

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  01/22/2013
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NAME OF PROVIDER OR SUPPLIER  ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 850 MAPLELEAF DR FRANKFORT, IN 46041
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K0000	<p>A Post Survey Revisit (PSR) for the Life Safety Code Recertification Survey conducted on 12/03/12 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 01/22/13</p> <p>Facility Number: 001116 Provider Number: 15G602 AIM Number: 100245620</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this PSR 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 fully sprinklered. The facility has a monitored fire alarm system with hard wired smoke detection in corridors, resident rooms and common living areas. The facility has a capacity of 8 and had a census of 7 at the</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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	<p>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 Impractical with an E-Score of 5.4.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/25/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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KS018	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2. Based on observation and interview, the facility failed to ensure 1 of 5 sleeping room doors were provided with latches suitable for keeping the door closed. This deficient practice affects all clients.</p> <p>Findings include:</p> <p>Based on observation with the group home programing coordinator on 01/22/13 at 1:00 p.m., the southeast sleeping room door, equipped with a positive latch, was closed and pushed twice to test the reliability of the latch. The door knob hung at a vertical angle and the door could be pushed open without turning the doorknob. The door knob could be spun around 180 degrees and would have been useless in this state had the latch worked. The group home programing coordinator said at the time of observation, a maintenance person had</p>	KS018	In regard to S018 and the consumer's bedroom in question, the repair has been scheduled with the agency's contracted provider. This is scheduled to be completed by the end of January. The GH Manager conducts a monthly inspection of all facilities and reports any unsafe findings to the Safety Committee for follow up and monitoring. The site checks are a written checklist to include all items to be reviewed. The Safety Committee meets bi-monthly and is headed by the agency's Director of Programming.	02/08/2013			

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	come in "the other day" and tried to fix the door latch and couldn't. She said the door would have to be replaced as it was also cracked and she had checked into getting one ordered "yesterday."			

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KS152	<p>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.</p> <p>(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.</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. Based on record review and interview, the facility failed to evaluate and take corrective action for problems with fire drill protocols to protect 7 of 7 clients. This deficient practice affects all occupants.</p> <p>Findings include:  Based on an interview with the group</p>	KS152	In regard to S152 deficiency, a second full-time staff for overnight shifts has been hired and in the process of training. The staff person will be on the schedule no later than February 1. The staffing calendar for the month of February, reflects the double staffing on every overnight. The GH Manager will report any staffing needs to the Recruiter as soon as needs are known. The	02/08/2013			

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	home Program Manager on 01/22/13 at 1:15 p.m., the Maplewood Group Home Evacuation Protocol reviewed on 12/03/12 at 1:50 p.m. was unchanged. Clients # 2, # 3, # 4, and # 5 were each documented in the Evacuation Protocol and care plans as being "at risk for falls" requiring constant "line of sight" observation. Client # 5 required assistance from "staff being no more than 12 inches from his side." Client # 6 noted to need assist into a wheelchair from a recliner or the bed had been discharged after a fall and injury resulting in hospitalization. The group home program coordinator said the protocols were appropriate for the clientele and necessary for their safety during evacuation and all clients needed supervision of some kind and the documented need for clients # 1, # 2, # 3, # 4, and # 5 for intervention and assistance was unchanged. She said there was budgetary approval for additional overnight staff but the additional staff assigned had "kept missing work" and had not been replaced, leaving one staff overnight. She said she was in the process of training someone. She said she was in the process of making a new schedule and had no second staff to meet the needs of clients overnight.		Recruiter maintains an on-going file of active candidates to reduce gaps in the schedule if a position becomes available. In addition, the agency Director conducts bi-monthly conference calls that include all hiring managers and the Recruiter to ensure staffing needs are being met.				

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