

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G520	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/25/2012
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6386 ELLSWORTH PL MERRILLVILLE, IN 46410
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 07/25/12</p> <p>Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245230</p> <p>Surveyor: W. Chris Greeney, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Dungarvin Indiana LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, client sleeping rooms and common living areas. The facility has a capacity of 8 and had a census of 7 at the time of this survey.</p>	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	<p>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 0.90.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/30/12.</p> <p>The facility was found not in compliance with the aforementioned requirements as evidenced by:</p>				

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KS018	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 bedroom doors latched into the door frame when it closed. This deficiency could affect the two clients who resided in that room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the home from 2:50 p.m. until 3:45 p.m. with the house manager, the first bedroom on the left when facing north had a door held open by a wall magnet and had a self-closing device. When the door was allowed to shut on its own it failed to latch into the door frame during three of three attempts. The house manager, during the observation, confirmed that the self-closing door was not latching into the door frame.</p>	KS018	<p><b>Corrective Action:</b> The maintenance department will determine the reason the door is not fully latching when it is released. The maintenance department will ensure that the issue is fixed so that the door closes and latches securely. The Program Director will re-train all staff on the importance of monitoring the condition of the home and to ensure that any issue such a door not closing and latching properly is reported to maintenance promptly for repair. The Program Director and Area Director will do routine visits and periodically check the doors to ensure that all doors are completely closing and latching.</p> <p><b>Responsible Staff:</b> Maintenance Director, Program Director, Area Director</p> <p><b>Timeframe for Completion:</b> 8/17/12</p>	08/24/2012			

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			<p><b>Systematic Correction:</b> The Area Director will re-train all the Program Directors on the expectation that staff are monitoring the condition of the homes and reporting any issues noted to the maintenance department promptly. The Area Director will re-train the Program Directors on the importance of ensuring that all doors close and latch properly, especially in the homes that do not have a sprinkler system. The Program Directors and Area Directors will do routine site visits and check the condition of the homes, including checking to ensure that all doors close and latch properly.</p> <p><b>Responsible Staff:</b> Area Director <b>Timeframe for Completion:</b> 8/24/12</p>		

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KS046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 electrical outlets in the bathroom located in the bedroom hallway were provided with functional ground fault circuit interrupter (GFCI) protection against electric shock. 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 counter top 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 in the facility.</p> <p>Additionally, based on observation and interview, the facility failed to ensure 1 of 1 extension cords was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and electrical equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires, unless</p>	KS046	<p><b>Corrective Action:</b> The Maintenance Department will replace the two GFCI outlets and ensure the replaced outlets are functional. The Program Director will re-train the lead staff on the completion of the Monthly Site Risk Management Checklist. One area reviewed on this checklist is that there are functional GFCI outlets in place in all bathroom and kitchen areas. The Program Director will re-train the lead staff on how to test the GFCI outlets to ensure the outlets are working properly. The lead counselor will test the GFCI outlets monthly and document the check on the Monthly Site Risk Management checklist. The checklist will be turned into the Program Director for review.</p> <p><b>Responsible Staff:</b> Maintenance Director, Program Director <b>Timeframe for completion:</b> 8/17/12</p> <p><b>Systematic Action:</b> The Area Director will re-train all the Program Directors on the expectation that the lead staff or the Program Directors are completing Monthly Site Risk Management Checklists. The Area Director will re-train all the Program Directors on the importance of ensuring that the GFCI outlets are not only in place</p>	08/24/2012			

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	<p>specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and any clients in the basement and ground floor levels.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Based on observations with the House Manager on 07/25/12 during a tour of the facility from 2:50 p.m. to 3:45 p.m., the bathroom located off the bedroom hallway had two electrical outlets within two feet of the handwash sink. The GFCI test button on both outlets was broken and was not able to activate the test to determine if the circuit could be interrupted. This was confirmed by the house manager at the time of observations.</li> <li>2. Based on observation with the house manager on 07/25/12 between 2:50 p.m. and 3:45 p.m., an extension cord provided power to a sump pump located in a pit area in the basement. The cord extended from the pump, up the basement wall to ceiling joists then along the bottom of the joist over an adjacent wall. The extension cord then was passed through a cutout made in the ceiling tile of an adjacent room to allow it to plug into a receptacle in the adjacent room. The house manager</li> </ol>		<p>in the homes, but also are functional. If there are any issues noted with a GFCI outlet, the Program Director will notify the maintenance department immediately so the issue can be fixed.</p> <p><b>Responsible Staff:</b> Area Director <b>Timeframe for Completion:</b> 8/24/12</p>		

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	confirmed the extension cord was permanently being used to power the pump.				

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KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 7 of 7 clients. Such instruction is reviewed by the staff not less than every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review on 7/25/12 at 2:40 p.m. of facility Fire Drill reports found there was no evidence that a fire drill had been</p>	KS147	<p><b>Corrective Action:</b> The Program Director will re-train all the staff at the site that fire drills are to be completed at various times and not the same time for each shift. The Program Director will re-train the Lead Counselor that any time a new staff is in the home for the first time the expectation is that a fire drill is completed with that new staff to ensure the staff understands what to do to maintain the safety of the individuals at the home in the event of a fire. The Lead Counselor or the Program Director will ensure that a Monthly Site Risk Management checklist is completed. When this checklist is completed, the Program Director or the Lead</p>	08/24/2012			

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	<p>conducted between December 1, 2011 and May 31, 2012 during the 11:00 p.m. to 6:00 a.m. shift designated on the report form as an overnight drill. Based on interview with the house manager on 7/25/12 at 2:50 p.m. it was confirmed there was no evidence that overnight staff had participated in an overnight drill between the above dates.</p> <p>Additionally, no evidence could be found on the fire drill reports that direct care staff (DCS) #1 had received training and participated in a drill during that shift. Further interview with the house manager indicated two staff were assigned to work the overnight shift and indicated DCS #1 was one of the two staff who had worked during the previous overnight (7/24-7/25). The house manger confirmed there was no evidence of DCS #1 participated in a fire drill and stated DCS #1 was "fairly new" to the home.</p>		<p>Counselor will review the fire drills that were completed for the month. The Program Director or Lead Counselor will verify that the fire drills were completed at various times on a shift. This review will be documented on the Monthly Site Risk Management Checklist and will be kept in the office for review.</p> <p><b>Responsible Staff:</b> Program Director</p> <p><b>Timeframe for Completion:</b> 8/24/12</p> <p><b>Systematic Correction:</b> The Area Director will re-train all the Program Directors on the expectation that fire drills are completing at different times during a shift. The Area Director will re-train all the Program Directors on the expectation that any new staff to the home must complete a fire drill with experienced staff the first time the new staff is in the home. The Area Director will re-train the Program Directors on the expectation that the lead staff of the home or the Program Director reviews fire drills on a monthly basis and documents the review on the Monthly Site Risk Management checklist. The Monthly Site Risk Management checklist will be turned into the office and tracked by the office manager. The Area Director will get a list monthly on the Monthly Site Risk Management.</p>		

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			<p><b>Responsible Staff:</b> Area Director</p> <p><b>Timeframe for Completion:</b> 8/24/12</p>	

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KS149	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 areas where smoking was permitted, noncombustible safety type receptacles were provided for discarded smoking materials. This deficiency could affect all clients, staff and visitors in the home.</p> <p>Findings include:</p> <p>Based on interview on 7/25/12 at 1:45 p.m. with the area coordinator at the group home office it was indicated the facility had a smoke-free policy and staff and clients who smoke must smoke outside at least 8 feet away from the building. During the tour of the home between 2:50 p.m. and 3:45 p.m. on 7/25/12, the house manager indicated the edge of the patio at the rear of the home was the designated smoking area for those who smoke. In that area a plastic flower pot with no cover was filled with dirt and contained discarded cigarette butts on top of the dirt. The house manager indicated there was not a non-combustible receptacle provided for discarded smoking materials.</p>	KS149	<p><b>Corrective Action:</b> The Area Director will work with the Office Manager to purchase an appropriate receptacle to place cigarette butts. The receptacles will be purchased and placed at the home. The Program Director will train all staff on the new receptacle and ensure the receptacle is used to discard cigarettes after smoking.</p> <p><b>Responsible Staff:</b> Area Director, Office Manager, Program Director</p> <p><b>Timeframe for Completion:</b> 8/24/12</p> <p><b>Systematic Correction:</b> The Area Director will discuss this finding with the other Area Directors. The Area Directors will work with the Program Directors to determine if there are appropriate receptacles at the sites for staff to utilize when smoking. For sites that do not have appropriate receptacles, the Area Director will work with the Program Director to ensure that appropriate receptacles are obtained and placed in the sites. The Program Director will train all the staff on the receptacle and the expectation that staff utilize the receptacles when smoking.</p>	08/24/2012			

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			<p><b>Responsible Staff:</b> Area Directors <b>Timeframe for Completion:</b> 8/24/12</p>	

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KS152	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -</p> <p>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;</p> <p>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must -</p> <p>(i) Actually evacuate clients during at least one drill each year on each shift;</p> <p>(ii) Make special provisions for the evacuation of clients with physical disabilities:</p> <p>(iii) File a report and evaluation on each drill:</p> <p>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and</p> <p>(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.</p> <p>Based on record review and interview, the facility administration failed to ensure evacuation drills were conducted quarterly on 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on review on 7/25/12 at 2:40 p.m.</p>	KS152	<p><b>Corrective Action:</b> The Program Director will re-train all the staff at the site that fire drills are to be completed at various times and not the same time for each shift. The Lead Counselor or the Program Director will ensure that a Monthly Site Risk Management checklist is completed. When this checklist is completed, the Program Director or the Lead Counselor will review the fire drills that were</p>	08/24/2012			

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	of facility Fire Drill reports found there was no evidence that a fire drill had been conducted between December 1, 2011 and May 31, 2012 during the 11:00 p.m. to 6:00 a.m. shift designated on the report form as an overnight drill. Based on interview with the house manager on 7/25/12 at 2:50 p.m. it was confirmed there was no evidence that that an overnight evacuation drill had been conducted during the first quarter of 2012.		<p>completed for the month. The Program Director or Lead Counselor will verify that the fire drills were completed at various times on a shift. This review will be documented on the Monthly Site Risk Management Checklist and will be kept in the office for review.</p> <p><b>Responsible Staff:</b> Program Director, Lead Counselor <b>Timeframe for Completion:</b> 8/24/12</p> <p><b>Systematic Correction:</b> The Area Director will re-train all the Program Directors on the expectation that fire drills are completing at different times during a shift. The Area Director will re-train the Program Directors on the expectation that the lead staff of the home or the Program Director reviews fire drills on a monthly basis and documents the review on the Monthly Site Risk Management checklist. The Monthly Site Risk Management checklist will be turned into the office and tracked by the office manager. The Area Director will get a list monthly on the Monthly Site Risk Management checklists that have been turned in. The Area Director will ensure that the fire drills are being monitored by the Program Directors.</p> <p><b>Responsible Staff:</b> Area Director <b>Timeframe for Completion:</b></p>		

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6386 ELLSWORTH PL MERRILLVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
			8/24/12		