STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/01/2013

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

(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
K010000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 11/01/13 Facility Number: 001116 Provider Number: 15G602 AIM Number: 100245620 Surveyor: Dennis Austill, Life Safety Code Specialist At this Life Safety Code survey, Abilities Services Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in corridors and in common living areas. The facility has a capacity for 8 and had a census of 7 at the time of this survey. Calculation of the Evacuation Difficulty	K010000		

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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	Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.96. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/04/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K01S032	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In slow and impractical evacuation capability facilities, the primary means of escape for each sleeping room is not exposed to living areas and kitchens. Exception: Buildings equipped with quick-response or residential sprinklers throughout. Standard response sprinklers are permitted for use in hazardous areas in accordance with 33.2.3.2. 32.2.2.2.2 Based on observation and interview, the facility failed to provide a primary means of escape which was not exposed to living areas and the kitchen for 7 of 7 clients in this Slow rated facility. This deficient practice could affect all seven clients in the facility. Findings include: Based on observation on 11/01/13 between 9:45 a.m. and 11:00 a.m. with the Programming Coordinator the following was noted: a. The smoke barrier door that separated the corridor where 4 of 5 sleeping rooms were located from the dining room, living room and kitchen automatically closed when the fire alarm was activated but did not latch into the frame. Based on interview at the time of observation, the Programming Coordinator acknowledged the smoke barrier door did not latch into the frame.	K01S032	In regard to KS032, one door did not latch properly and one door did not contain a self closing mechanism. ASI has fixed both items listed. Weekly site checks (which means a management level staff will be in the home once a week to do an environmental check) have been implemented to identify any issues with home, including doors not latching and any other maintenance issues. Site checks will be reviewed in bi-weekly safety meetings to follow up on issues noted weekly to ensure they have been fixed. Paperwork for site checks are immediately sent to the Safety Chairperson to review in case of any issues needing immediately addressed. Staff have also been trained to notify their supervisor of any maintenance issues immediately upon finding them. Leadership team reviews safety minutes monthly to additionally check for any outstanding issues.	12/01/2013

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	b. The door separating the north bedroom from the kitchen did not have a door closer on the door and was not self closing or automatically closing. The north bedroom had a separate door with a direct primary exit to the front porch. Based on interview at the time of observation, the Programming Coordinator acknowledged the primary means of egress from the north bedroom would be exposed to the kitchen due to the lack of a self closing door which separated the bedroom from the kitchen.			

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K01S123	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Every bathroom door is designed to allow opening from the outside during an emergency when locked. 32.2.2.5.4, 33.2.2.5.4 Based on observation and interview, the facility failed to provide a key for the operable lock for 1 of 2 bathroom doors. This deficient practice could affect any of the seven clients in the facility if they locked themselves in the bathroom and staff could not reach them during an emergency. Findings include: Based on observation on 11/01/13 at 10:50 a.m. with the Programming Coordinator, the east bathroom door was equipped with a lock which was operable from inside the bathroom. A key near the door was not observed and based on interview at the time of observation, the Programming Coordinator indicated the only device available was a paper clip which did not unlock the east bathroom door.	K01S123	In regard to KS123, the bathrooms did not have immediate access from the hallway because the doors could be locked from the inside and there was not a key available to get in if needed. ASI has fixed this. Weekly site checks (which means a management level staff will be in the home once a week to do an environmental check) have been implemented to identify any maintenance issues in the home. Site checks will be reviewed in bi-weekly safety meetings to follow up on issues noted weekly to ensure they have been fixed. Paperwork for site checks are immediately sent to the Safety Chairperson to review in case of any issues needing immediately addressed. Staff have also been trained to notify their supervisor of any maintenance issues immediately upon finding them. Leadership team reviews safety minutes monthly to additionally check for any outstanding issues.	12/01/2013

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K01S148	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1 Based on observation and interview, the facility failed to ensure the smoking policy and procedures were followed. This deficient practice could affect all clients. Findings include: Based on observation on 11/01/13 at 10:35 a.m. with the Programming Coordinator, a ceramic container with 15 to 20 cigarette butts was sitting on the back patio next to the house. Based on interview with the Programming Coordinator at the time of observation, the facility adopted a nonsmoking policy last May or June.	K01S148	ASI is a non smoking facility. The staff have been re-trained that this means there is no smoking allowed on the group home property anywhere. Both scheduled and unscheduled site checks will occur three times a week by management staff to ensure that policies and procedures are being followed. A site visitation form is completed for these visits and is immediately sent to the Director of Programming for review. Any issues needing immediately addressed are phoned in to the Director of Programming. Otherwise they are reviewed within 24 hours. Smoking or issues with cigarette butts are an immediate call to the Director. Managers have been trained on this. Site visitations are also reviewed in Safety bi-monthly meetings and safety minutes are reviewed in monthly Leadership meetings to ensure all noted issues are being or have been addressed.	12/01/2013

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K01S152	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. (2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. (3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 quarters. This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Drill Log at 10:10 a.m. on 11/01/13 with the	K01S152	Staff did not run fire drills according to posted schedule. Staff will again be trained on the schedule/ procedures and protocol for running drills. Disciplinary action will occur for not running a drill that is assigned to the shift. PC will oversee schedule and immediately reschedule a drill that isn't completed on the date scheduled. PC is responsible for	12/01/2013

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	Programming Coordinator, there was no record of a fire drill for the first shift of the first quarter of 2013 and for the third shift of the second quarter of 2013. This was acknowledged by the Programming Coordinator at the time of record review.		reporting completed drills to the safety committee weekly. The safety committee will track all drills needing completed. The agency leadership team will review safety minutes monthly to ensure that all drills are being completed monthly.	

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K01S154	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility did not have a complete policy to address the sprinkler system being out of service for four hours or more in a 24 hour period to protect 7 of 7 clients. This deficient practice could affect all occupants of the facility if a fire should occur while the sprinkler system was not working. Findings include: Based on a review of the "Group Home Fire/Sprinkler Alarm Out of Service Procedure" with the Programming Coordinator on 11/01/13 at 10:30 a.m., the procedure indicated to contact the contracted fire monitoring agency and one or more of the administrative staff and did not indicate the authorities having jurisdiction would be notified. Based on interview at the time of record review, the Programming Coordinator acknowledged the procedure lacked instructions to notify the Indiana State Department of Health or	K01S154	Abilities Services has procedures for Fire/Sprinkler Alarm out of service. The copy of the procedure in the safety binder was not copied on both sides. Safety binders will be checked by safety committee monthly to ensure all procedures are in place, available to all staff, and updated as needed Meeting minutes will reflect checking of the binders by safety committee. All numbers and procedures are listed in the home. Specific wording says that Administrative staff will call in additional staff to walk the building every 15 minutes checking every room for signs of fire. They must ensure all pathways and exits are clear. There is a form to document the checks. Specific wording is that staff are to call the contracted fire monitoring agency immediately and notify them of the outage. They are also to call one or more of the listed administrative staff and administrative staff will call the fire dept, state board of health and fire monitoring system. All numbers are posted.	12/01/2013

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	the local fire department.			

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K01S155	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility did not have a complete policy to address the fire alarm system being out of service for four hours or more in a 24 hour period to protect 7 of 7 clients. This deficient practice could affect all occupants of the facility if a fire should occur while the fire alarm system was not working. Findings include: Based on a review of the "Group Home Fire/Sprinkler Alarm Out of Service Procedure" with the Programming Coordinator on 11/01/13 at 10:30 a.m., the procedure indicated to contact the contracted fire monitoring agency and one or more of the administrative staff and did not indicate the authorities having jurisdiction would be notified. Based on interview at the time of record review, the Programming Coordinator acknowledged the procedure lacked instructions to notify the Indiana State Department of Health or	K01S155	Abilities Services has procedures for Fire/Sprinkler Alarm out of service. The copy of the procedure in the safety binder was not copied on both sides. Safety binders will be checked by safety committee monthly to ensure all procedures are in place, available to all staff, and updated as needed Meeting minutes will reflect checking of the binders by safety committee. All numbers and procedures are listed in the home. Specific wording says that Administrative staff will call in additional staff to walk the building every 15 minutes checking every room for signs of fire. They must ensure all pathways and exits are clear. There is a form to document the checks. Specific wording is that staff are to call the contracted fire monitoring agency immediately and notify them of the outage. They are also to call one or more of the listed administrative staff and administrative staff will call the fire dept, state board of health and fire monitoring system. All numbers are posted.	12/01/2013

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