STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G182	A. BUILDING 01 B. WING	05/04/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 01	A 2nd Post Survey Revisit (PSR) to the Post Survey Revisit (PSR) conducted on 04/03/23 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: 05/04/23 Facility Number: 000715 Provider Number: 15G182 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 05/08/23	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenna Metcalfe	Director of Quality Assurance	06/18/2023

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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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 affect all occupants. Findings include: Based on observations and interview on 05/04/23 during a tour of the facility between 10:00 a.m. and 10:50 a.m. with the Program Director, 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 PD 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 Program Director at the time of discovery and again with the Program Director during the exit conference. This deficiency was cited on 02/14/23 and 04/03/23. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S331	Area Director to ensure documentation is present in the EPP binder to show that the painted wood paneling was treated to provide a flame spread rating of a Class A, B, or C interior finish. Area Director placed documentation in EPP binder on 5/23/2023 to show that the painted wood paneling was treated to provide a flame spread rating of a Class A, B, or C interior finish (documentation attached). The painting was completed several years ago, therefore pictures of the containers as requested is not available. Area Director to complete monthly checks to ensure documentation is present in EPP binder. Area Director placed documentation in EPP binder on 5/23/2023 to show that the painted wood paneling was treated to provide a flame spread rating of a Class A, B, or C interior finish	06/08/2023

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			(documentation attached). The painting was completed several years ago, therefore pictures of the containers as requested is not available. The incomplete paperwork for the no-burn was submitted on 6/8/23 to ISDH. The correct paperwork to include treatment of wood paneling is attached to this. Area Director to complete monthly checks to ensure documentation is present in EPP binder	
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 05/04/23 during a tour of the facility between 10:00 a.m. and	K S346	A policy revision has been proposed to include language stating that the person(s) conducting the fire watch will have "no other duties while conducting the fire watch." It also include contacting ISDH. Once approved, policy will be replaced in the home. A revision has been completed to	06/07/2023

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	10:50 a.m. with the Program Director, the documentation provided did not include a complete Fire watch plan for fire alarm system impairment. The plan failed to include language stating that the person(s) conducting the fire watch will have "no other duties while conducting the fire watch." The fire watch plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. This deficiency was discussed with the Program Director at the time of discovery and again with the Program Director during the exit conference. This deficiency was cited on 02/14/23 and 04/03/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		include language stating that the person(s) conducting the fire watch will have “no other duties while conducting the fire watch” and includes contacting ISDH. Updated policy attached.	
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			

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	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 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 05/04/23 during a tour of the facility between 10:00 a.m. and 10:50 a.m. with the Program Director, 3 of 3 consumer sleeping rooms in the non-sprinklered facility were not equipped with functional smoke detection. The contractor had installed detector heads, however the wiring had not been completed and the PD stated it could be another month before the facilities contractor can get back to finish the installation. This deficiency was discussed with the Program Director at the time of discovery and again with	K S347	As of 5/22/2023, the required smoke detecting in each bedroom has been installed. As of 5/22/2023, the required smoke detecting in each bedroom has been installed. Invoice attached.	05/22/2023

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	the Program Director during the exit conference. This deficiency was cited on 02/14/23 and 04/03/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			
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 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	K S363	Koorsen has been contacted to repair the door in sleeping room #3 to ensure it self-closes and latches. Repair is scheduled for 5/26/2023. Koorsen has been contacted to repair the door in sleeping room #3 to ensure it self-closes and latches. Inspection of door was completed on 5/26/2023 by Koorsen and it was determined by them that it was functioning correcting. See attached inspection report.	05/26/2023

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	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 05/04/23 during a tour of the facility between 10:00 a.m. and 10:50 a.m. with the Program Director, sleeping room door #3, equipped with a self-closing device, was would not self-close and latch in the door frame. The Program Director stated that the door was fixed and then the closing device broke off again. This deficiency was discussed with the Program Director at the time of discovery and again with the Program Director during the exit conference. This deficiency was cited on 02/14/23 and 04/03/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		**Koorsen has been contacted to repair the door in sleeping room #3 to ensure it self-closes and latches. Inspection of door was completed on 5/26/2023 by Koorsen and it was determined by them that it was functioning correcting. See attached inspection report.** **The report does not specify "sleep room #3" due to Koorsen not referring to rooms in the same way as ISDH. The "door holder" referred to in the report is the same as "sleep room #3."**	