STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G602	A. BUILDING -- B. WING	05/06/2025

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

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 05/06/25 Facility Number: 001116 Provider Number: 15G602 AIM Number: 100245620 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 The facility has eight certified beds. All eight beds are certified for Medicaid. At the time of the survey, the census was seven. Quality Review completed on 05/09/25	E 0000		
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a	E 0039	In response to E0039, facility failed to complete a community based or table top exercise. The QIDP will oversee that the facility conducts a community based and or a table top drill according to the regulations. The director will oversee that the QIDP has completed the exercises by reviewing the documentation and participating in the exercise.	05/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Johnson	QIDP/Asst. Director	06/19/2025

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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	community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Assistant Director of Group Homes at 10:30 a.m. on 05/06/25, the facility conducted a facility-based drill but failed to conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or individual, facility-based. b. A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed. c. Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed. Based on interview on 05/06/25 at 10:32 a.m., the Director of Group Homes acknowledged that the facility failed to ensure participation in two full-scale exercises or a full-scale and a tabletop exercise and emergency events, and revise the ICF/IID facility's emergency plan, as needed adding that the exercise had been recently scheduled and would be conducted soon.			
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 05/06/25 Facility Number: 001116 Provider Number: 15G602 AIM Number: 100245620 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 2012 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas, as well as heat detectors within the unused attic space. The facility has a capacity of eight and had a census of seven at the time of this survey.	K 0000		

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	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 0.32. Quality Review completed on 05/09/25			
K S100 Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to ensure four of four portable fire extinguishers throughout the home were inspected. NFPA 10, Standard for Portable Fire Extinguishers, 7.2.1.2 requires that fire extinguishers shall be inspected either manually or by means of an electronic monitoring device / system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, or on an inspection checklist maintained in a file, or by an electronic method. Records shall be kept to demonstrate that at least 12 monthly inspections have been performed. This deficient practice could affect all occupants. Findings include: Based on record review with the Assistant Director of Group Homes at 10:30 a.m. on 05/06/25, none of the four fire extinguishers located throughout the facility had been checked monthly for the months of January, through April of 2025. Based on interview on 05/06/25 at 10:32 a.m., the Assistant Director of Group Homes acknowledged the aforementioned four fire extinguishers as all	K S100	In response to KS100, the facility failed to have fire extinguishers inspected as required by state regulations. B & R was called and scheduled to come to the home and completed the inspections. The ITT team is responsible for ensuring the inspections are completed. The Director and CEO will oversee the ITT to ensure inspections are up to date.	05/09/2025

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	having undocumented monthly visual checks in the aforementioned months adding that she would speak to staff about the missing monthly inspections.			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 33.2.3.4.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on record review with the Assistant Director of Group Homes at 11:09 a.m. on 05/06/25, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. The annual fire alarm inspection was dated 03/05/24 but there was no semi-annual visual documentation available for review. Based on interview at 11:11 on 05/06/25, the Assistant Director of Group Homes agreed that the documentation of a visual semi-annually	K S345	In response to KS345, the facility failed to have fire alarm system semi-annual inspections as required by state regulations. B & R was called and scheduled to come to the home and completed the inspections. The ITT team is responsible for ensuring the inspections are completed. The Director and CEO will oversee the ITT to ensure inspections are up to date.	05/09/2025

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	inspection of the fire-alarm system was not available for review at the time of this survey adding that the documentation may be at the main office and that she would look into the matter as soon as possible.			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems was tested and inspected in accordance with NFPA 25. NFPA 25, 5.2.5 requires water flow alarm devices to be inspected quarterly to verify that they are free of physical damage and 5.3.3.2 which says Vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operation condition and free of physical damage. Section 3.3.35 states a test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks. This deficient practice could affect all clients. Findings include: Based on record review with the Assistant Director of Group Homes at 11:09 a.m. on 05/06/25, there were no current sprinkler system testing documents available for review. The inspections available for review were all over a year old with the most recent testing documentation available being dated 01/12/24. Based on an interview on 05/06/25 at 11:13 a.m., the Assistant Director of Group Homes confirmed there were no current quarterly sprinkler system inspection documents available for review as of the time of this survey	K S353	In response to KS353, the facility failed to have all the fire sprinklers inspected as required by state regulations. B & R was called and scheduled to come to the home and completed the inspections. The ITT team is responsible for ensuring the inspections are completed. The Director and CEO will oversee the ITT to ensure inspections are up to date.	05/09/2025

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	adding that they may be at the main office and that she would look into the matter as soon as possible.			