

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G237	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3222 S 125 E SHELBYVILLE, IN 46176
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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: 02/11/15</p> <p>Facility Number: 000760 Provider Number: 15G237 AIM Number: 100243330</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Developmental Service Alternatives 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 sprinkled. The facility has a fire alarm system with smoke detection in the corridors and common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</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>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 .72.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/17/15.</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, 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</p>	K010130	The management staff for the home are responsible for ensuring completion of the inspection of all portable fire extinguishers in the home no less than monthly. The inspection shall ensure that the extinguishers are present and are adequately charged so that they will operate if needed. The management staff for the home will receive training on how to perform the inspections and ensure completion of monthly inspections as required. Additionally, a monthly physical plant inspection of the facility will be completed by agency administrative staff. This inspection will include a check of the extinguishers to ensure that their inspection has been completed and documented as required. The	03/13/2015

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K01S014	<p>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 area director on 02/11/15 from 12:00 p.m. to 1:15 p.m., service and inspection tags for the portable fire extinguishers located in the kitchen and the laundry room each bore a service inspection tag indicating the most recent annual inspection was 05/12/14, but no monthly checks were documented on the inspection tags for June, July, August, September, and October of 2014. Based on interview at the time of observation, the area director 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 June, July, August, September, and October of 2014. This was acknowledged by the area director at the exit conference on 02/11/15 at 1:15 p.m.</p>		<p>administrator will be notified of any deficiencies to ensure the inspection is completed and recorded.</p> <p>Responsible Party: Residential Director</p>	

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K01S043	<p>LIFE SAFETY CODE STANDARD Interior wall and ceiling finish is Class A or Class B in accordance with section 10.2, 33.2.3.2. There are no requirements for interior floor finish.</p> <p>Exception: Class C interior wall and ceiling finish is permitted in prompt evacuation capability facilities.</p> <p>Based on observation and interview, the facility failed to ensure the interior finish in 1 of 11 rooms was rated Class A, Class B or Class C for a Prompt rated facility. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 02/11/15 at 12:30 p.m. with the area director, the laundry room walls were covered with wood paneling. Based on an interview with the area director on 02/11/15 at 12:40 p.m., there was no evidence the wood paneled walls had a flame spread rating of a Class A, Class B, or Class C interior finish. This was verified by the area director at the time of observation and interview and acknowledged at the exit conference on 02/11/15 at 1:15 p.m.</p> <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>	K01S014	<p>Agency maintenance staff will ensure that the wood paneling noted has the required flame spread rating interior finish. The needed work will be completed to ensure this space meets the requirements of the code. The maintenance staff will be trained on the requirements of this Life Safety Code Standard to ensure that the interior finish of all rooms in all agency facilities are at a flame spread rating of Class A, Class B or Class C. This information will also be reviewed with administrative staff so that any observed concerns during routine professional visits in this facility and all agency facilities can promptly be corrected.</p> <p>Responsible Party: Maintenance supervisor</p>	03/13/2015	

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K01S046	<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 exits was locked against egress when the building was occupied. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 02/11/15 at 12:55 p.m. with the area director, the front exit door handle failed to open the exit door on three separate attempts. Based on an interview with the area director on 02/11/15 at 1:00 p.m., the front exit is the primary exit for client evacuation from the sleeping room corridor. The lack of the front exit door handle opening and allowing egress was verified by the area director at the time of observation and acknowledged at the exit conference on 02/11/15 at 1:15 p.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 bathrooms was provided with ground fault circuit interrupter (GFCI) protection against</p>	K01S043	<p>The maintenance staff will ensure the front exit door handle is repaired or replaced to ensure it consistently opens this exit door.</p> <p>The maintenance and management staff for the facility are responsible for ensuring all means of exit open properly and without issue. These staff will be trained on their responsibility to ensure all exit doors open properly. When management staff notes any issues, the maintenance staff will be contacted to correct the problem promptly. Administrative staff also will perform physical plant inspections no less than monthly, this inspection will include a check of all doors of the home to ensure they function and open properly. Any concerns will be reported to the administrator immediately to ensure prompt correction.</p> <p>Responsible Party: Maintenance Supervisor</p>	03/13/2015
		K01S046	<p>The maintenance staff will ensure that all bathrooms in the facility are provided with ground fault circuit interrupter (GFCI) protection against electric shock near the</p>	03/13/2015

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	<p>electric shock near an electrical outlet. NFPA 101, 33.2.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms, and kitchens at receptacles intended to serve the counter top surfaces. Note: Moisture can reduce the contact resistance of the body and electrical insulation is more subject to failure. This deficient practice affects all clients who would use the client bathroom near the laundry room.</p> <p>Findings include:</p> <p>Based on observation on 02/11/15 at 12:50 p.m. with the area director, the client bathroom near the laundry room had an electric outlet one foot from the hand wash sink not provided with a ground-fault circuit interrupter. Furthermore, the main electric panel in the fire alarm panel room was checked and confirmed that the electric receptacle in the client bathroom near the laundry room was not provided with GFCI protection to prevent electric shock. This</p>		<p>electrical outlets. This will be installed in the bathroom that was cited as deficient. The requirement of this code will be reviewed with maintenance staff to ensure all agency facilities are in compliance and that GFCI protection is in place in all required areas. Administrative staff will follow-up to ensure the maintenance staff makes the necessary changes to ensure GFCI protection in the required areas in this facility and other agency facilities.</p> <p>Responsible Party: Maintenance supervisor</p>	

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K01S147	<p>was verified by the area director at the time of observation and acknowledged at the exit conference on 02/11/15 at 1:15 p.m.</p> <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 8 of 8 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>	K01S147	Management staff for the facility will ensure that directcare staff (personnel) are all trained on the facility emergency plan and their responsibilities within this plan no less than every 2 months. This review will occur during staff meetings and during completion of monthly fire evacuation drills. The management staff will also be responsible for conducting fire evacuation drills no less than	03/13/2015

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	<p>Findings include:</p> <p>Based on record review of the Developmental Services Inc. Emergency Action Plan on 02/11/15 at 12:05 p.m. with the area director, 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 area director on 02/11/15 at 12:10 p.m., there was a period of three months between fire drills dating from the fire drill conducted on 05/27/14 at 6:34 p.m. to the fire drill conducted on 08/14/14 at 6:00 p.m., and a period of three months between fire drills dating from the fire drill conducted on 08/14/14 at 6:00 p.m. and fire drill conducted on 11/07/14 at 7:08 p.m. Based on an interview with the area director on 02/11/15 at 12:15 p.m., the area director 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 05/27/14 and 08/14/14, and between 08/14/14 and 11/07/14. The lack of two month updates for employees during the two three</p>		<p>monthly when on site. The management staff will be responsible for providing any needed review of the emergency plan when these monthly drills are completed. The drills and personnel review of the emergency plan will be recorded on the agency fire evacuation drill form. The management staff will be trained on their responsibilities to ensure compliance with this code. All documentation of completed personnel review of the emergency plan and completed drills will be provided to the administrator. The administrator will have a method for tracking and ensuring compliance.</p> <p>Responsible party: Residential Director</p>		

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K01S152	<p>month period was acknowledged by the area director at the exit conference on 02/11/15 at 1:15 p.m.</p> <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 4 of the last 4 calendar quarters and 3 of 3 shifts over the past year. This deficient practice</p>	K01S152	The Residential Director for the home will be responsible for ensuring required fire evacuation drills are completed. Their completion will be scheduled on the staffing schedule. They will be	03/13/2015

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	<p>could affect all clients.</p> <p>Findings include:</p> <p>Based on a review of Fire Drill Reports on 02/11/14 with the area director at 12:05 p.m., there was no record of a fire drill conducted on first shift for the second quarter of the year 2014, first and third shift for the third quarter of the year 2014, and first and third shift for the fourth quarter of the year 2014. This was verified by the area director at the time of record review and the area director confirmed there were no other records to indicate the missed fire drills were conducted at the exit conference on 02/11/15 at 1:15 p.m.</p>		<p>scheduled so that adrilla is completed for each shift of personnel no less than quarterly. Drills will be scheduled to be completed by the 10th of each month. The Residential Director will ensure completion within 3 business days.</p> <p>The Residential Director will provide the Administrator documentation within 5 business days to verify completion of the drill and the timing of the drill. Should the Administrator not receive verification of the completed drill by the 20th of each month, the Residential Director will be directed to conduct the required drill and submit record of the completed drill by the 25th. The Administrator will use a tracking system to ensure compliance. The Residential Director will also ensure a copy of each drill report is maintained in the home and available for review. This will be checked routinely by administrators completing visits in the facility. All agency Residential Directors will be trained on their responsibility to ensure completion of required fire evacuation drills.</p> <p>Responsible Party: Residential Director</p>		