ENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G499			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 04/05/2013	
	PROVIDER OR SUPPLIE		76	03 E 10	DRESS, CITY, STATE, ZIP CODE DTH ST		
DEVELC	PMENTAL SERVIO	CE ALTERNATIVES INC	IN	DIANAI	POLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TA	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K010000							
K010000	Survey was con State Department with 42 CFR 48 Survey Date: 0 Facility Number Provider Number AIM Number: Surveyor: Marl Code Specialist At this Life Safe Developmental was found not in Requirements for Medicaid, 42 C Life Safety from Edition of the N Association (NI Code (LSC), Ch Residential Boa This one story to be fully sprinkle	4/05/13 r: 001013 er: 15G499 100245100 k Caraher, Life Safety , ety Code survey, Service Alternatives Inc. n compliance with or Participation in FR Subpart 483.470(j), n Fire and the 2000 Vational Fire Protection FPA) 101, Life Safety napter 33, Existing urd and Care Occupancies. puilding was determined to ered. The facility has a m with smoke detection in	K01000	0			
	corridors and in facility has a ca	m with smoke detection in all living areas. The pacity of 6 and had a ne time of this survey.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED:

04/26/2013

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 COMPLETED A. BUILDING 15G499 04/05/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7603 E 10TH ST DEVELOPMENTAL SERVICE ALTERNATIVES INC INDIANAPOLIS, IN 46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.1. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/11/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 02DO21 Facility ID: 001013 If continuation sheet Page 2 of 7

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ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G499	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/05/2013	
NAME OF I	PROVIDER OR SUPPLIEF	ł			ADDRESS, CITY, STATE, ZIP CODE			
DEVELC	PMENTAL SERVIC	E ALTERNATIVES INC			10TH ST APOLIS, IN 46219			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETIO DATE	
K01S056	 483.470(j)(1)(i) LIFE SAFETY CO PROMPT Where an automa installed, for either coverage, the sys Section 9.7, 33.2 alarm system in a The adequacy of documented to th jurisdiction. Exception No. 1: facilities, an autor accordance with the Installation of and two Family D Homes, is permit are not required i sq. ft. and in bath sq. ft., provided th finished with lath providing a 15 mi Exception No. 2: Exception No. 3: evacuation capata automatic sprinkl with NFPA 13, St of Sprinkler Syste are not required i sq. ft and in bath ft., provided that with lath and plas 15 minute thermata Exception No. 4: evacuation capata including four sto accordance with 	DDE STANDARD atic sprinkler system is er total or partial building stem is in accordance with .3.5.2 and activates the fire accordance with 33.2.3.4.1. the water supply is ne authority having In prompt evacuation matic sprinkler system in NFPA 13D, Standard for Sprinkler Systems in One wellings and Manufactured ted. Automatic sprinklers n closets not exceeding 24 rooms not exceeding 55 nat such spaces are and plaster or materials nute thermal barrier. Not applicable In prompt and slow bility facilities where an er system is in accordance andard for the Installation ems, automatic sprinklers n closets not exceeding 24 rooms not exceeding 24 rooms not exceeding 55 sq. such spaces are finished ster or material providing a						

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STATEME	YOR MEDICARE & MEDICAID SERVICES 1ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 15G499 B. WING 01					OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 04/05/2013	
	PROVIDER OR SUPPLIEF	R CE ALTERNATIVES INC		7603 E	ADDRESS, CITY, STATE, ZIP E 10TH ST NAPOLIS, IN 46219	CODE	
(X4) ID		TATEMENT OF DEFICIENCIES	—	ID	1		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
-	Residential Occu	pancies up to and Including eight, are permitted.					
	Exception No. 5:	Not applicable					
	system is not req	Initiation of the fire alarm uired for existing cordance with 33.2.3.5.5.					
	installed, for eithe coverage, the sys Section 9.7 and a system in accord	atic sprinkler system is er total or partial building stem is in accordance with activates the fire alarm ance with 33.2.3.4.1. The water supply is documented aving jurisdiction.					
	Exception No. 1:	Not Applicable					
	Exception No. 2:	Not Applicable					
	evacuation capal automatic sprinkl with NFPA 13, St of Sprinkler Syste are not required i sq. ft. and in bath sq. ft., provided th finished with lath	In prompt and slow bility facilities where an er system is in accordance tandard for the Installation ems, automatic sprinklers in closets not exceeding 24 prooms not exceeding 55 hat such spaces are and plaster or material inute thermal barrier.					
	evacuation capal including four sto accordance with the Installation of Residential Occu	In prompt and slow bility facilities up to and ries in height, systems in NFPA 13R, Standard for Sprinkler Systems in pancies up to and Including eight, are permitted.					
	Exception No. 5:	Not Applicable					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 . BUILDING 15G499 04/05/2013 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7603 E 10TH ST DEVELOPMENTAL SERVICE ALTERNATIVES INC INDIANAPOLIS, IN 46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5. **IMPRACTICAL** 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. Exception No. 1: Not Applicable. 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. Exception No. 3: Not Applicable. Exception No. 4: Not Applicable. 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 02DO21 Facility ID: 001013 If continuation sheet Page 5 of 7

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G499	(x2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED 04/05/2013	
	PROVIDER OR SUPPLIE		7603	f address, city, state, zip code E 10TH ST NAPOLIS, IN 46219		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO	
TAG	1	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE	
	Automatic sprink bathrooms not e that such spaces plaster or materi thermal barrier. Exception No. 6: system is not rec installations in ac Based on record interview; the fa 1 sprinkler gaug years. LSC 33.2 systems to be in LSC 9.7.5 requi systems be insp maintained in ac Standard for the Maintenance of Protection Syste 2-3.2 states gau five years or tes comparison with Gauges not accu the full scale shi replaced. This ca affect all clients Findings includ Based on review Security "Sprint documentation of Residential Direc	and closets are sprinklered. ders are not required in xceeding 55 sq. ft., provided a are finished with lath and als providing a 15 minute a Initiation of the fire alarm quired for existing ccordance with 33.2.3.5.5. I review, observation and acility failed to ensure 1 of ges was tested every five 2.3.5.2 requires sprinkler a ccordance with 9.7. There automatic sprinkler ected, tested and ccordance with NFPA 25, a Inspection, Testing, and Water-Based Fire ems. NFPA 25, Section ges shall be replaced every ted every five years by h a calibrated gauge. urate to within 3 percent of all be recalibrated or deficient practice could a, staff and visitors. e: v of Koorsen Fire & kler Inspection Report" dated 08/13/12 with the ector during record review to 2:15 p.m. on 04/05/13,	K01S056	The company will ensure that the sprinkler system gauge is routinely tested to ensure that it is functioning within the appropriate range and that it is recalibrated as needed. Further, the company will ensure that the date of these inspections is included on the gaug itself. Maintenance personnel will review this to ensure that following the inspection by the Fire and Security Agency that this has occurred. Persons Responsible: Maintenance personnel	e	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 01 A. BUILDING 15G499 04/05/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7603 E 10TH ST DEVELOPMENTAL SERVICE ALTERNATIVES INC INDIANAPOLIS, IN 46219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG the inspection report stated "2006" as the response to "Test date" for the sprinkler system gauge. Koorsen's "Sprinkler Inspection Report" dated 02/11/13 did not list a "Test date" for the sprinkler system gauge. Based on observation with the Residential Director during a tour of the facility from 2:15 p.m. to 2:40 p.m. on 04/05/13, the one sprinkler system gauge was dated 2006 on the face of the gauge with no recalibration date recorded on the gauge. Based on an interview at the time of record review and of observation, the Residential Director acknowledged the sprinkler system gauge was dated 2006 and had not been replaced or recalibrated every five years. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 02DO21 Facility ID: 001013 If continuation sheet Page 7 of 7

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