STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING -- B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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: 04/08/25 Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860 At this Emergency Preparedness survey, Developmental Services Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 04/11/25	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants.	E 0006	DSi addressed the deficiencies in the emergency preparedness plan identified through this survey by updating the EPP on 4.18.25 to include the Kaiser Permanente Assessment, including missing persons. It was also recommended to add information about RACE; Rescue, Alarm, Confine and Extinguish/Evacuate. This information was added on	04/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Armfield	Vice President	04/25/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING -- B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
	Findings include: Based on records review with the House Supervisor and the Maintenance Manager on 04/08/25 at 1:56 p.m., the EPP did list the top hazards for the facility, but no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. Based on an interview at 1:56 p.m., the House Supervisor and the Maintenance Manager stated documentation of a risk assessment utilizing an all-hazards approach could not be found. The finding was reviewed with the House Supervisor and the Maintenance Manager during the exit conference at 3:00 p.m.		4.18.25. Each Group Home has a current Life Safety book including all required documentation present in the home. DSi will train the WML staff by 4.23.25 on the revisions to the EPP. DSi will review and update the EPP yearly at minimum. DSi's EPP is set to be reviewed again annually on 3.2026. Amy Helder, Director of Quality and Compliance, manages these reviews and updates.	
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: 04/08/25 Facility Number: 012527 Provider Number: 15G802 AIM Number: 201024860 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 01 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
	This one story facility was fully sprinklered. This facility has a fire alarm system with smoke detectors in client sleeping rooms, the corridors, and common living areas with heat detection in the attic. The facility has a capacity of 8 and had a census of 6 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.52 Quality Review completed on 04/11/25			
K S222 Bldg. 01	NFPA 101 Egress Doors Based on observation and interview; the facility failed to ensure 1 of 1 pantry closet doors can be readily opened from the inside if locked. LSC 33.2.2.5.3 states every closet door latch shall be readily opened from the inside. This deficient practice affects all clients. Findings include: Based on observation with the House Supervisor and the Maintenance Manager on 04/08/25 at 2:46 p.m., the pantry door in the kitchen had a lockable latch on the outside of the door that could not opened from the inside when locked allowing someone to be locked inside the closet with no means of escape. Based on interview at 2:46 p.m., the House Supervisor and the Maintenance Manager agreed the pantry door could be locked and could not be opened from the inside when locked. The finding was reviewed with the House	K S222	DSi addressed the deficiency of K0222 by removing the lock installed on the pantry door. A new keypad lock will be installed on 4.18.25 that has a lever on the inside the pantry that always allows access to exit. DSi will monitor the home to ensure approved locks are utilized throughout the home on a routine basis. DSi administrative staff will complete the required monitoring in the group homes on a scheduled rotation. Throughout these reviews, DSi administrative staff are required to complete staff observations of their findings while in the home.	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 01 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
	Supervisor and the Maintenance Manager during the exit conference at 3:00 p.m. NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in 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 records review with the House Supervisor and the Maintenance Manager on 04/08/25 at 2:22 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 01/31/25. Based on an interview at 2:22 p.m., the House Supervisor and the Maintenance Manager stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted.			
K S345 Bldg. 01		K S345	DSi addressed the deficiency of K0345 by adding semi-annual fire alarm system and Sprinkler System inspections with Ryan's Fireprotection, Inc. to the rotation for all Group Homes. Ryan's Fireprotection Inc. will now visit annually and semi-annually. Bobby Lashley, Assistant Director of Facilities, is responsible for monitoring and maintain all scheduled appointments with Ryan's Fireprotection, Inc.	04/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 01 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
	The finding was reviewed with the House Supervisor and the Maintenance Manager during the exit conference at 3:00 p.m.			
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the House Supervisor and the Maintenance Manager on 04/08/25 at 2:07 p.m., the provided fire watch plan did not indicate staff conducting fire watches were trained on fire watch procedures and had no other duties during the fire watch. Based on an interview at 2:07 p.m., the House Supervisor and the Maintenance Manager agreed the fire watch documentation provided was missing training of staff and did not mention staff could have no other duties during the fire watch. The finding was reviewed with the House Supervisor and the Maintenance Manager during the exit conference at 3:00 p.m.	K S346	DSi addressed the deficiency of staff not being trained on the Fire Watch/Sprinkler System plan by scheduling a training by 4.23.25 for all DSPs to be trained on the entire Life Safety book present in the home. During this training staff will be trained on the EPP which includes the Fire Watch and Sprinkler System watch requirements. Amy Helder, Director of Quality and Compliance, will update the Life Safety books for the Group Homes and review all documents within this book on a yearly basis. Amy will ensure training is completed to the Group Home Director and Assistant Director yearly. GH Director and Assistant Director will ensure all staff are trained.	04/23/2025
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 33.2.3.5.8,	K S353	DSi addressed the deficiency of KS353 by DSi contacting Ryan Fireprotection, Inc. to complete	04/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 01 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
	systems installed in accordance with NFPA 13D shall be inspected, tested, and maintained in accordance with 33.2.3.5.8.1through 33.2.3.5.8.15, which reference specific sections of NFPA 25, The frequency of the inspection, test, or maintenance shall be in accordance with this Code, whereas the purpose and procedure shall be from NFPA 25. Section 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. 14.2.1.4 Non-metallic pipe shall not be required to be inspected internally. This deficient practice could affect all occupants. Findings include: Based on records review with the House Supervisor and the Maintenance Manager on 04/08/25 at 2:23 p.m., no documentation of an internal inspection of metallic sprinkler piping was available for review. Based on observation at 2:33 p.m., the facility had metallic sprinkler piping throughout the home. Based on an interview at 2:33 p.m., the House Supervisor and the Maintenance Manager agreed the sprinkler piping was metallic and stated it was unknown if the piping was internally inspected within the last five years. The finding was reviewed with the House Supervisor and the Maintenance Manager during the exit conference at 3:00 p.m.		the 5-year internal sprinkler pipe inspection. Ryan's informed DSi that the 5-year inspection had been completed and provided a copy of the "5 year Internal Inspection of Sprinkler Piping and Valves" form completed on 7.8.2024. DSI added semi-annual fire alarm system and Sprinkler System inspections with Ryan Fireprotection, Inc. to the rotation for all Group Homes. Ryan's Fireprotection Inc. will now visit annually and semi-annually. Bobby Lashley, Assistant Director of Facilities, is responsible for monitoring and maintain all scheduled appointments with Ryan Fireprotection, Inc. Bobby will keep documentation of the 5-year inspections, so they are available upon request.	
K S354 Bldg. 01	NFPA 101 Sprinkler System - Out of Service			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 01 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
	Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the House Supervisor and the Maintenance Manager on 04/08/25 at 2:07 p.m., the provided fire watch plan did not indicate staff conducting fire watches were trained on fire watch procedures and had no other duties during the fire watch. Based on an interview at 2:07 p.m., the House Supervisor and the Maintenance Manager agreed the fire watch documentation provided was missing training of staff and did not mention staff could have no other duties during the fire watch. The finding was reviewed with the House Supervisor and the Maintenance Manager during	K S354	DSi addressed the deficiency of staff not being trained on the Fire Watch/Sprinkler System plan by scheduling a training by 4.23.25 for all DSPs to be trained on the entire Life Safety book present in the home. During this training staff will be trained on the EPP which includes the Fire Watch and Sprinkler System watch requirements. Amy Helder, Director of Quality and Compliance, will update the Life Safety books for the Group Homes and review all documents within this book on a yearly basis. Amy will ensure training is completed to the Group Home Director and Assistant Director yearly. GH Director and Assistant Director will ensure all staff are trained.	04/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 01 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
	the exit conference at 3:00 p.m.			
K S712 Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct evacuation/fire drills for staff and clients at least quarterly for each shift under varied conditions for 2 of 4 quarters. This deficient practice affects all staff and clients. Findings include: Based on records review with the House Supervisor and the Maintenance Manager on 04/08/25 at 1:56 p.m., there was no documentation of third shift fire drills in the third and fourth quarters of 2024. Based on an interview at 1:56 p.m., the House Supervisor and the Maintenance Manager stated documentation of the missing fire drills could not be found. The finding was reviewed with the House Supervisor and the Maintenance Manager during the exit conference at 3:00 p.m.	K S712	**DSi will correct this deficiency by retraining DSPs and house manager on Fire and Safety Requirements and the required schedule that needs to be followed. DSPs and house manager of the group home will be provided a copy of the 2025 safety drill schedule. Drills are required to be completed on all shifts quarterly. DSPs will ensure that they are following the provided schedule. House Managers will ensure all completed drills are turned into the Group Home Director by the 20th of every month. It is the responsibility of the GH Director to ensure that all drills have been submitted timely by each group home. If the GH Director does not have the required drills, the GH Director has 10 days to ensure the drills are completed by the home.** **Group Home staff will be trained by 4.21.25.** **DSi GH Manager will monitor completion of all drills monthly. If drills are not completed by the 20th, the GH Manager is responsible for ensuring that the drills are completed at the times**	04/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G802	A. BUILDING 01 B. WING	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICES INC	112 E WESTMORELAND KOKOMO, IN 46901

(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
			outlined on the schedule before the end of the month. DSi's safety manager tracks and monitors the completion of all drills throughout the year.	