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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G182	A. BUILDING -- B. WING	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICE ALTERNATIVES	2326 BERWICK DR SHELBYVILLE, IN 46176

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 02/14/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 04/03/23 Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640 At this PSR Emergency Preparedness survey, Developmental Service Alternatives was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. All 6 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 04/05/23	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 02/14/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 04/03/23 Facility Number: 000715 Provider Number: 15G182	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenna Metcalfe	Director of Quality Assurance	04/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	AIM Number: 100234640 At this PSR Life Safety Code survey, Developmental Service Alternatives was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This two-story building with a basement was determined to be nonsprinklered. The facility has a fire alarm system with smoke detection on all levels in corridors and in all living areas. The facility has a capacity of 6 and had a census of 6 at the time of this survey. 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 0.4. Quality Review completed on 04/05/23			
K S331 Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING (Prompt) Interior wall and ceiling finish in accordance with section 10.2. In Prompt Evacuation Capability facilities, Class A, Class B, or Class C is permitted. There are no requirements for interior floor finish. 33.2.3.3, 33.2.3.3.3			
	Based on observation and interview, the facility failed to ensure the interior finish in the dining area was rated Class A, Class B or Class C for a Prompt rated facility. This deficient practice could	K S331	Area Director to ensure documentation is present in the EPP binder to show that the painted wood paneling was treated	04/22/2023

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	affect all occupants. Findings include: Based on observations and interview on 04/03/23 during a tour of the facility between 2:20 p.m. and 3:15 p.m. with the Team Lead, the walls in the dining area were covered with wood paneling approximately 1/3rd of the way up. Based on an interview at the time of observation, the Team Lead stated there was no documentation available to confirm the painted wood paneling was treated to provide a flame spread rating of a Class A, Class B or Class C interior finish. This deficiency was discussed with the Team Lead at the time of discovery and again with the Team Lead and Program Director during the exit conference. This deficiency was cited on 02/14/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		to provide a flame spread rating of a Class A, B, or C interior finish.	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in	K S345	CG-DSA has established a contract with Koorsen for	04/22/2023

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	accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on observations and interview on 04/03/23 during records review between 2:20 p.m. and 3:15 p.m. with the Team Lead, no documentation was provided regarding a visual inspection of the fire alarm system six months before or after the annual fire alarm inspections conducted on 02/18/22 and 02/11/21. Based on interview at the time of records review, the Team Lead stated no other documentation was available. The Program Director arrived with additional documentation however the aforementioned missing semiannual visual inspection was not accounted for. This deficiency was discussed with the Team Lead at the time of discovery and again with the Team Lead and Program Director during the exit conference. This deficiency was cited on 02/14/23. The facility failed to implement a systemic plan of correction		semi-annual inspections of the fire alarm system. Contract attached with POC. Annual fire alarm system took place on 2/2023 indicating next semi-annual inspection will take place 8/2023. Area Director to ensure compliance.	

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	to prevent recurrence.			
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6			
	Based on record review and interview, the facility failed to provide a complete written fire watch policy for when the fire alarm system is out of service for more than four hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on observations and interview on 04/03/23 during records review between 2:20 p.m. and 3:15 p.m. with the Team Lead, the documentation provided did not include a Fire watch plan for fire alarm system impairment. During the PSR no plan could be located for review. The Program Director arrived and could not locate the Fire Watch Policy. This deficiency was discussed with the Team Lead at the time of discovery and again with the Team Lead and Program Director during the exit conference. This deficiency was cited on 02/14/23. The facility failed to implement a systemic plan of correction	K S346	Area Director to ensure fire watch plan has been added to EPP binder. Area Director to provide staff training on fire watch procedure. Training no later than 4/12/2023.	04/22/2023

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K S347 Bldg. 01	NFPA 101 Smoke Detection Smoke Alarms 2012 EXISTING (Prompt) Approved smoke alarms shall be provided in accordance with 9.6.2.10, unless either of the following exist: 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, or 2. Buildings are protected throughout by an approved automatic sprinkler system, in accordance with 33.3.2.5, 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. Smoke alarms shall be installed on all levels, including basement but excluding crawl spaces and unfinished attics. Additional smoke alarms shall be installed for living rooms, dens, day rooms, and similar spaces. These alarms shall be powered from the building electrical system and when activated, shall initiate an alarm that is audible in all sleeping areas. 33.2.3.4.3.			
	Based on observation and interview, the facility failed to ensure smoke detectors were installed in	K S347	CG-DSA has established a contract with Koorsen to install	04/22/2023

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	3 of 3 client sleeping rooms in non-sprinklered homes. This deficient practice could affect all clients, staff, and visitors. Findings include: Based on observations and interview on 04/03/23 during a tour of the facility between 2:20 p.m. and 3:15 p.m. with the Team Leader, 3 of 3 consumer sleeping rooms in the non-sprinklered facility were not equipped with any type of smoke detection. This deficiency was discussed with the Team Lead at the time of discovery and again with the Team Lead and Program Director during the exit conference. This deficiency was cited on 02/14/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		the required smoke detecting in each bedroom. See attached contract. Program Director will assure the general condition of the smoke detectors when completing the monthly physical plant inspection. The smoke detectors will be maintained in accordance with regulatory requirements. Person Responsible: Program Director	
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7			

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	Based on observation and interview, the facility failed to ensure 1 of 3 clients sleeping rooms were provided with a door which would self-close and latch securely in the door frame in accordance with LSC 7.2.1.8. LSC 7.2.1.8.1 states a door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with LSC 7.2.1.8.2 which states in any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met: (1) Upon release of the hold-open mechanism, the leaf becomes self-closing. (2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door leaf becomes self-closing. This deficient practice could affect 2 clients. Findings include: Based on observations and interview on 04/03/23 during a tour of the facility between 2:20 p.m. and 3:15 p.m. with the Team Lead, sleeping room door #3, equipped with a self-closing device, would not self-close and latch in the door frame. The Team Leader stated that the door was fixed and then the closing device broke off again this past weekend.	K S363	The door in sleeping room #3 will be repaired to ensure it self-closes and latches by 4/22/23. Program Director to complete weekly visits to ensure proper function and Area Director to complete monthly visit to home to ensure proper function.	04/22/2023

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	This deficiency was discussed with the Team Lead at the time of discovery and again with the Team Lead and Program Director during the exit conference. This deficiency was cited on 02/14/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. 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. 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. 42 CFR 483.470(i)			

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	Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 1 of 4 quarters. This deficient practice affects all staff and clients. Findings include: Based on observations and interview on 04/03/23 during records review between 2:20 p.m. and 3:15 p.m. with the Team Lead, there was no documentation for a 1st, 2nd, and 3rd shift fire drill for the first quarter of 2023. The Program Director arrived and stated that no other documentation for fire drills could be located. The Plan of Correction stated that Program Director will ensure there are documented fire drills completed on 1st shift, 2nd shift, and 3rd shift. This will be completed no later than 03/12/23. Program Director will schedule and confirm completion of monthly fire drills on an ongoing basis. Program Director will train staff on monthly completion of fire drills no later than 03/12/2023. Area Director or designee to train Program Director on fire drill schedule and expectations no later than 03/12/2023. This deficiency was discussed with the Team lead at the time of discovery and again with the Team Lead and Program Director during the exit conference. This deficiency was cited on 02/14/23. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S712	Area Director will ensure there are documented fire drills completed on 1st shift, 2nd shift, and 3rd shift. This will be completed no later than 4/22/23 Program Director will schedule and confirm completion of monthly fire drills on an ongoing basis. Area Director will train staff on monthly completion of fire drills no later than 4/22/23 Area Director or designee to train Program Director on fire drill schedule and expectations no later than 4/22/23 Area Director to complete monthly audits of fire drills to ensure compliance.	04/22/2023