STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G479	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	422 MARQUETTE TR MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K0000	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/28/12 Facility Number: 000993 Provider Number: 15G479 AIM Number: 100244950 Surveyor: W. Chris Greeney, Life Safety Code Specialist 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. This one story facility with a basement was not sprinklered. The facility has a monitored fire alarm system with smoke detection on both levels including the corridors and common living areas. There were battery operated smoke detectors in four of five client sleeping rooms. The facility has a capacity of 8	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	and had a census of 8 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 1.5. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/02/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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KS018	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 Doors are self-closing or automatic closing in accordance with 7.2.1.8 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. Based on observation and interview, the facility failed to ensure the 3 of 5 bedroom doors closed and latched into the door frame. This deficiency could affect the five clients who resided in those rooms. Findings include: Based on observation during a tour of the home on 9/28/12 from 11:00 a.m. until 11:45 a.m. with the Lead Counselor, three bedroom doors failed to securely latch into the door frame when the alarm was activated. The door of the east bedroom at the north end of the bedroom hallway failed to close when the alarm tested. It was held completely open by a magnet attached to the wall, and the door failed to disengage from the magnet when the alarm was activated. Additionally, the doors of the west bedroom at the north	KS018	Corrective Action: The Area Director spoke to the maintenance department in regards to the doors not latching into the frames and the door not releasing from the magnet when the fire alarm is activated. The Maintenance department will fix the doors to ensure the door are latching into the frames securely and all doors will release from the magnets when the fire alarms is activated. The Program Director will re-train the Lead Counselor on the completion of the Monthly Site Risk Management checklist. The Monthly Site Risk Management checklist identifies specific areas in the home to be inspected to ensure things are in good working order and that the home is safe for the individuals. The Monthly Site Risk Management checklist identifies that the person completing the form inspect the doors that they are working properly. The	10/26/2012

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	end of the bedroom hallway as well as the east bedroom at the south end of the bedroom hallway failed to latch into the frame when the alarm was activated. Interview with the Lead Counselor during the observation confirmed the doors were not latching securely into the frame.		Program Director will re-train the Lead Counselor that to do the inspection, the Lead Counselor will activate the alarm and ensure the doors release from the magnets and the doors latch properly. The Lead Counselor will be trained that in the event a fire door does not release properly, or the door does not latch securely, the Lead Counselor will notify the Program Director and the Program Director will work with maintenance to get the issue resolved. Responsible Staff: Maintenance DepartmentTimeframe for completion: 10/26/12Systematic Correction: The Area Director will re-train all Program Directors on the expectation that any home that does not have a sprinkled fire alarm system must have doors that release from the magnets when the fire alarm is activated and that all doors must latch into the frames when they do release from the magnets. The Program Directors will ensure they re-train staff on the expectation that when a fire drill is conducted at a home without a sprinkler system, the staff will check the doors to ensure that all doors released from the magnets and latched securely in the frames. Monthly the Lead Counselor or the Program Director will complete a monthly site risk management checklist. The Lead Counselor or Program Director will check the fire doors as a part of the	

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			checklist. The Program Directors and Lead Counselors will be re-trained to ensure that the fire doors latch securely into the frames and release from the magnets. Should the Program Director or Lead Counselor find an issue with the fire doors, a maintenance request will be completed to ensure the issue is corrected. Verification the the site risk management checklist is completed will be tracked by the Office Manager and monthly the Area Directors will ensure that the site risk management checklists have been completed for each home. Responsible Staff: Area DirectorTimeframe for Completion: 10/26/12	