

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
--	---

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

K010000	<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: 04/05/13</p> <p>Facility Number: 000994 Provider Number: 15G480 AIM Number: 100244960</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist,</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 one story building was not sprinklered. The facility has a fire alarm system with smoke detection in corridors and all living areas. The facility has a capacity of 6 and had a census of 6 at the time of this survey.</p>	K010000		
---------	--	---------	--	--

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: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
--	---

(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>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 0.6.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/11/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229			
(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			
K01S051	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on record review, observation and interview; the facility failed to ensure 2 of 2 batteries for the manual fire alarm system were maintained. LSC 9.6.1.4 states a fire alarm system required for life safety shall be tested and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 7-2.2 Test Methods states batteries shall be replaced in accordance with the recommendations of the alarm equipment manufacturer or when the recharged battery voltage or current falls below the manufacturer's recommendations. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Inspection and Test Report" documentation dated 02/21/13 with the</p>	K01S051	The batteries in the fire alarm system have been replaced with new five year batteries as a result of their failure. Maintenance will review the results of the annual inspections to ensure that all issues are addressed in a timely manner. Persons responsible: Maintenance personnel	05/05/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
--	---

(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
	Residential Director during record review from 12:00 p.m. to 12:40 p.m. on 04/05/13, under the item listed as "FACP Battery Test - Test Results" it was indicated it "Failed." Based on observation with the Residential Director during a tour of the facility from 12:40 p.m. to 1:15 p.m. on 04/05/13, the two batteries in the fire alarm panel had an inspection sticker affixed to each battery with "battery test date" of "02/07/12" written on each sticker. In addition, the battery closest to the outside edge of the fire alarm control panel box had "08" written with a black marker on the battery. Based on interview at the time of observation, the Residential Director did not know if either battery had been replaced after the 02/21/13 inspection by Koorsen and acknowledged the inspection report listed the batteries test results as failed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
--	---

(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
K01S053	<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 has demonstrated that testing, maintenance, and a battery replacement program ensure the reliability of power to smoke alarms.</p> <p>Based on record review, observation and interview; the facility failed to ensure 2 of 8 smoke detectors were tested and within their listed and marked sensitivity range. LSC Section 9.6.2.10.1 refers to NFPA 72, National Fire Alarm Code. NFPA 72,</p>	K01S053	The Sensitivity and Detection inspection was completed on 2/9/12 and 2/21/13. At that time all of the devices passed the sensitivity test. See attachment A. The sensitivity was documented on the 2/9/12 survey. The two identified as MP	04/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229			
(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>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> <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 		<p>are manual pull stations. The legend has been included for reference. Maintenance will continue to ensure that the annual sensitivity tests are completed on each of the smoke detectors and ensure that they are and remain within the appropriate ranges. Persons responsible: Maintenance personnel</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 04/05/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229		
(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>jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or replaced. 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, staff, and visitors.</p> <p>Findings include:</p> <p>Based on review of Koorsen Fire & Security "Detector Sensitivity Test Report" dated 02/07/12 with the Residential Director from 12:00 p.m. to 12:40 p.m. on 04/05/13, six smoke detectors in the facility were sensitivity tested. Koorsen Fire & Security "Inspection & Test Report" documentation dated 02/21/13 indicated eight smoke detectors installed in the facility were functional tested. Based on observations with the Residential Director during a tour of the facility from 12:40 p.m. to 1:15 p.m. on 04/05/13, eight smoke detectors were installed in the facility. Based on interview at the time of record review and of the observations, the Residential Director stated she was unaware if two additional smoke detectors had been installed in the facility after 02/07/12 and acknowledged sensitivity</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
--	---

(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
	testing documentation for the most recent two year period for all facility smoke detectors was not available for review.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
--	---

(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
K01S152	<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.</p> <p>Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the first shift for 1 of 4 quarters. This deficient practice affects all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Residential</p>	K01S152	Staff will be in-serviced on completing drills in compliance with regulations. Please see the attached training on drill compliance with staff. The Residential Director will be responsible to schedule specific staff to complete drills at a frequency which is compliant with regulations. This schedule has been placed in the site. The drills and schedule will be monitored by	05/05/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G480	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/05/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9520 E GEMINI DR INDIANAPOLIS, IN 46229
--	---

(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
	Director during record review from 12:00 p.m. to 12:40 p.m. on 04/05/13, documentation of a fire drill conducted on the first shift in the fourth quarter of 2012 was not available for review. Based on interview at the time of record review, the Residential Director acknowledged documentation of a fire drill conducted on the first shift in the fourth quarter of 2012 was not available for review.		the Residential Director and Area Director to assure compliance. Additionally, clerical staff will track the completion of the drills and provide periodic reports to the Residential Director and Area Director who will assure compliance. Persons Responsible: Residential Director and Area Director	