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	04/29/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 04/29/25 Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640 At this Emergency Preparedness survey, Developmental Service Alternatives Inc. 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 3. Quality Review completed on 05/02/25	E 0000	**K-0100 – General Requirements** **The facility failed to ensure 1 of 3 portable extinguishers had documented the current 6-year maintenance on the container in accordance with NFPA 10.** The facility had the ¿re extinguisher inspection at the group home done by Koorsen services in February of this year. The company reached out to Koorsen for corrective action, and it was communicated by Koorsen to rep that they would have the ¿re extinguisher changed at their earliest. Copy of email is attached as reference. In future, the RSD / QIDP will ensure to check the ¿re extinguishers manufacturing date to ensure that all ¿re extinguishers which are older than 6 years have a cover sleeve affixed to them to demonstrate that the container has been checked and deemed safe for use.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shamepane Martin	Quality Assurance Manager	05/22/2025

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 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 04/29/25 Facility Number: 000715 Provider Number: 15G182 AIM Number: 100234640 At this 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, in all living areas and in all client sleeping rooms. The facility has a capacity of 6 and had a census of 3 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 1.2. Quality Review completed on 05/02/25	K 0000	**K-0100 – General Requirements** **The facility failed to ensure 1 of 3 portable extinguishers had documented the current 6-year maintenance on the container in accordance with NFPA 10.** The facility had the ¿re extinguisher inspection at the group home done by Koorsen services in February of this year. The company reached out to Koorsen for corrective action, and it was communicated by Koorsen to rep that they would have the ¿re extinguisher changed at their earliest. Copy of email is attached as reference. In future, the RSD / QIDP will ensure to check the ¿re extinguishers manufacturing date to ensure that all ¿re extinguishers which are older than 6 years have a cover sleeve affixed to them to demonstrate that the container has been checked and deemed safe for use.	

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K S100 Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 3 portable fire extinguishers had documented current 6-year maintenance on the container in accordance with NFPA 10. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) at	K S100	**K-0100 – General Requirements** ***The facility failed to ensure 1 of 3 portable ¿re extinguishers had documented the current 6-year maintenance on the container in accordance with NFPA 10.*** The facility had the ¿re extinguisher inspection at the group home done by Koorsen services in February of this year. The company reached out to Koorsen for corrective action, and it was communicated by Koorsen to rep that they would have the ¿re extinguisher changed at their earliest. Copy of email is attached as reference. In future, the RSD / QIDP will ensure to check the ¿re extinguishers manufacturing date to ensure that all ¿re extinguishers which are older than 6 years have a cover sleeve affixed to them to demonstrate that the container has been checked and deemed safe for use.	05/13/2025

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	2:07 p.m. on 04/29/25, the portable fire extinguisher located at the top of the stairs on the second floor indicated it was manufactured in 2017 but had no 6-year maintenance maintenance collar or sticker affixed to the container. Based on interview at 2:07 p.m. on 04/29/25, the QIDP agreed 6-year maintenance for the second floor portable fire extinguisher was past due. These findings were reviewed with the QIDP during the exit conference.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure corridor doors to 1 of 3 client bedrooms was self-closing or automatic closing for a non-sprinklered facility. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observations with the Qualified Intellectual Developmental Professional (QIDP) at 2:03 p.m. on 04/29/25, the corridor door to the bedroom at the top of the stairs by the bathroom on the second floor was equipped with a self-closing device but the door was propped in the fully open position with a wedge placed on the floor under the door which caused the door to not be self-closing or automatic closing. Based on interview at 2:03 p.m. on 04/29/25, the QIDP agreed the aforementioned bedroom door was not self-closing or automatic closing because the door was propped in the fully open position which caused an impediment to be self-closing or automatic closing. These findings were reviewed with the QIDP	K S363	K S363: The door wedges have been removed from the home and staff have been instructed that the door wedges are not allowed to be used to keep the door propped open. Koorsen has been contacted and waiting for installation of the magnetic door stopper to be attached with the fire alarm system. Until the installation is completed, staff have been instructed and trained to assist the client of the bedroom in entering/exiting his room with his walker. A bell has been placed which he uses to let staff know he needs assistance in opening the door for the interim duration. It is planned that the door stopper will be installed by Jun 10 2025, however facility is awaiting confirmation by the contractor for completion date.	06/10/2025

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	during the exit conference.			
K S712 Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the: a. first shift for 3 of 4 quarters. b. on the second shift for 1 of 4 quarters. c. on the third shift for 3 of 4 quarters. This deficient practice affects all clients, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Qualified Intellectual Developmental Professional (QIDP) at 1:35 p.m. on 04/29/25, documentation of a fire drill conducted on the first shift in the second quarter (April, May, June) 2024, the third quarter (July, August, September) 2024 and in the fourth quarter (October, November, December) 2024 was not available for review. Documentation of a fire drill conducted on the second shift in the third quarter 2024 was also not available for review. In addition, documentation of a fire drill conducted on the third shift in the third quarter 2024, the fourth quarter 2024 and in the first quarter (January, February, March) 2025 was also not available for review. Based on interview at the time of record review, the QIDP stated the facility operates three shifts per day, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the aforementioned shifts and quarters was not was not available for review. These findings were reviewed with the QIDP	K S712	**K-0712 – <u>Fire Drills</u>** ***The facility failed to provide documentation of a ¿re drill conducted on the:*** ***a First shift of 3 of 4 quarters.*** ***b On the second shift of 1 of 4 quarters.*** ***c On the third shift of 3 of 4 quarters.*** The omission is regretted. The previous RSD did not ensure that Fire drills were uploaded on company portal and could not be presented to the surveyor at the time of the survey. The facility has developed a plan of action to ensure that ¿re drills are regularly conducted, and a database is maintained as under: a The QIDP has developed a schedule for the conduct of ¿re drills for the year, to ensure that a ¿re drill is conducted for every shift in every quarter. b RSD / QIDP will ensure ¿re drills are conducted as per the	05/13/2025

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	during the exit conference.		schedule, going forward. c Facility's QA Dept has developed a tracking sheet to maintain oversight that ¿re drills are conducted and loaded onto the facility's portal. d On a monthly basis the facility's QA Dept checks to ensure all ¿re drills have been uploaded and are uploaded as per the schedule. Noncompliance will be forwarded to the Regional Director by the last week of each month, to ensure timely action.	