

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 09/21/2015
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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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K 0000 Bldg. 01	<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: 09/21/15</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 sprinkled. 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>	K 0000		
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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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K S053 Bldg. 01	<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 0.64.</p> <p>Quality Review completed 09/22/15 - DA.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Approved smoke alarms are provided in accordance with 9.6.2.10. These alarms are powered from the building electrical system and when activated, initiate an alarm that is audible in all sleeping areas. Smoke alarms are installed on all levels, including basements but excluding crawl spaces and unfinished attics. Additional smoke alarms are installed for living rooms, dens, day rooms, and similar spaces. 33.2.3.4.3.</p> <p>Exception No 1: Buildings protected throughout by an approved automatic sprinkler system, in accordance with 33.2.3.5, that uses quick response or residential sprinklers, and protected with approved smoke alarms installed in each sleeping room in accordance with 9.6.2.10, that are powered by the building electrical system.</p> <p>Exception No. 2: Where buildings are protected throughout by an approved automatic sprinkler system, in accordance with 32.3.2.5, that uses quick-response or residential sprinklers, with existing</p>				

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	<p>battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on record review and interview, the facility failed to ensure 7 of 7 smoke detectors were tested for sensitivity every two years. LSC 9.6.2.10.1 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3 requires testing to be in accordance with Section 7-3, Inspection and Testing Frequency. NFPA 72, 7-3.2.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods:</p> <p>(1) Calibrated test method. (2) Manufacturer's calibrated sensitivity</p>	K S053	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Records of sensitivity tests from 9/5/2013 (attachment A) and 9/9/2015 (attachment B) have been obtained from Koorsen and will be attached. Copies will be placed in house files. · Emergency drill protocol has been revised to include provisions for ensuring sensitivity tests are performed and documented and filed. (attachment C) · QIDPs and QASSM will be in-serviced on revised drill protocol on 10/21/15 <p>How will we identify others:</p> <ul style="list-style-type: none"> · QIDPs from all counties will contact Koorsen and ensure that there has been sensitivity tests conducted every two years. <p>Measures put in place:</p> <ul style="list-style-type: none"> · Emergency drill protocol <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · Quality Assurance manager will perform monthly reviews of 	10/21/2015

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	<p>test instrument.</p> <p>(3) Listed control equipment arranged for the purpose.</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range.</p> <p>(5) Other calibrated sensitivity method acceptable to the authority having jurisdiction</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced.</p> <p>The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all occupants in the facility including staff, and visitors.</p> <p>Findings include:</p> <p>Based on a review of Koorsen Fire Alarm System records on 09/21/15 at 10:40 a.m. with the team lead, the only record available for review was an annual functional test of all fire alarm system components dated 09/09/15. Based on an interview with the team lead on 09/21/15 at 10:50 a.m., when asked if there was a current sensitivity test report for the</p>		<p>drills that will include ensuring sensitivity tests are current and documented in drill books.</p>				

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K S147 Bldg. 01	<p>seven hard wired smoke detectors located throughout the facility, the team lead indicated there are no records available for review. The lack of a current sensitivity test for the seven smoke detectors in the facility was acknowledged by the team lead at the exit conference on 09/21/15 at 11:35 a.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 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</p>	K S147	<p>Corrective actions taken:</p> <p>QIDPs will in-service all house staff regarding their duties and responsibilities under the written</p>	10/21/2015			

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	<p>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 Fire Drill Reports on 09/21/15 at 10:20 a.m. with the team lead, the only documentation indicating employees were periodically instructed and kept informed with respect to their duties and responsibilities were the Fire Drill Reports. Based on a review of Fire Drill Reports with the team lead on 09/21/15 at 10:25 a.m., there was a period of three months between fire drills dating from the fire drill conducted on 12/20/14 at 1:26 a.m. to the fire drill conducted on 03/10/15 at 11:37 p.m., and a period of five months between the fire drill conducted on 03/10/15 at 11:37 p.m. and the fire drill conducted on 08/28/15 at 4:37 p.m. Based on an interview with the team lead on 09/21/15 at 10:35 a.m., the team lead indicated there was no other documentation available for review to indicate employees were periodically instructed and kept informed with respect</p>		<p>emergency plan</p> <ul style="list-style-type: none"> Cheryl Yeager QIDP in-serviced house staff on drill protocol on 9/24/15 (attachment D) <p>How will we identify others:</p> <ul style="list-style-type: none"> John Kirk, Agency Safety Coordinator, will review drills to ensure that they are completed per agency policy <p>Measures put in place:</p> <ul style="list-style-type: none"> Emergency Drill protocol John Kirk Agency safety Coordinator will review drills on a monthly basis to ensure compliance <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> John Kirk, agency safety coordinator, will review drills monthly to ensure compliance 	

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K S152 Bldg. 01	<p>to their duties and responsibilities between the three month period dating from 12/20/14 and 03/10/15, and the five month period dating from 03/10/15 and 08/28/15. The lack of two month updates for employees during the period between 12/20/14 and 03/10/15, and period between 03/10/15 and 08/28/15 was acknowledged by the home manager at the exit conference on 09/21/15 at 11:35 a.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</p>			

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	<p>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 could affect all clients.</p> <p>Findings include:</p> <p>Based on a review of Fire Drill Reports on 09/21/15 with the team lead at 10:20 a.m., there was no record of a fire drill conducted on first and second for the first quarter of the year 2015, first, second and third shift for the second quarter of the year 2015, and third shift for the third quarter of the year 2014 or 2015. This was verified by the team lead at the time of record review and the acknowledged there were no other fire drill records available for review at the exit conference on 09/21/15 at 11:30 a.m.</p>	K S152	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Emergency Drill Protocol has been implemented · Mel Fields, Director of Industry and Community Services in-serviced QIDPs and RPM on emergency drills on 9/16/15 (attachment E) · Cheryl Yeager QIDP in-serviced house staff on drill protocol on 9/24/15 (attachment D) <p>How will we identify others:</p> <ul style="list-style-type: none"> · John Kirk, Agency Safety Coordinator, will review drills monthly to ensure that they are completed per agency policy <p>Measures put in place:</p> <ul style="list-style-type: none"> · Emergency Drill protocol <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · John Kirk, agency safety coordinator, will review drills 	10/21/2015	

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