

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G461	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/23/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 631 N ELM ST SEYMOUR, IN 47274
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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: 07/23/14</p> <p>Facility Number: 000975 Provider Number: 15G461 AIM Number: 100244820</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 fully sprinkled excluding the fourteen foot by fourteen foot sunporch. 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		

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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K01S149	<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 0.7.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/28/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2 Based on observation and interview, the facility failed to provide a metal container with a self closing cover for 1 of 2 areas where smoking is permitted. This deficient practice could affect all clients in the facility.</p> <p>Findings include:  Based on observation of the outside</p>	K01S149	An appropriate container for disposal of smoking material will be purchased and placed at this group home. QIDP and SGL Manager will ensure that all group homes have the appropriate container. Staff will be responsible to report the need to replace any such container as this need arises. Responsible for QA: QIDP, SGL Manager	08/22/2014			

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K01S152	<p>porch back exit smoking location on 07/23/14 at 11:20 a.m. with the home manager, the outside porch back exit smoking location was provided with a flower pot filled with soil and twenty unlit cigarette butts, but lacked a metal container with a self closing cover for discarded smoking material. This was verified by the home manager at the time of observation and acknowledged at the exit conference on 07/23/14 at 12:15 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</p>			

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	<p>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 1 of the last 4 calendar quarters and 1 of 3 shifts. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on a review of Fire Drill Reports on 07/23/14 with the home manager at 10:20 a.m., there was no record of a fire drill conducted on the second shift for the first quarter of the year 2014. This was verified by the home manager at the time of record review and acknowledged at the exit conference on 07/23/14 at 12:10 p.m.</p>	K01S152	<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. QIDP will retrain staff as needed when failure to follow the drill schedule is noted.</p> <p>Responsible for QA: QIDP</p>	08/22/2014