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	02/19/2024

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: 02/19/24 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 7. Quality Review completed on 02/21/24 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Helder	Senior Director of Compliance	02/29/2024

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	02/19/2024

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
	§483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must			

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	02/19/2024

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
	develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan (EPP) that was based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and 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. Findings include: Based on review of the facility's EPP with the Residential House Manager (RHM) on 02/19/24 at	E 0006	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. DSI director of compliance reviewed the Emergency Preparedness book to discover that the house manager did not have the updated copy to provide to the life safety representative. All the forms reported as missing are in the updated binder. The correct binder will be given to the house manager and the house manager will be counseled to provide the correct binder to the life safety	03/01/2024

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	02/19/2024

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
	10:30 a.m., no documentation was available to show that the group home EPP was based on and included a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment. Based on interview at the time of records review, the RHM agreed paper work of a risk assessment did not include missing clients. This finding was reviewed with the Assistant Director of Facilities at the exit conference.		representative. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The facility reviewed all clients, not only in this home but others, to ensure that the most current Emergency Preparedness plan is in the home and accessible to all staff. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. All Emergency Preparedness binders will be reviewed, updated and placed in the homes annually. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include: The Programming team will work together to get all the Emergency Preparedness manuals updated and into the homes annually.	

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	02/19/2024

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
			Quality Assurance will review the EPPs during the quarterly audits.	
E 0007 Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(3), 441.184(a)(3), 482.15(a)(3), 483.475(a)(3), 483.73(a)(3), 484.102(a)(3), 485.625(a)(3), 485.68(a)(3), 485.727(a)(3), 485.920(a)(3), 491.12(a)(3), 494.62(a)(3) EP Program Patient Population §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of			

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	02/19/2024

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
	operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.4753(a)(3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Residential House Manager (RHM) on 02/19/24 at 10:40 a.m., the provided EPP did not address client population and special needs of its client population during an emergency. Based on interview at the time of records review, the RHM agreed the patient population policy could not be found in the EPP. This finding was reviewed with the Assistant Director of Facilities at the exit conference.	E 0007	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. DSI director of compliance reviewed the Emergency Preparedness book to discover that the house manager did not have the updated copy to provide to the life safety representative. All the forms reported as missing are in the updated binder. The correct binder will be given to the house manager and the house manager will be counseled to provide the correct binder to the life safety representative. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The facility reviewed all clients, not only in this home but others, to ensure that the most current Emergency Preparedness plan is in the home and accessible to all staff. Describe the steps or systemic changes the facility has made or will make to ensure that the	03/01/2024

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	02/19/2024

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
			deficient practice does not recur , including any in-services, but this also should include any system changes you made. All Emergency Preparedness binders will be reviewed, updated and placed in the homes annually. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include: The Programming team will work together to get all the Emergency Preparedness manuals updated and into the homes annually. Quality Assurance will review the EPPs during the quarterly audits.	
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	02/19/2024

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
	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.			

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	02/19/2024

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
	(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This	E 0018	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. DSI director of compliance reviewed the Emergency Preparedness book to discover that the house manager did not have the updated copy to provide to the life safety representative. All the forms reported as missing are	03/01/2024

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	02/19/2024

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
	deficient practice could affect all occupants Findings Include: Based on review of the facility's EPP with the Residential House Manager (RHM) on 02/19/24 at 10:55 a.m., the plan provided did not address policy and procedures for tracking of staff and clients. Based on interview at the time of records review, the RHM stated there was no client and staff tracking policy found in the EPP. The finding was reviewed with the Assistant Director of Facilities during the exit conference.		in the updated binder. The correct binder will be given to the house manager and the house manager will be counseled to provide the correct binder to the life safety representative. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The facility reviewed all clients, not only in this home but others, to ensure that the most current Emergency Preparedness plan is in the home and accessible to all staff. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. All Emergency Preparedness binders will be reviewed, updated and placed in the homes annually. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include:	

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	02/19/2024

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 Programming team will work together to get all the Emergency Preparedness manuals updated and into the homes annually. Quality Assurance will review the EPPs during the quarterly audits.	
E 0025 Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b)(7), 482.15(b)(7), 483.475(b)(7), 483.73(b)(7), 485.625(b)(7), 485.920(b)(6), 494.62(b)(6) Arrangement with Other Facilities §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.			

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	02/19/2024

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
	*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures (EPP) include the development of arrangements with other ICF/IID facilities or other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Residential House Manager (RHM) on 02/19/24 at 11:00 a.m., the EPP did not include a transfer agreement of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients. Based on interview at the time of record review, the RHM agreed the EPP did not address arrangements with other ICF/IID facilities	E 0025	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. DSI Director of Compliance consulted with the Senior Director to create a plan on where the clients will be relocated in the event the clients need to evacuate. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions the facility took to correct the deficient practice for any client the facility identified as being affected. The facility reviewed all clients, not only in this home but others, to ensure that this section will be updated in all individual house plans. Describe the steps or systemic changes the facility has made or	03/01/2024

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	02/19/2024

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
	or other providers to receive residents in the event of limitations or cessation of operations. There was documentation provided that listed a local church to be used as a relocation site but no documentation of a transfer agreement. This finding was reviewed with the Assistant Director of Facilities during the exit conference.		will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Update the form in all the group homes EPPs. The EPPs will be updated on an annual basis. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include: The Quality Assurance Coordinator will monitor the Emergency Preparedness Manual to ensure that all required sections are in the book during the quarterly audits.	
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: 02/19/24 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	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	02/19/2024

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
	Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. 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 7 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 1.36 Quality Review completed on 02/21/24			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of			

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	02/19/2024

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
	NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided.			

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	02/19/2024

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
	_____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff. Findings include: Based on record review with the Assistant Director of Facilities (ADF) on 02/19/24 at 11:42 a.m., there was no 2023 fourth quarter inspection for the waterflow alarm device and supervisory alarm devices available for review. Based on interview at the time of observation, the ADF stated that these are the sprinkler inspection	K S353	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. The Director of Compliance consulted with the director of facilities regarding the missing reports. The Director of facilities obtained the missing reports. They are uploaded as supporting documentation of this report. Director of facilities moved the two sprinkler heads that were not in protective slots. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. Director of Compliance will collaborate with the Director of Facilities to ensure that all reports are ready for review when life safety arrives for an inspection.	03/01/2024

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	02/19/2024

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
	reports available for review at this time. There was sprinkler report provided from 10/11/23 titled Control Valve Form but it did not include the required testing. This finding was reviewed with the ADF at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature to which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation with the ADF during a tour of the facility at 01:05 p.m. on 02/19/24, 7 spare sprinklers were in the spare sprinkler cabinet but 2 were not in protective slots and were laying in the bottom of the spare sprinkler cabinet. This could allow them to fall out of the box when opened causing the sprinkler spares to be damaged. Based on interview at the time of the observation, the ADF acknowledged 2 spare sprinklers were		Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include: the Quality Assurance Coordinator will monitor the Fire protection agency folder to ensure that each report is present and that all sprinkler heads are in a safe location during the quarterly audits.	

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	02/19/2024

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
	laying in the bottom of the spare sprinkler cabinet unprotected. This finding was reviewed with the ADF at the exit conference.			
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring according to 33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 4 clients and staff. Findings include: Based on observation with the Assistant Director of Facilities (ADF) on 02/19/24 at 12:45 p.m., in the office, bedroom #1, and bedroom #2 electrical equipment was powered by an extension cord. Based on interview at the time of observation, the ADF agreed electrical equipment was powered by an extension cord in the aforementioned locations. This finding was reviewed with the ADF at the exit conference.	K S511	Describe what the facility did to correct the deficient practice for each client cited in the deficiency. DSI Director of Compliance consulted with the Director of facilities (DOF). The DOF stated that the knockout boxes have all been replaced. DOF stated that he has calls out to obtain quotes on all the GFCI outlets. Once he receives those quotes, work will be scheduled to correct the deficiencies. Director of Compliance has communicated to the house manager to remove all the extension cords and multiplug adapters. DOF will be asking for a quote on new wiring throughout the house. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice, and state, what actions	03/01/2024

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	02/19/2024

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
	2. Based on observation, the facility failed to ensure 2 of 4 electrical outlets in the kitchen, 1 of 1 electrical outlet in the staff restroom, and 1 of 1 electrical receptacles in the main bathroom were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 33.2.5.1 requires that utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the National Electrical Code. NFPA 70, Article 210.8, Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms, and kitchens at receptacles intended to serve the countertop surfaces. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects all clients and staff. Findings include: Based on observation with the ADF on 02/19/24 at 12:35 p.m., the kitchen had a sink with 2 electric receptacles on the wall within six feet of the sink that did not trip when tested with a GFCI tester. There was also a GFCI receptacle in the Staff restroom and the Main bathroom that did not trip when tested. The ADF said that he will have a contractor correct the GFCI receptacles concerns mentioned. These findings were reviewed with ADF at the exit conference. 3. Based on observation and interview, the facility failed to ensure 2 of 2 multiplug adapters were not used as a substitute for fixed wiring according to 33.2.5.1. NFPA 70, 2011 Edition, Article 400.8		the facility took to correct the deficient practice for any client the facility identified as being affected. House Manager removed the extension cords, electrical work is being scheduled and the junction boxes have been replaced. Describe the steps or systemic changes the facility has made or will make to ensure that the deficient practice does not recur , including any in-services, but this also should include any system changes you made. House Manager removed the extension cords, electrical work is being scheduled and the junction boxes have been replaced. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Monitoring should include: The Quality Assurance Coordinator will monitor the use of extension cords during the quarterly PSRs. Maintenance will check the facilities and report any errors to the electrical and junction boxes during their monthly preventative maintenance checks.	

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	02/19/2024

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
	requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 3 clients. Findings include: Based on observation with the ADF on 02/19/24 at 12:50 p.m., bedroom #1 contained a 2 to 3 prong adapter powering an electrical equipment and at 01:00 p.m. there was a multiplug adapter in use in bedroom #5. Based on interview at the time of observation, the ADF acknowledged the aforementioned condition. These finding were reviewed with the ADF at the exit conference. 4. Based on observation and interview, the facility failed to ensure 2 of 2 junction boxes, one located in the basement and one in bedroom #3, were protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect all clients and staff. Findings include: Based on observations on 02/19/204 at 12:55 p.m. and 01:05 p.m. during a tour of the facility with the ADF, there was an electrical receptacle box located in bedroom #3 with exposed wires because the junction box was not protected with a cover and an electrical box at the bottom of the basement's stairs with a 1/2 inch knockout removed but was not used or covered. Based on interview at the time of each observations, the ADF acknowledged the missing cover and uncovered knockout hole concerns would be fixed			

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	02/19/2024

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
	by maintenance as soon as possible. These findings were reviewed with the ADF at the exit conference.			