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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G093 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 01/20/2012 |
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| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3514 GREENBRIAR DR COLUMBUS, IN 47203 |
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| (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 |
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| K0000 | <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 12/05/11 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 01/20/12</p> <p>Facility Number: 000633 Provider Number: 15G093 AIM Number: 100233950</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this PSR 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and all resident sleeping rooms. The facility has a capacity of five and had a census of five at the time of this visit.</p> | K0000 | | |
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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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| | <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.35</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/26/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |
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| KS018 | <p>Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 sleeping room doors would close and latch into the door frame. This deficient practice could affect 2 of 5 clients in the facility as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 1/20/12 at 1:55 p.m. with the House Manager, the two south client bedroom doors were not equipped with self closing devices. Based on interview on 1/20/12 at 1:59 p.m. it was acknowledged by the House Manager the two south client bedroom doors did not self close.</p> <p>This deficiency was cited on 12/05/11. The facility failed to implement a systematic plan of correction to prevent recurrence.</p> | KS018 | <p>We have ordered the automatic closing mechanism for both doors. These will be installed as soon as possible to bring this deficiency into compliance. QIDP's and SGL Manager are examining sleeping room doors at each facility to determine non-compliance with this regulation. Appropriate action will be taken in each area found out of compliance.</p> | 02/17/2012 | | | |

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