

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2016
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
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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: 03/02/16</p> <p>Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640</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 two story facility with a basement was not sprinkled. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 6 and had a census of 5 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 .50.</p> <p>Quality Review completed on 03/07/16 - 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 battery-powered smoke alarms in each sleeping room, and where, in the opinion of the authority having jurisdiction, the facility</p>			

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	<p>has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms. Based on record review and interview, the facility failed to ensure 3 of 5 smoke detectors were tested by a qualified service technician within the past 2 years. LSC Section 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 test instrument.</p>	K S053	<p>All smoke detectors sensitivity was tested by Koorsen Fire and Security on 2/3/16. The initial report provided by Koorsen and presented at the survey listed sensitivity as "green" for several detectors. Koorsen's was contacted by the agency maintenance supervisor to update the report to include the sensitivity point at test. This was done and the updated report was provided. See the attached. Koorsen's has been directed to note the actual sensitivity point on these reports versus just noting it was green indicating the detector is within range. The maintenance supervisor receives all reports from Koorsen's and will ensure they are completed as required. Responsible Party: maintenance supervisor</p>	03/03/2016

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	<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 clients in the facility including staff, and visitors.</p> <p>Findings include:</p> <p>Based on a review of the Sensitivity Testing Report with the residential director on 03/02/16 at 10:15 a.m., the last semiannual Sensitivity Testing Report dated 02/03/16 listed five smoke detectors. Furthermore, the garage smoke detector, the dining area smoke detector, and the top of stairs smoke detector each had a percent of obscuration on the results column as Green. The other two smoke detectors</p>			
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K S147 Bldg. 01	<p>listed their results as 1.2 and 2.6 percent of obscuration. The lack of the garage smoke detector, dining area smoke detector and top of stairs smoke detector listing the results in a percent of obscuration on the 02/03/16 Sensitivity Testing Report was verified by the residential director at the time of record review and acknowledged at the exit conference on 03/02/16 at 11:10 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</p>	K S147	The QIDP for the home is responsible for ensuring facility staff are periodically instructed regarding their duties and	04/01/2016			

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	<p>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> <p>Findings include:</p> <p>Based on record review of the Developmental Services Alternatives Fire Emergency Procedure Plan on 03/02/16 at 10:10 a.m. with the residential 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 residential director on 03/02/16 at 10:10 a.m., there was a period of three months between fire drills dating from the fire drill conducted on 11/12/15 at 6:45 p.m. to the fire drill conducted on 02/01/16 at 9:03 p.m., and a period of four months between fire drills dating from the fire drill conducted on 04/16/15 at 8:30 a.m. and fire drill conducted on 08/05/15 at 5:20 p.m., and a period of three months between fire drills dating from the fire drill conducted on 08/05/15 at 5:20 p.m. to the fire drill conducted on 11/12/15 at 6:45 p.m. Based on an interview with the residential director on 03/02/16 at 9:30</p>		<p>responsibilities regarding the agency emergency evacuation plans. The QIDP will receive training to ensure that she completes this instruction no less than every 2 months. She will also ensure a copy of the evacuation plan remains available to staff. She will provide evidence that this has been completed to the administrator. The administrator will routinely verify compliance.</p> <p>Responsible Party: Residential Director</p>	

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K S152 Bldg. 01	<p>a.m., the residential 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 Alternatives Fire Emergency Procedure Plan between the four month period dating from 04/16/15 and 08/05/15, and a three month period between 11/12/15 and 02/01/16 and 08/05/15 and 11/12/15. The lack of two month updates for employees during the three periods listed above was acknowledged by the residential director at the exit conference on 03/02/16 at 11:10 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</p>			

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	<p>drills, including accidents and take corrective action: and</p> <p>(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 2 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 03/02/16 at 10:10 a.m. with the residential director, there was no record of a fire drill conducted on first shift for the first quarter of the year 2015, third shift for the second quarter of the year 2015, first and third shift for the third quarter of the year 2015, and first shift and third shift for the fourth quarter of the year 2015. Based on an interview with the residential director at the time of record review, there were no other records available to indicate the missed fire drills were conducted. This was verified by the residential director at the time of record review and acknowledged</p>	K S152	<p>The agency has a Professional Presence policy which includes the use of a home visit note that directs items professional staff review when in the program. The QIDP is in the home no less than weekly and completed the form. This form has been updated to include a review of evacuation drills that have been completed and to take steps to ensure any needed drills are completed. A copy of this form is provided for review as an attachment. The QIDP will be trained on this updated expectation. The QIDP will also will retrain all staff in the home regarding the expectations for completing evacuation drills. The administrator will be copied on provided training to verify completion. The administrator is also provided copies of the completed home visit notes to verify the QIDP is reviewing and ensuring completion of required evacuation drills.</p> <p>Responsible Party: QIDP</p>	04/01/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	at the exit conference on 03/02/16 at 11:15 a.m.				