

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G639	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2016
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 426 E MONTGOMERY RD. GREENSBURG, IN 47240
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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: 05/18/16</p> <p>Facility Number: 001214 Provider Number: 15G639 AIM Number: 100234330</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. 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 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</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 0130 Bldg. 01	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.32.</p> <p>Quality Review completed on 05/23/16 - DA</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguishers were inspected at least monthly and the inspections were documented for 3 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 quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p>	K 0130	<p>Corrective actionstaken: · All QIDPs and group home staff will bein-serviced on fire extinguisher inspections How we will identifyothers: · The group home quality assurance manager willinspect fire extinguishers during her monthly home audits. She will identifyany fire extinguisher that needs inspection and ensure that the QIDP becomesaware of the need. · Night auditors will be trained to identify fireextinguishers that need inspected and how to inspect them. Measures put inplace: · Group home record review audit (Attachment A) · Night audit (Attachment B) Monitoring ofcorrective action: · The regional program manager reviews the qualityassurance manager's audits on a monthly basis. Any deficiency noted, includingthe failure to inspect fire extinguishers, will be addressed by the regionalprogram manager. A corrective action will be routed</p>	06/15/2016

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K S053 Bldg. 01	<p>Based on observation during a tour of the facility with direct support professional #1 on 05/18/16 from 8:30 a.m. to 10:45 a.m., service and inspection tags for the portable fire extinguishers located in the kitchen, the laundry room, and the client sleeping room corridor each bore a service inspection tag indicating the most recent annual inspection was 09/17/15, but no monthly checks were documented on the inspection tags for October, November and December 2015. Based on interview at the time of observation, direct support professional #1 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 the months listed above. This was acknowledged by direct support professional #1 at the exit conference on 05/18/16 at 10:55 a.m.</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</p>		to the QIDP for follow-up. The QIDP and team lead will review and follow up with night auditor reports.				

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	<p>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 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 10 of 10 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</p>	K S053	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> Records of sensitivity tests have been requested from KOORSEN and are attached (Attachments D&E). Copies will be placed in house files. QIDPs will be in-serviced on the need to maintain sensitivity reports in the house <p>How will we identify others:</p> <ul style="list-style-type: none"> QIDPs from all counties will audit their drill books to ensure 	06/15/2016

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	<p>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> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (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. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. <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</p>		<p>sensitivity tests are in place for every two years.</p> <ul style="list-style-type: none"> · The quality assurance manager conducts monthly audits of all group homes. She will audit the drill book to ensure sensitivity tests are being done every two years. <p>Measures put in place:</p> <ul style="list-style-type: none"> · Group home record review audit (Attachment A) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · The QA for group homes will audit the home monthly to ensure sensitivity tests are completed in the home every two years. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. 	

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K S056 Bldg. 01	<p>deficient practice could affect all clients in the facility including staff, and visitors.</p> <p>Findings include:</p> <p>Based on a review of Koorsen Fire & Security Fire Alarm System Reports with direct support professional #1 on 05/18/16 at 9:30 a.m., the only reports available for review were the semi-annual reports dated 12/15/15 and 09/23/15 which listed a functional test of all devices in the facility. Based on an interview with direct support professional #1 at the time of record review, there was no evidence provided of a two year sensitivity test for the ten smoke detectors located throughout the facility. The lack of a current two year sensitivity test on the facility's ten smoke detectors was verified by direct support professional #1 at the time of record review and acknowledged at the exit conference on 05/18/16 at 10:55 a.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD PROMPT Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7, 33.2.3.5.2 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p>						

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	<p>Exception No. 1: In prompt evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, is permitted. Automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 2: Not applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not applicable</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>SLOW Where an automatic sprinkler system is</p>			

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	<p>installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The adequacy of the water supply is documented to the authority having jurisdiction.</p> <p>Exception No. 1: Not Applicable</p> <p>Exception No. 2: Not Applicable</p> <p>Exception No. 3: In prompt and slow evacuation capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers are not required in closets not exceeding 24 sq. ft. and in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or material providing a 15 minute thermal barrier.</p> <p>Exception No. 4: In prompt and slow evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted.</p> <p>Exception No. 5: Not Applicable</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5.</p> <p>IMPRACTICAL Where an automatic sprinkler system is installed, for either total or partial building coverage, the system is in accordance with Section 9.7 and activates the fire alarm system in accordance with 33.2.3.4.1. The</p>			

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	<p>adequacy of the water supply is documented to the authority having jurisdiction. 33.2.3.5.2.</p> <p>Exception No. 1: Not Applicable.</p> <p>Exception No. 2: In slow and impractical evacuation capability facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and Two Family Dwellings and Manufactured Homes, with a 30 minute water supply, is permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 3: Not Applicable.</p> <p>Exception No. 4: Not Applicable.</p> <p>Exception No. 5: In impractical evacuation capability facilities up to and including four stories in height, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, are permitted. All habitable areas and closets are sprinklered. Automatic sprinklers are not required in bathrooms not exceeding 55 sq. ft., provided that such spaces are finished with lath and plaster or materials providing a 15 minute thermal barrier.</p> <p>Exception No. 6: Initiation of the fire alarm system is not required for existing installations in accordance with 33.2.3.5.5. Based on observation and interview, the</p>	K S056	Corrective actions taken:	06/15/2016

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K S150 Bldg. 01	<p>facility failed to ensure 1 of 46 sprinkler heads in the facility were maintained. This deficient practice could all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 05/18/16 at 10:35 a.m. with direct support professional #1, the client sleeping room bathroom sprinkler was missing the sprinkler escutcheon. This was verified by direct support professional #1 at the time of observation and acknowledged at the exit conference on 05/18/16 at 10:55 a.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>Based on record review, interview and observation, the facility failed to ensure new draperies and curtains were flame resistant for 1 of 5 client sleeping rooms. LSC Section 10.3.1 requires draperies, curtains, and other similar loosely</p>	K S150	<p>A work order was placed on 6/3/16 to Koorsen to replace the missing sprinkler escutcheon in client #1's bathroom.</p> <p>How we will identify others:</p> <ul style="list-style-type: none"> The group home quality assurance manager will inspect sprinklers during her monthly home audits. She will identify any sprinkler that needs repair and ensure that the QIDP becomes aware of the need. <p>Measures put in place:</p> <ul style="list-style-type: none"> Group home record review audit (Attachment A) Monitoring of corrective action: The regional program manager reviews the quality assurance manager's audits on a monthly basis. Any deficiency noted, including sprinklers in need of repair, will be addressed by the regional program manager. A corrective action will be routed to the QIDP for follow-up. <p>Corrective actions taken:</p> <ul style="list-style-type: none"> The house QIDP has purchased flame resistant spray for curtains and will apply to all house curtains that need it. The QIDP will make a copy of the receipt and date 	06/15/2016

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	<p>hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect 1 clients who resides in the west client sleeping room.</p> <p>Findings include</p> <p>Based on observation and interview with direct support professional #1 on 05/18/16 at 10:00 a.m., the west client sleeping room was converted from the staff office to a sleeping room over the past year. Furthermore, direct support professional #1 indicated the client sleeping room curtains were purchased new at the time the room was converted into a sleeping room. Based on observation of the window curtains in the west client sleeping room on 05/18/16 at 10:05 a.m., the window curtains had no attached label indicating the curtains were flame resistant and direct support professional #1 indicated at the time of observation there is no documentation available for review to indicated the flame resistant rating of the window curtains. The lack of flame resistance documentation for the west client sleeping rooms window curtains was verified by direct support professional at</p>		<p>and place in the drill book.</p> <ul style="list-style-type: none"> QIDPs will be in-serviced on the need to have flame resistant curtains in homes on <p>How we will identify others:</p> <ul style="list-style-type: none"> The group home quality assurance manager will inspect curtains during her monthly audits. She will identify any curtain that needs replaced or treated and ensure that the QIDP becomes aware of the need. <p>Measures put in place:</p> <ul style="list-style-type: none"> Group home record review audit (attachment A) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> The regional program manager reviews the quality assurance manager's audits on a monthly basis. Any deficiency noted, including curtains that need treated, will be addressed by the regional program manager. A corrective action will be routed to the QIDP for follow-up. 				

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K S152 Bldg. 01	<p>the time of record review and observation and at the exit conference on 05/18/16 at 10:55 a.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(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 -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill;</p> <p>(iv) Investigate all problems with evacuation 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 1 of the last 4 calendar quarters and 1 of 3 shifts over the past year. This deficient practice could affect all clients.</p>	K S152	<p>Corrective actions taken:</p> <p>·Emergency Drill Protocol has been implemented</p>	06/15/2016			

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	<p>Findings include:</p> <p>Based on a review of Fire Drill Reports on 05/18/16 with direct support professional #1 at 9:15 a.m., there was no record of a fire drill conducted on first shift for the fourth quarter of the year 2015. This was verified by direct support professional #1 at the time of record review and direct support professional #1 confirmed there were no other records to indicate the missed fire drill was conducted at the exit conference on 05/18/16 at 10:55 a.m.</p>		<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 · The night auditor will review drill log for completed drills <p>Measures put in place:</p> <ul style="list-style-type: none"> · Group home record review audit (attachment A) · Night audit (Attachment B) · Emergency Drill protocol (attachment C) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · John Kirk, agency safety coordinator, will review drills monthly to ensure compliance. The group home manager will request copy of drills to be turned in monthly to ensure continuing compliance. · The regional program manager reviews the quality assurance manager's audits on a monthly basis. Any deficiency noted will be addressed by the regional program manager. A corrective action will be routed to the QIDP for follow-up · The QIDP and team lead will review and follow up with night auditor reports. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G639	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 05/18/2016
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 426 E MONTGOMERY RD. GREENSBURG, IN 47240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	