

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/19/2013
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 113 JENNINGS ST NORTH VERNON, IN 47265
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K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 12/19/13</p> <p>Facility Number: 000907 Provider Number: 15G393 AIM Number: 100244410</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Developmental 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 determined to be fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, in common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 7 at the</p>	K010000		
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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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K010130	<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 Prompt with an E-Score of 1.24.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/26/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly and the inspections were documented for 2 of 3 months since the last annual inspection date, including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public even if not required by the Code, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection</p>	K010130	<p>K130</p> <p>These fire extinguishers have been inspected now and staff have been trained on this regulation.</p> <p>All extinguishers will be inspected and dated as required. QIDP or designee along with maintenance will routinely check inspection tags for continued compliance in this</p>	01/18/2014			

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	<p>and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the home manager on 12/19/13 from 9:00 a.m. to 11:00 a.m., service and inspection tags for the portable fire extinguishers located in the kitchen and the North Hall client sleeping room corridor each bore a service inspection tag indicating the most recent annual inspection was 09/06/13, but no monthly checks were documented on the inspection tags for October or November 2013. Based on interview at the time of observation, the home manager stated there is no written documentation of monthly fire extinguisher inspections for the facility and acknowledged the facility did not perform monthly fire extinguisher inspections for October and November of 2013.</p>		<p>area.</p> <p>Responsible for QA:</p> <p>QIDP</p>				

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K01S017	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15 minute thermal barrier. Sleeping room doors are substantial doors, such as those of 1¾ inch thick, solid-bonded wood core construction or other construction of equal or greater stability and fire integrity. Any vision panels are fixed fire window assemblies in accordance with 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2.</p> <p>Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4.</p> <p>Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>Exception No. 4: In previously approved</p>						

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	<p>facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms are separated from escape routes by walls and doors that are smoke resistant.</p> <p>No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited.</p> <p>Based on observation and interview, the facility failed to ensure 4 of 8 sleeping room walls were separated with smoke partitions from the common spaces and corridors in a sprinkled facility in accordance with 8.2.4. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations with the home manager on 12/19/13 during a tour of the facility from 9:00 a.m. to 11:00 a.m., the following room and corridor walls separating the client sleeping room corridor from the common spaces in the facility were not smoke resistant where the walls were attached to the ceiling;</p> <p>a. The kitchen corridor to dining room wall had a twelve foot section of wall with a three quarter inch gap in the drywall along the twelve foot long wall</p>	K01S017	<p>K0017</p> <p>SGL Manager has reported to the Property Manager the findings cited at this tag. Appropriate</p> <p>fire rated material will be used to bring these areas up to code. Maintenance will routinely inspect the home</p> <p>for problems in this area. QIDP and</p> <p>house staff will report any structural changes immediately to maintenance for</p> <p>repair.</p>	01/18/2014	

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	<p>where it met the ceiling.</p> <p>b. The kitchen corridor wall had a ten foot section of wall with a one half inch gap in the drywall along the ten foot long wall where it met the ceiling.</p> <p>c. The kitchen corridor wall along the seven foot long section by the food storage room had a one half inch gap in the drywall where it met the ceiling.</p> <p>d. The east client bathroom north and south walls had a nine foot long section of the two walls with a three quarter inch gap in the drywall where the ceiling met the walls.</p> <p>e. The west client bathroom wall had a six foot section of wall with a one half inch gap in the drywall where it met the ceiling.</p> <p>f. The second east client sleeping room corridor wall had a twenty foot section of wall with a half inch gap in the drywall where it met the ceiling.</p> <p>The above listed walls' drywall separating from the ceiling was verified by the home manager at the time of observations and acknowledged by the home manager at the exit conference on 12/19/13 at 11:00 a.m.</p>		<p>Responsible for QA: QIDP, SGL Manager</p>		

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K01S056	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD PROMPT</p> <p>Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7, 33.2.3.5.2 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.</p> <p>Exception No. 1: In prompt evacuation 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, is permitted. Automatic sprinklers are not required in closets not exceeding 24 sq. ft. and 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.</p> <p>Exception No. 2: Not applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow 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</p>						

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	<p>Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not applicable</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>SLOW 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.</p> <p>Exception No. 1: Not Applicable</p> <p>Exception No. 2: Not Applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow 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.</p> <p>Exception No. 5: Not Applicable</p>			

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	<p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>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.</p> <p>Exception No. 1: Not Applicable.</p> <p>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.</p> <p>Exception No. 3: Not Applicable.</p> <p>Exception No. 4: Not Applicable.</p> <p>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</p>			

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	<p>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.</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>1. Based on observations and interview, the facility failed to ensure 4 of 15 rooms were provided with sprinkler heads free of paint. LSC 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations on 12/19/13 during a tour of the facility from 9:00 a.m. to 11:00 a.m. with the home manager, the laundry room sprinkler, the first east client sleeping room sprinkler above the television, the second west</p>	K01S056	<p>K0056</p> <p>A request has been submitted to the fire and safety contractor who maintains our system for replacement of or documentation that this sprinkler gauge has been recalibrated.</p> <p>Records in each home will be reviewed to ensure compliance in this area.</p> <p>Responsible for QA: QIDP, SGL Manager</p>	01/18/2014	

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	<p>client sleeping room sprinkler above the closet, and the first west client sleeping room sprinkler were covered in white paint. This was verified by the home manager at the time of each observations and acknowledged at the exit conference on 12/19/13 at 11:00 a.m.</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 sprinkler gauges was tested every five years or replaced. LSC 33.2.3.5.2 requires sprinkler systems to be in accordance with 9.7 and 9.7.5 requires automatic sprinkler systems be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on record review with the home manager on 12/19/13 at 9:30 a.m., the Simplex inspection reports dated</p>						

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	12/2/13, 09/12/13, 06/26/13 and 03/15/13 did not indicate if the gauge had been replaced or list the last date the sprinkler gauge was recalibrated. Based on observation of the sprinkler gauge in the sprinkler riser room next to the kitchen on 12/19/13 at 10:00 a.m. with the home manager, the sprinkler gauge did not have a date on the face of the gauge or have any date written on the gauge or attached inspection tags to indicate a replacement date. This was verified by the home manager at the time of observation and acknowledged at the exit conference on 12/19/13 at 11:00 a.m.				

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K01S147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility administration failed to periodically instruct and keep employees informed with respect to their duties and responsibilities under the written emergency plan not less than every 2 months to protect 7 of 7 clients. A copy of the plan is readily available at all times within the facility. This deficient practice would affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on record review of the Developmental Services Inc. Emergency</p>	K01S147	<p>K0147</p> <p>QIDP's have been retrained on this standard requiring periodic review of the emergency plans for each home. QIDP's will review with employee's at least every two months their duties and responsibilities as outlined in each emergency action plan.</p>	01/18/2014	

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	<p>Action Plan on 12/19/13 at 9:30 a.m. with the home manager, the only documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities under the plan were Fire Drill Reports. Based on a review of Fire Drill Reports with the home manager on 12/19/13 at 9:00 a.m., there was a period of three months between fire drills dating from the fire drill conducted on 04/11/13 at 6:55 a.m. to the fire drill conducted on 07/20/13 at 1:10 p.m. Based on an interview with the home manager on 12/19/13 at 9:40 a.m., the home manager indicated there was no other documentation available for review to indicate employees were periodically instructed and kept informed with respect to their duties and responsibilities under the Developmental Services Inc. Emergency Action Plan between the three month period dating from 04/11/13 and 07/20/13. The lack of two month updates for employees during this three month period was acknowledged by the home manager at the exit conference on 12/19/13 at 11:00 a.m.</p>		<p>Responsible for QA: QIDP</p>				

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(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			
K01S152	<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 conduct fire drills quarterly on each shift for 2 of the last 4 calendar quarters and 2 of 3 shifts over the past year. This deficient practice could affect all clients.</p> <p>Findings include: Based on a review of Fire Drill Reports</p>	K01S152	<p>K152</p> <p>QIDP will retrain staff on the requirements for regular evacuation drills. A schedule of the drills will be posted in the</p>	01/18/2014			

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	on 12/19/13 with the home manager at 9:00 a.m., there was no record of a fire drill conducted on third shift for the third quarter of the year 2013 and first and second shift for the second quarter of the year 2013. This was verified by the home manager at the time of record review and confirmed at the exit conference on 12/19/13 at 11:00 a.m.		home. Staff will turn in monthly documentation to the QIDP of the evacuation drills completed that month. QIDP will compare with the drill schedule to ensure compliance in this area. Responsible for QA: QIDP		