

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 10/17/2013
--	---	--	---

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 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
--------------------	--	---------------	---	----------------------

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: 10/17/13</p> <p>Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245210</p> <p>Surveyor: Bridget Brown, 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 in corridors and in common living areas. The facility has the capacity for 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</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.

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 10/17/2013
--	---	--	---

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 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
	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.5.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/18/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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 10/17/2013	
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 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			
K010130	<p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly, and the inspections were documented, including the date and initials of the person performing the inspection. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice affects all client, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation with the house manager between 12:30 p.m. and 1:00 p.m. on 10/17/13, the service and inspection tags for the portable fire extinguishers located in the kitchen and basement each noted they were placed in service 08/06/13. A monthly check was documented 10/16/13. The house manager acknowledged at the time of observations, the tags were the only</p>	K010130	<p>Corrective Action- The program director will ensure that there are tags on all the portable fire extinguishers in the home. Monthly, the Lead Counselor or designated staff conducts a monthly site risk assessment. This assessment is documented on the Monthly Site Risk Checklist. The person that completes the checklist will ensure the portable fire extinguishers are inspected to ensure they are in working order. The check will be documented on the Monthly Site Risk Management Checklist, and the staff will initial the tag on the fire extinguisher to document the check. Weekly, the program director will do an on-site visit. One time a month, the program director will check the tags on the fire extinguishers to ensure the staff are placing their initials on the tag after the check. The area director will conduct at least quarterly site visits and ensure the staff are checking the fire extinguishers monthly and documenting the checks on the tags. Systematic Correction- The area director will re-train all the program directors on the expectation that each portable fire extinguisher in the homes has a tag. The program directors will re-train all of their staff on the expectation that when the monthly risk assessment is</p>	11/08/2013			

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 10/17/2013
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 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	
	documentation for the monthly inspections and the extinguisher checks had not been noted during September 2013.		completed in the home, the staff that completes the Monthly Site Risk Checklist documents the checks of the fire extinguishers on the checklist, but also initials the tag on the portable fire extinguisher verifying the check. The program directors will all complete weekly on-site visits and at least monthly will check the tag on the fire extinguisher to ensure the staff are documenting the checks appropriately. All the area directors will complete quarterly on-site visits and will check the fire extinguisher tags to ensure the staff are initialling the tags when the checks are being completed.		