

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  05/30/2012
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
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K0000	<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: 05/30/12</p> <p>Facility Number: 000632 Provider Number: 15G092 AIM Number: 100233940</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 not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and common living areas. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K0000		

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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	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.0.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0130	<p>Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguishers were inspected at least monthly, and that the inspections were documented, 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, 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 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 05/30/12 from 10:40 a.m. to 12:20 p.m., service and inspection tags for the four portable fire extinguishers located in the staff office, client sleeping room corridor, dining room and kitchen bore service inspection tags indicating there was no monthly check conducted for April 2012.</p>	K0130	<p>Staff will be retrained on requirements for regular monthly inspections of fire extinguishers and proper documentation of inspections. QIDP and agency maintenance personnel will also routinely check when in the home to see that inspections are current. Responsible for QA: QIDP</p>	06/29/2012			

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	The annual inspection was conducted 09/16/2011. This was verified by the home manager at the time of observations.			

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KS043	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit doors was provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. LSC 32.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one familiar to the average person. Generally, a two step release such as a knob and independent dead-bolt is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect all the clients.</p> <p>Findings include:</p>	KS043	<p>The sliding glass door is equipped with only one working lock that is twisted to unlock. The locking latch next to the door knob lock that is cited in this report is not functional. This was verified by the SGL Manager through the home manager after the surveyor had exited the facility. This exit door and all other exit doors will be inspected to ensure that all doors meet the requirement of this standard. Responsible for QA: QIPD, SGL Manager</p>	06/29/2012

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	Based on observation on 05/30/12 at 11:40 a.m. with the home manager, the dining room sliding glass exit door was provided with a door knob with a lock tab in the center that had to be twisted to unlock, and a locking latch next to the door knob lock. This was verified by the home manager at the time of observation.			

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KS147	<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 6 of 6 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 Action Plan on 05/30/12 at 11:20 a.m. with the home manager, the only</p>	KS147	<p>QIDP's will be retrained on this standard requiring periodic review of the emergency plans for each home. QIDP's will review with employees at least every two months their duties and responsibilities as outlined in each emergency action plan. Responsible for QA: QIDP</p>	06/29/2012			

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	documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities under the plan was dated 03/2009. Based on a review of the Fire Drill Reports with the home manager on 05/30/12 at 11:00 a.m., there was no evidence of a second shift fire drill for the first quarter of the year 2012 or a third shift drill for the third quarter of the year 2011. Based on an interview with the home manager on 05/30/12 at 11:30 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 every two months.			

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KS152	<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.</p> <p>Based on record review and interview, the facility failed to conduct fire drills at least quarterly on 2 of 3 shifts during the past year. This deficient practice affects all clients in the facility.</p> <p>Findings include:  Based on a review of the Fire Drill Reports with the home manager on</p>	KS152	<p>QIDP will retrain staff on the requirements for regular evacuation drills. A schedule of the drills will be posted in the 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</p>	06/29/2012			

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	05/30/12 at 11:00 a.m., there was no evidence of a second shift fire drill for the first quarter of the year 2012 or a third shift drill for the third quarter of the year 2011. Based on a review of the Fire Drill Reports by the home manager and interview on 05/30/12 at 11:15 a.m., it was confirmed there was no other evidence available for review to indicate the missed fire drills were conducted.			