

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G389	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 823 ALHAMBRA ANDERSON, IN 46011
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: January 7, 8, 9, 10, 11, and 14, 2013.</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>Facility Number: 000903 Provider Number: 15G389 AIMS Number: 100244370</p> <p>This federal deficiency also reflect a state finding in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 1/18/13 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G389		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/14/2013	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 823 ALHAMBRA ANDERSON, IN 46011			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional clients (#5, #6, #7, and #8), by not ensuring an evacuation drill was conducted quarterly for the overnight shift (12 Midnight - 6 AM) from 2/10/2012 until 6/15/2012.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 1/7/13 at 2:15 PM. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 for the period between 2/10/2012 at 4:10am and 6/15/2012 at 5:30am, for the overnight shift personnel.</p> <p>Interviews with the AD (Area Director) on 1/7/13 at 2:35 PM, and on 1/14/13 at 1:30pm, indicated she was unable to locate any further evacuation drills for the overnight shift of personnel for clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>9-3-7(a)</p>	W0440	W440 The QMRP has received additional training (appendix A) regarding the requirement that evacuation drills are to be completed once per shift per quarter. She has additionally received training regarding her responsibility to assure that the drills are scheduled and completed no less than as per regulation. Staff will receive additional training regarding their responsibility to complete evacuation drills as scheduled. The QMRP will use a tracking system to monitor for and assure compliance.	02/13/2013			