

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/25/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G602	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 12/28/2022
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP COD 850 MAPLELEAF DR FRANKFORT, IN 46041
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 12/28/22</p> <p>Facility Number: 001116 Provider Number: 15G602 AIM Number: 100245620</p> <p>At this Emergency Preparedness survey, Abilities Services Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 7.</p> <p>Quality Review completed on 01/03/23</p>	E 0000		
E 0004 Bldg. --	<p>403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a)</p> <p>Develop EP Plan, Review and Update Annually</p> <p>§403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).</p> <p>The [facility] must comply with all applicable</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Johnson	QIDP/Asst. Director	01/23/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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>Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:</p> <p>(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:</p> <p>* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.</p> <p>* [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.</p> <p>* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.</p> <p>. Based on record review and interview, the facility failed to maintain an emergency preparedness</p>	E 0004	In response to E0004, that the facility failed to maintain and	01/19/2023

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E 0013 Bldg. --	<p>plan that was reviewed and updated at least every 2 years in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 12/28/22 at 1:40 p.m. with the Assistant Director present, the facilities Emergency Preparedness plan entitled "Emergency Preparedness Plan" had not been updated within the last two-year period with the last documented update being listed as 09/14/2009. Based on an interview at the time of record review, the Assistant Director agreed that the Emergency Preparedness Plan had not been documented as being updated within the last two-year period.</p> <p>This item was again discussed at the exit conference with the Assistant Director on 12/28/22 at 2:19 p.m.</p> <p>403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b)</p> <p>Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).</p> <p>(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at</p>		<p>updated EAP. The EAP book is updated yearly in August. The QIDP was out of the office on leave during this review. The Asst. Director does not oversee the EAP and QIDP is not sure what book they were reviewing. The QIDP will make sure the person sitting for QIDP has the correct binder for review during survey. The Assistant PC will make sure the binder in the home matches the main binder. The QIDP will ensure the Asst. PC has the updated material for the binder and check to every six months, to make sure the binders are updated. The binders will come to the office for the checks. The Director will check yearly that both binders match.</p>		

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	<p>paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.</p> <p>*Additional Requirements for PACE and ESRD Facilities:</p> <p>*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.</p> <p>*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must</p>			

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E 0029	<p>develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.</p> <p>Based on record review and interview, the facility failed to review and update emergency preparedness policies and procedures at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 12/28/22 at 1:40 p.m. with the Assistant Director present, the facilities Emergency Preparedness plans policies and procedures had not been updated within the last two-year period with the last documented update being listed as 09/14/2009. Based on an interview at the time of record review, the Assistant Director agreed that the Emergency Preparedness policies and procedures had not been documented as being updated within the last two-year period.</p> <p>This item was again discussed at the exit conference with the Assistant Director on 12/28/22 at 2:19 p.m.</p> <p>403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c),</p>	E 0013	<p>In response to E0013, that the facility failed to maintain and updated EAP. The EAP book is updated yearly in August. The QIDP was out of the office on leave during this review. The Asst. Director does not oversee the EAP and QIDP is not sure what book they were reviewing. The QIDP will make sure the person sitting for QIDP has the correct binder for review during survey. The Assistant PC will make sure the binder in the home matches the main binder. The QIDP will ensure the Asst. PC has the updated material for the binder and check to every six months, to make sure the binders are updated. The binders will come to the office for the checks. The Director will check yearly that both binders match.</p>	01/18/2023
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Bldg. --	<p>484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c)</p> <p>Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).</p> <p>(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities].</p> <p>Based on record review and interview, the facility failed to maintain an emergency preparedness communication plan that complies with Federal, State, and local laws that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review on 12/28/22 at 1:40 p.m. with the Assistant Director present, the facilities Emergency Preparedness communication plan had not been updated within the last two-year period with the last documented update being listed as 09/14/2009. Based on an interview at the time of record review, the Assistant Director agreed that the Emergency Preparedness communication plan had not been documented as being updated within the last two-year period.</p> <p>This item was again discussed at the exit conference with the Assistant Director on</p>	E 0029	In response to E0029, that the facility failed to maintain and updated EAP. The EAP book is updated yearly in August. The QIDP was out of the office on leave during this review. The Asst. Director does not oversee the EAP and QIDP is not sure what book they were reviewing. The QIDP will make sure the person sitting for QIDP has the correct binder for review during survey. The Assistant PC will make sure the binder in the home matches the main binder. The QIDP will ensure the Asst. PC has the updated material for the binder and check to every six months, to make sure the binders are updated. The binders will come to the office for the checks. The Director will check yearly that both binders match.	01/18/2023	

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E 0036 Bldg. --	<p>12/28/22 at 2:19 p.m.</p> <p>403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)</p> <p>EP Training and Testing</p> <p>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.</p> <p>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph</p>			

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	<p>(a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.</p> <p>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).</p> <p>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.</p> <p>Based on record review and interview, the facility failed to review and update the training and testing program at least every 2 years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants.</p>	E 0036	In response to E0036, that the facility failed to maintain and updated EAP. The EAP book is updated yearly in August. The QIDP was out of the office on	01/18/2023	

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K 0000 Bldg. 01	<p>Findings include:</p> <p>Based on record review on 12/28/22 at 1:40 p.m. with the Assistant Director present, the facilities Emergency Preparedness plans testing and training program had not been updated within the last two-year period with the last documented update being listed as 09/14/2009. Based on an interview at the time of record review, the Assistant Director agreed that the Emergency Preparedness testing and training program had not been documented as being updated within the last two-year period.</p> <p>This item was again discussed at the exit conference with the Assistant Director on 12/28/22 at 2:19 p.m.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 12/28/22</p> <p>Facility Number: 001116 Provider Number: 15G602 AIM Number: 100245620</p> <p>At this Life Safety Code survey, Abilities Services Inc. was found in compliance with Requirements for Participation in Medicaid, 42 CFR subpart 483.470(j), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p>	K 0000	<p>leave during this review. The Asst. Director does not oversee the EAP and QIDP is not sure what book they were reviewing. The QIDP will make sure the person sitting for QIDP has the correct binder for review during survey. The Assistant PC will make sure the binder in the home matches the main binder. The QIDP will ensure the Asst. PC has the updated material for the binder and check to every six months, to make sure the binders are updated. The binders will come to the office for the checks. The Director will check yearly that both binders match.</p>		

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	<p>This one-story facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard-wired detectors in client sleeping rooms. The facility has a capacity of eight and had a census of seven at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.36.</p> <p>Quality Review completed on 01/03/23</p>				