

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 10/21/2013
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 422 MARQUETTE TR MICHIGAN CITY, IN 46360
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K010000	<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: 10/21/13</p> <p>Facility Number: 000993 Provider Number: 15G479 AIM Number: 100244950</p> <p>Surveyor: Dennis Austill, Life Safety Code Supervisor</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 monitored fire alarm system with smoke detection on both levels including the corridors and in common living areas. There were battery operated smoke detectors in four of five client sleeping rooms. The facility has a capacity of 8</p>	K010000		

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>and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.54.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/28/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K01S018	<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. Based on observation and interview, the facility failed to ensure 1 of 5 bedroom doors closed and latched into the door frame. This deficiency could affect the client who resided in that room.</p> <p>Findings include:</p> <p>Based on observation during a tour of the home on 10/21/13 from 10:30 a.m. until 12:00 p.m. with the Program Director, the northeast bedroom door failed to close when the fire alarm was tested. Additionally, the door failed to securely latch into the door frame when the door was pulled and released from the magnet holding the door open. Interview with the Program Director during the observation confirmed the door did not release when the fire alarm was activated and it did not latch securely into the frame.</p>	K01S018	<p>Corrective Action- The maintenance supervisor was notified of the issue of the door not releasing when the fire alarm is pulled.. The maintenance supervisor will look to replace the magnet on the door to ensure the door releases each time the fire alarm is activated. All staff will be re-trained to ensure they check all the doors during a fire drill to ensure the doors release from the magnets and close securely in the frame. The staff will be re-trained on the system to be used to put in a maintenance request in the event a door does not release or close securely to ensure the maintenance department fixes the issue timely. Systematic Correction- The maintenance supervisor will be checking the fire doors at all the group homes to ensure they release when the alarm is activated. All the program directors have been re-trained on</p>	11/11/2013	

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			the expectation that staff check to ensure fire doors close during fire drills. All program directors have been re-trained on the expectation that staff complete maintenance requests in the event a door does not release from the magnet or close securely in the frame to ensure the issue is fixed timely.	

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K01S021	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Vertical openings are protected so as not to expose a primary means of escape. Vertical opening are considered protected if separated by smoke partitions in accordance with 8.2.4 that prevent the passage of smoke from one story to any primary means of escape on another story. Smoke partitions have a fire resistance rating of not less than ½ hour. Any doors or openings to the vertical opening are capable of resisting fire for not less than 20 minutes. 32.2.3.1.1, 33.2.3.1.1</p> <p>Exception: Stairs are permitted to be open where complying with Exception no. 2 or Exception No. 3 to 32.2.2.4, 33.2.2.4. Based on observation and interview, the facility failed to ensure 1 of 1 interior stairway doors would self close and latch into the door frame. LSC 8.2.4.3.5 states doors shall be self closing or automatic closing in accordance with 7.2.1.8. LSC 7.2.1.8.1 states a door normally required to be kept closed shall not be secured in the open position and shall be self closing or automatic closing in accordance with 7.2.1.8.2. This deficient practice could affect all clients.</p> <p>Findings include: Based on observation with the Program Director at 11:30 a.m. on 10/16/13, the door in the kitchen at the top of the stairwell to the basement was equipped</p>	K01S021	<p>Corrective Action- The area director met with the maintance supervisor in the Marquette home to discuss the basement door not closing. The mechanism that closes the door did not seem to be working correctly. The maintenance department has replaced the closing mechanism and the basement door is now securely latching into the frame. All staff will be trained on the expectation that the basement door is checked during a fire drill to ensure the door is securely latching into the frame. If the staff find the door is not latching securely, the staff will complete a maintenance request and the maintenance department will ensure the issue is fixed immediately. Systematic Correction- The maintenance supervisor is checking all doors</p>	11/11/2013			

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	with a self closing device but the door did not latch into the frame. The basement stairway door opens into the kitchen which is open to the dining room and living room which is a primary escape route for those areas. Based on interview at the time of observation, the Program Director acknowledged the stairwell door to the basement did not latch into the frame.		going into basement areas to ensure the doors are all latching into the frame securely. The maintenance supervisor has fixed one other door in a home other than Marquette and is ensuring that all other issues are corrected. All the program directors have been trained on the expectation that staff are checking the basement doors during fire drills to ensure those doors are closing securely into the frame as well as the other fire doors in the home. The program directors will be trained on the expectation that all staff complete a maintenance request if it is found that a basement door is not latching securely in the frame.		

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K01S152	<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 failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Drill Records at 10:45 a.m. on 10/21/13 with the</p>	K01S152	Corrective action- The program director will re-train the staff on the expectation that fire drills are completed quarterly for each shift. The program director has developed a schedule of fire drills to ensure the staff are aware of when fire drills are completed. Monthly, the program director will check to ensure the fire drills are being completed as scheduled. In the event a fire drill is missed,	11/15/2013			

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	Program Director, there was no record of a fire drill for the evening and overnight shifts during the fourth quarter of 2012. This was acknowledged by the Program Director at the time of record review.		the program director will ensure the staff on the shift complete the fire drill. Quarterly the area director will complete an on-site visit and will verify the fire drills are being completed as assigned. Systematic Correction- All the program directors were re-trained on the expectation that fire drills are completed one per each shift per quarter. The program directors were trained on the expectation that fire drills reports are being reviewed monthly to ensure the fire drills are being completed as expected. The area directors will complete quarterly visits and will monitor the fire drills to ensure fire drills are being completed as required.		