

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/09/2012
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NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN47905
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K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 01/09/12</p> <p>Facility Number: 005592 Provider Number: 15G736 AIM Number: 200859130</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>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.</p> <p>This one story facility was partially sprinklered. Closets and bathrooms were unsprinklered.</p>	K0000		

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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K0130	<p>The facility has a fire alarm system with smoke detection in corridors, sleeping rooms and common living areas. The facility has the capacity for 6 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.9.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/12/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>	K0130	<p>As noted in W130, there was no documentation of monthly fire extinguisher checks. On 1/24/12, all the fire extinguishers were services and hung at the Earl Group Home. Monthly tracking will take place on the 15th of the month, and be documented not only on the fire extinguisher tags but also in the fire safety binder. The binder is kept in the Group</p>	01/24/2012	
	<p>Based on observation, record review and interview; the facility failed to ensure 3 of 3 portable fire extinguishers were inspected at least monthly, and the inspections were documented, including at least the date and initials of the person performing</p>				

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	<p>the inspection. LSC 4.5.7 requires any device, equipment or service required for compliance with provisions of this Code shall be thereafter maintained unless the code exempts such maintenance. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires monthly, at least the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice affects all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with Staff # 1 between 12:50 p.m. and 1:20 p.m. on 01/09/12, the service and inspection tags for the portable fire extinguishers located in the kitchen, garage and office lacked documentation of monthly checks since placed in service in January 2011. Staff # 1 said at the times of observation, she did not know of any other record for documentation of the monthly</p>		Home staff office. The Programming Coordinator for Tippecanoe County services will monitor this on a monthly basis to ensure compliance.		

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KS051	<p>inspection. The residential manager on hand at the time of record review on 01/09/12 at 12:30 p.m., had no other information to provide.</p> <p>A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with Section 9.6. LSC 9.6.1.4 requires that all facilities maintain the fire alarm system in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals shall be distinctly and descriptively annunciated. NFPA 72 at 1-5.4.5.2 requires where status indicators are provided for emergency</p>	KS051	Based on the details of W051, there was a malfunction with the fire panel. It has since been serviced and will be checked again in two weeks by the fire protection complany. At the time of the service, the panel was working. The Tippecanoe County Programming Manager will be responsible for ensuring the panel is working at all times. This will occur, in part, by the monthly fire drills conducted at the home. The Safety Committee will monitor compliance on a quarterly basis.	01/24/2012	

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	<p>equipment, they shall reflect the actual status of the associated equipment. This deficient practice could affect all 6 clients in the house at the time of the survey.</p> <p>Findings include:</p> <p>Based on observation of the fire alarm panel prior to testing the fire alarm with Staff # 1 on 01/09/12 at 12:30 p.m., the main fire alarm panel LED and adjunct panel in the kitchen showed the fire alarm system was "Normal." Staff # 1 attempted to demonstrate the operation of the fire alarm system on 01/09/2012 at 12:50 p.m. after calling the monitoring station to notify them of an impending alarm. She attempted to initiate the alarm using the pull station located by the back door but the alarm did not sound. She reset the pull station and no alarm resulted. An immediate check of the fire alarm control panels revealed the system to be in "normal" status while the pull station was open and no alarm was sounding. Staff # 1 said she did not know what the problem was and this pull station</p>				

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	was most often used to conduct fire drills. Pull stations at the front door, kitchen and garage were activated and alarms occurred as expected. No trouble light or alarm was ever activated with the malfunction of the pull station. Upon calling the monitoring company after testing, Staff # 1 reported they had no evidence of trouble in the system at their end.				

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KS056	<p><b>PROMPT</b></p> <p>Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7, 33.2.3.5.2 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: In prompt evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, is permitted. Automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 2: Not applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted.</p>				

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	<p>Exception No. 5: Not applicable</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>SLOW Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: Not Applicable</p> <p>Exception No. 2: Not Applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not Applicable</p> <p>Exception No. 6: Initiation of the fire alarm</p>				

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	<p>system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>IMPRACTICAL</p> <p>Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction. 33.2.3.5.2.</p> <p>Exception No. 1: Not Applicable.</p> <p>Exception No. 2: In slow and impractical evacuation capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and Two Family Dwellings and Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 3: Not Applicable.</p> <p>Exception No. 4: Not Applicable.</p> <p>Exception No. 5: In impractical evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished</p>				

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	<p>with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was inspected quarterly. LSC 33.2.3.5.2 refers to LSC 9.7, and 9.7.5 requires all automatic sprinkler systems to be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Table 2-1, Summary of Sprinkler System Inspection, Testing and Maintenance requires annual inspection of the hangers, pipes and fittings, sprinklers and spare sprinklers and annual testing of antifreeze solution and valves. Table 2.1 also requires quarterly testing of the alarm devices and main drain. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with Staff</p>	KS056	As noted in S056, there was no evidence of quarterly sprinkler checks at Earl Group Home. Since that inspection, the sprinklers have been checked and will continue to be done at quarterly intervals. The Tippecanoe County Programming Coordinator will be responsible for ensuring the checks are done and the paperwork of the checks will be kept in the Fire/Safety binder. The Safety Committee will monitor compliance on a monthly basis.	01/24/2012

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KS147	<p># 1 on 01/09/12 at 12:45 p.m., there was no evidence of a sprinkler system inspection for the fourth quarter of 2011. Staff # 1 said at the time of record review, she knew nothing about sprinkler inspections. The residential manager, on hand at the time of record review said all inspection records were provided and there may have been a lapse since there was no house manager.</p> <p>The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility administration failed to ensure all employees are periodically</p>	KS147	As described in S147, Earl staff did not have regular training regarding evacuation plans for all consumers. This will be completed on a bi-monthly basis	01/24/2012	

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	<p>instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 6 of 6 clients. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review of Fire Drill Logs with Staff # 1 on 01/09/12 at 12:30 p.m., lapses in staff fire safety training times were more than the two months allowed as evidenced by the lack of any record of fire drills for the first shift during the first and second quarters of 2011 or the third shift during the second quarter of 2011. There was a nine month lapse in training from January 2011 to September 2011 and three month lapse in training from September 2011 to date for the first shift. On the third shift there was a lapse of six months between March and September fire drills. Staff # 1 said at the time of record review, there were no Fire</p>		(in the even months) during regular staff meetings. This will be documeted as a training and kept not only in their individual personal records but also in the Fire/Safety binder kept at the Group Home. It is the responsibility of the Tippecanoe County Programming Coordinator to ensure these trainings are done. The agency's Safety Committee will follow up on a quarterly basis.		

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KS148	<p>Drill Logs or other fire safety training records for these periods.</p> <p>Smoking regulations are adopted by the administration of board and care occupancies. 32.7.4.1, 33.7.4.1</p> <p>Based on record review, interview and observation; the facility failed to provide documentation of a smoking policy to protect 6 of 6 clients. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on a review of records provided with Staff # 1 on 01/09/12 at 12:25 p.m., a smoking policy was not found. Staff # 1 said at the time of record review, she knew there was one but she did not know where to find it. She said smoking was permitted in a designated area outside the house. An area on the back deck, observed on 01/09/11 at 1:40 p.m. with Staff # 1 had a can for butt disposal. The residential manager was on hand at the time of record review, and she could not provide a copy of the smoking policy.</p>	KS148	Regarding the S148 deficiency, Abilities Services does not currently have a policy regarding designated smoking locations at the Group Home. The Leadership Team has drafted a document to be approved by the Board of Directors on this topic.	01/24/2012

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KS152	<p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities;</p> <p>(iii) File a report and evaluation on each drill;</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(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.</p> <p>(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.</p> <p>Based on record review and interview, the facility failed to ensure fire and evacuation drills were provided for each shift for 3 of 4 quarters. This deficient practice affects all occupants.</p>	KS152	As noted in S152, Earl Group Home staff have not participated in regular safety drills at the home. It is the responsibility of the Tippecanoe County Programming Coordinator to ensure that all drills are done as scheduled throughout the year and	01/24/2012	

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KS154	<p>Findings include:</p> <p>Based on review of Fire Drill Logs on 01/09/12 at 12:30 p.m. with Staff # 1, documentation of fire drills were not found for the first shift during the first, second and fourth quarter of 2011; and the third shift during the second quarter of 2011. Staff # 1 said at the time of record review, she could find no addition records for fire drills conducted for these shifts.</p> <p>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</p> <p>Based on record review and interview, the facility failed to provide a written policy containing all procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 6 of 6 clients. LSC 33.7.1 requires plans for the protection of residents</p>	KS154	<p>documented in the Fire/Safety Binder. The Safety Committee will follow up on these expectations on a quarterly basis.</p> <p>In regard to S154, Abilities Services has the appropriate policy regarding sprinkler outages. However, the staff present at the survey were unable to produce it. The Programming Coordinator will include this topic in the bi-monthly fire/safety training at the regularly scheduled staff meetings. These will occure in the even months. All training will be documented in the staff files and in the Fire/Safety binder</p>	01/24/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  01/09/2012
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	<p>shall include special staff response, including the fire protection procedures needed to ensure the safety of any resident. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with Staff # 1 on 01/09/12 at 12:30 p.m., the records provided did not include the procedure to be followed in the event the sprinkler system was out of service for four hours or more in a 24 hour period. Staff # 1 said at the time of record review, she did not know what a fire watch was. The residential manager, on hand at the time of record review said she knew there was a fire watch procedure because it had been cited at another facility and provided with the plan of correction, but she had no documentation to offer.</p>		<p>at the Group Home. The agency's Safety Committee will monitor for compliance on a quarterly basis.</p>		

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KS155	<p>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</p> <p>Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period to protect 6 of 6 clients. LSC 33.7.1 requires every residential board and care facility to have in effect and available to all supervisory personnel a plan for the protection of all persons. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review with Staff # 1 on 01/09/12 at 12:30 p.m., the records provided did not include the procedure to be followed in the event the fire alarm system was out of service for four hours or more in a 24 hour period. Staff # 1 said at the</p>	KS155	In regard to S155, Abilities Services does have that policy but the staff present at the survey were unable to produce it. The Tippecanoe County Programming Coordinator will include training on this policy in the bi-monthly fire/safety training at the regularly scheduled staff meetings. These will be documented in the staff's training file but also in the Fire/Safety binder at the Group Home. The agency's Safety Committee will monitor on a quarterly basis.	01/24/2012	

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