

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
--	--

(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
--------------------	--	---------------	---	----------------------

K 000 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: 03/02/15</p> <p>Facility Number: 003184 Provider Number: 15G697 AIM Number: 200368720</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, 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</p>	K 000		
-----------------------	--	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
--	--

(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
K 130 Bldg. 01	<p>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 .18.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 03/04/15.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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 5 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</p>	K 130	In order to ensure that all SGL portable facility fire extinguishers are either maintained or removed as needed on a monthly basis, all county QIDPs will be expected to make monthly checks of all home fire extinguishers. This standard will be presented during the SGL monthly meeting on 3/18/15. The QIDPs will be expected to document on their monthly observations when and where they inspected the fire extinguisher and the outcome of the inspection. The QIDPs will be made aware that the fire extinguishers need to be hanging	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203		
(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	
	<p>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> <p>Based on observation during a tour of the facility with quality assistant #1 on 03/02/15 from 12:15 p.m. to 1:35 p.m., service and inspection tags for the portable fire extinguishers located in the kitchen, the client sleeping room corridor, and the garage each bore a service inspection tag indicating the most recent annual inspection was 09/11/14, but no monthly checks were documented on the inspection tags for December 2014, or January and February 2015. Based on interview at the time of observation, quality assistant #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 December 2014 and January and February 2015. This was acknowledged by quality assistant #1 at</p>		<p>from a bracket, in good condition with the indicator showing a full charge. The QASSM and the RPM will ensure through monthly house inspections that the fire extinguishers are being inspected by the QIDPs.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
--	--

(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
K 018 Bldg. 01	<p>the exit conference on 03/02/15 at 1:50 p.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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. Based on observation and interview, the facility failed to ensure 1 of 4 sleeping room doors was capable of resisting smoke for at least 1/2 hour. This deficient practice could affect two clients who reside in the south client sleeping room.</p> <p>Findings include:</p> <p>Based on observation with quality assistant #1 on 03/02/15 at 1:10 p.m., the corridor door to the south client sleeping room was not smoke resistant due to a gap one inch wide along the latch side of the door in the closed position. This was verified by quality assistant #1 at the time of observation and at the exit conference</p>	K 018	<p>The agency maintenance staff were notified of this deficiency. On 3/16/15, maintenance staff toured the home and inspected the sleeping doors in question. Plans have been made to close any and all gaps found on client doors at the facility by 4/1/2015. All QIDPs will be instructed to inspect all doors at each facility in order to ensure that all DSI group homes are in compliance regarding gaps in sleeping room doors. County QIDPs will ensure that all SGL remain in compliance by inspecting sleeping room doors at least three times a month. If during those times a door is found to have a gap, the maintenance staff will be directed to repair the door immediately.</p>	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
--	--

(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
K 043 Bldg. 01	<p>on 03/02/15 at 1:50 p.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 exit doors were provided with releasing devices having an obvious method of operation and readily operated under all lighting conditions. LSC 32.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4 requires that where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is that the method of release be one that is familiar to the average person. Generally, a two-step release such as a knob and independent dead-bolt is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 03/02/15 during</p>	K 043	In order to ensure that clients have the ability to open house exit doors , DSI will provide home exit doors with releasing mechanisms that have obvious methods of operations under all lighting conditions. On 3/16/15, maintenance staff inspected the home. Staff assessed the doors and refitting plans are under way and will be completed by 4/1/2015. The RPM will ask maintenance staff to address all SGL homes in order to ensure that all agency homes are in compliance with LSC 7.2.1.5.4.	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
--	--

(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
K 046 Bldg. 01	<p>a tour of the facility from 12:15 p.m. to 1:35 p.m. with quality assistant #1, the front exit door and patio exit door were both provided with a door knob and a dead bolt lock above the door knob, which took two steps to release the door knobs. This was verified by quality assistant #1 at the time of observations and acknowledged at the exit conference on 03/02/15 at 1:50 p.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 bathrooms were provided with ground fault circuit interrupter (GFCI) protection against electric shock near an electrical outlet. NFPA 101, 33.2.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms, and kitchens at receptacles intended to serve the counter top surfaces. Note: Moisture can reduce the contact resistance of the body and</p>	K 046	In order to conform to LSC 9.1.2, maintenance will ensure that all bathroom and kitchen counter outlets in agency group homes are fitted with a ground-fault-circuit-interrupter (GFCI). The RPM will also direct maintenance staff to inspect main electrical panels in each home to ensure that bathroom and kitchen circuits are protected by GFCL circuit breakers. The Maintenance staff will also label each outlet and circuit breaker as being GFCI protected.	04/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/02/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
--	--

(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
--------------------	--	---------------	---	----------------------

K 152 Bldg. 01	<p>electrical insulation is more subject to failure. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>Based on observations on 03/02/15 during a tour of the facility from 12:15 p.m. to 1:35 p.m. with quality assistant #1, the client sleeping room corridor bathroom and the client bathroom next to the living room each had an electric outlet one foot from the hand wash sink not provided with a ground-fault circuit interrupter. Furthermore, the main electric panel in the garage was checked and confirmed that the electric receptacle in the client sleeping room corridor bathroom and the client bathroom next to the living room were not provided with GFCI protection to prevent electric shock. This was verified by quality assistant #1 at the time of observations and acknowledged at the exit conference on 03/02/15 at 1:50 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</p>			
-----------------------	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203			
(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			
	<p>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 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 2 of the last 4 calendar quarters and 1 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 03/02/15 with quality assistant #1 at 12:15 p.m., there was no record of a fire drill conducted on first shift for the second quarter of the year 2014, and first shift for the fourth quarter of the year 2014. This was verified by quality assistant #1 at the time of record review</p>	K 152	In order to ensure that drills are being done in a timely manner, the county QIDPs will continue to create monthly schedules, noting when drills are to take place. The QIDPs will post this schedule in the homes in order for staff to be more aware of when drills are to take place. The QIDPs will turn the schedules in to the RPM with other end of month paperwork. The RPM will receive a copy of the drills that were completed during the month and ensure that the appropriate numbers of drills are being conducted at	04/01/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/02/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203		
(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	
	and quality assistant #1 confirmed there were no other records to indicate the missed fire drills were conducted at the exit conference on 03/02/15 at 1:50 p.m.				