan (BSP) available for review. -Client #2's 12/13/18 admission physician's order indicated "Seroquel for behaviors" daily. Client #2's 1/3/19 "New Patient" physician's visit indicated "Seroquel x (for) 5 days, 300mg (milligrams)" for behaviors. Client #2's 1/28/19 physician's order indicated "Quetiapine (Seroquel) 300mg, take one tablet by mouth at bedtime" for behaviors.	W 0262	Upon admission the ill have the consumer sign a consent form authorizing ASI employees to administer their listed medications. The QIDP will meet with the behavior specialist to ensure a BSP will be development within 45 days of admission for the psychotropic medications.	02/26/2019

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	-Client #2's 1/29/19 psychological review indicated "change Seroquel 300mg to Seroquel 100mg P.O. (by mouth) BID (twice) (daily) due to increased sedation and decreased range of affect. Seroquel 500mg P.O. PRN (as needed) for agitation." Client #2's record did not indicate an HRC approved Behavior Support Plan available for review. On 2/22/19 at 10:00am, a review was conducted of the facility's HRC minutes for the period from 2/2018 through 2/2019. The facility's HRC committee met on 1/24/19 and 9/6/2018 and failed to include a review and the approval of client #2's Seroquel medication. On 2/21/19 at 9:00am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the agency's Registered Nurse (RN). The QIDP and RN both indicated client #2's Seroquel medication was for behaviors. The QIDP stated client #2 "did not have a BSP developed yet" and stated the Behavior Consultant was "in the process of developing a plan." The QIDP indicated client #2 was admitted to the facility on 11/15/2018 and was taking the Seroquel medication for behaviors when he was admitted to the group home. The QIDP indicated the agency's HRC committee had not reviewed and approved client #2's medications used for behaviors. 9-3-4(a)			
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors			

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	for which the drugs are employed. Based on record review and interview, for 1 of 3 sampled clients (client #2), the facility failed to develop an active treatment program for the use of client #2's Seroquel (for behaviors) medication. Findings include: Client #2's record was reviewed on 2/20/19 at 11:50am. Client #2's record indicated he was admitted to the facility on 11/15/2018. Client #2's 12/15/18 ISP (Individual Support Plan) did not indicate the use of Seroquel medication for behaviors. Client #2's record did not indicate a Behavior Support Plan (BSP) available for review. -Client #2's 12/13/18 admission physician's order indicated "Seroquel for behaviors" daily. Client #2's 1/3/19 "New Patient" physician's visit indicated "Seroquel x (for) 5 days, 300mg (milligrams)" for behaviors. Client #2's 1/28/19 physician's order indicated "Quetiapine (Seroquel) 300mg, take one tablet by mouth at bedtime" for behaviors. -Client #2's 1/29/19 psychological review indicated "change Seroquel 300mg to Seroquel 100mg P.O. (by mouth) BID (twice) (daily) due to increased sedation and decreased range of affect. Seroquel 500mg P.O. PRN (as needed) for agitation." Client #2's record did not indicate a developed Behavior Support Plan available for review. On 2/21/19 at 9:00am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the agency's Registered Nurse (RN). The QIDP and RN both indicated client #2's Seroquel medication was for behaviors. The QIDP stated client #2 "did not have a plan developed yet," did not have a BSP developed, and stated	W 0312	The QIDP will meet with the behavior specialist to ensure a BSP will be developed within 45 days of admission for the psychotropic medication.	02/26/2019

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	the Behavior Consultant was "in the process of developing a plan." The QIDP indicated client #2 was admitted to the facility on 11/15/2018 and was taking the Seroquel medication for behaviors when he was admitted. The QIDP indicated the medications should have been included in client #2's BSP because the medication was used for behaviors. 9-3-5(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 4 additional clients (clients #4, #5, #6, and #7), the facility failed to keep medications locked when the medications were out of staff's eyesight. Findings include: On 2/20/19 from 5:30am until 8:00am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home and accessed each area of the group home including the medication area which did not have a door enclosure. On 2/20/19 at 6:50am, GHS (Group Home Staff) #3 selected and popped client #4's oral medication tablets into a medication cup. GHS #3 missed the medication cup when she popped client #4's "Loratadine 10mg (milligrams), 1 tablet by mouth once daily for seasonal allergies" and the medication tablet fell to the floor. GHS #3 did not observe the tablet missing the medication cup. After GHS #3 had finished dispensing the oral	W 0382	The home manger and house lead DSP will ensure that all destruction medication is locked in the medication cart until it can be brought to the office the next business day. The Nurse will check the medication cart weekly for any destruction medications.	02/26/2019

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	medication tablets into the medication cup, the surveyor asked GHS #3 how many medication tablets client #4 was to have received, and GHS #3 stated "eight" tablets. When asked to count the medication tablets in the medication cup, GHS #3 indicated seven tablets were in the cup. GHS #3 began looking for the missing medication tablet and located the tablet on the floor. GHS #3 picked up the Loratadine medication tablet, placed it in an envelope, wrote the medication information on the outside of the envelope, and placed the medication on the shelf of the medication area at eye level. GHS #3 indicated the staff placed medications to be destroyed on the shelf for staff to take to the nurse for destruction at the agency by the nurse. GHS #3 indicated the medication area did not have a door on the medication area. GHS #3 indicated the agency followed Core A/Core B medication administration training to administer medications in the group home. From 6:55am until 8:00am, client #4's medication envelope with the Loratadine medication laid on the shelf and was not locked. On 2/20/19 at 9:30am, an interview was conducted with the Registered Nurse (RN). The RN indicated the staff had brought client #4's Loratadine medication tablet into the facility for destruction when they arrived at the agency owned workshop today. The RN indicated the facility followed Core A/Core B medication training and medications should be locked when not being administered by the facility staff. The RN indicated the staff should keep medications to be destroyed locked inside the medication cart until the staff transported the medication to the agency to be destroyed by the nurse. On 2/20/19 at 10:10am, the agency's 4/2018 policy and procedure for "Medication Administration			

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	System" indicated the agency followed the Core A/Core B medication training. The policy and procedure indicated medications should be locked when not being administered. On 2/20/19 at 10:10am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson #3: Principles of Administering Medications" indicated medications should be kept secured/locked when not being administered. On 2/22/19 at 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and the RN was conducted. The QIDP and the RN both indicated medications should be kept locked when not administered by the facility staff. The QIDP and the RN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT 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.			
	Based on observation, record review, and interview, for 1 of 3 sampled clients (client #2) who had prescribed adaptive equipment, the facility failed to teach and encourage client #2 to wear his prescribed eye glasses. Findings include:	W 0436	Staff will prompt the consumers to use their adaptive equipment; such as, glasses, dentures, braces, timers, electronic toothbrushes, etc. If a consumer refuses, staff will educate the consumer on the importance of using the equipment. Staff will	02/26/2019

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	On 2/19/19 from 2:40pm until 6:00pm and on 2/20/19 from 5:30am until 8:00am, client #2 completed meal preparation, medication administration, looked at a magazine, swept the floors, watched television, and did not wear his prescribed eye glasses. During the observation periods, client #2 was not encouraged by staff to wear his prescribed eye glasses. On 2/21/19 at 10:15am, client #2 was observed at the agency owned workshop and sorted playing cards at his table and did not wear his prescribed eye glasses. At 10:15am, an interview was conducted with client #2 and the QIDP (Qualified Intellectual Disabilities Professional). When asked if he wore eye glasses, client #2 stated "a staff has my glasses. They (the unidentified staff) is (sic) keeping them (his glasses) safe." The QIDP asked the staff's name and client #2 indicated he was unable to recall the name. When asked if his glasses were broken, client #2 stated "no." Client #2's record was reviewed on 2/20/19 at 11:50am. Client #2's 12/15/18 ISP (Individual Support Plan) indicated he wore prescribed eye glasses to see. Client #2's 1/4/19 visual examination indicated he wore prescribed eye glasses to see. On 2/21/19 at 9:00am, an interview was conducted with the RN (Registered Nurse) and the QIDP (Qualified Intellectual Disabilities Professional). The RN and the QIDP both indicated client #2 wore prescribed eye glasses to see. The RN indicated client #2 should have been asked to wear his prescribed eye glasses. The QIDP indicated the facility staff should have him to wear his eye glasses when opportunities existed.		document the teaching, training, and refusal in CareTracker. The QIDP will monitor the training opportunities monthly to determine if a formal goal is needed.	

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	On 2/22/19 at 9:00am, an interview was conducted with QIDP. The QIDP indicated client #2 should have been asked to wear his prescribed eye glasses. 9-3-7(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 7 of 7 clients (clients #1, #2, #3, #4, #5, #6, and #7) who resided in the home, to ensure an evacuation drill was conducted at least every 90 days on the day shift (6:00am-10:00am) and the night shift (10:00pm-8:00am) for facility personnel. Findings include: On 2/19/19 at 1:55pm and on 2/21/19 at 8:30am, a review was conducted of the facility's evacuation drills for the period of 2/01/18 through 2/19/19. The review of the evacuation drill records included evacuation drills which were conducted for personnel and clients #1, #2, #3, #4, #5, #6, and #7. The review indicated the following completed emergency evacuation drills: For day shift: -On 2/2/19 at 7:15am. -On 12/27/18 at 7:50am. -On 12/5/18 at 7:30am. -On 8/4/18 at 7:30am. -On 3/15/18 at 7:47am. For night shift: -On 12/16/18 at 6:00am. -On 2/6/18 at 2:00am.	W 0440	The home manager will notify staff the day of the scheduled drill to remind them to conduct the drill. The home manager will check the next day to ensure that the drill was performed and fax the drill form over to Administration to be logged. The drill will be sent back to the home to be placed in the drill book.	03/06/2019

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	On 2/21/19 at 8:30am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated no additional drills were available for review. The QIDP indicated the day shift was 6:00am-8:00am and night shift was 10:00pm until 8:00am. The QIDP indicated there was not a documented emergency drill available for review for every 90 days from 2/1/18 through 2/19/19 for the day shift and the night shift of personnel and clients #1, #2, #3, #4, #5, #6, and #7. On 2/25/19 at 9:30am, an interview was conducted with the QIDP and the CEO (Chief Operating Officer). The CEO and the QIDP indicated no additional completed emergency drills were available for review for the period from 2/1/2018 through 2/25/19. 9-3-7(a)			