

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  11/06/2014
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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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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: 11/6/14</p> <p>Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245230</p> <p>Surveyor: Brett Overmyer, 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 the corridors and in the living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</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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K01S018	<p>Calculation of the Evaluation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.16.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 11/20/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <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, the facility failed to ensure 2 of 4 sleeping room doors would close and latch into the door frame in accordance with 7.2.1.8. LSC 7.2.1.8 Self-Closing Devices, states a door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or</p>	K01S018	On 11/10/14 the magnet for the bedroom #3 door was replaced by agency maintenance . The dresser is no longer placed in front of the door to hold it open. This was verified by the maintenance supervisor and the Program Director / QIDP on 11/21/14. On 11/10/14 the latching mechanism for the	12/06/2014

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	<p>automatic closing in accordance with LSC 7.2.1.8.2. LSC 7.2.1.8.2 states in any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p> <p>(1) Upon release of the hold-open mechanism, the door becomes self-closing.</p> <p>(2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed.</p> <p>This deficient practice could affect two of eight clients in the facility.</p> <p>Findings include:</p> <p>Based on observations on 11/6/14 between 1:05 p.m. and 1:45 p.m. with the Lead DSP, the following was noted:</p> <p>1) Bedroom 3 door was held open with a dresser. Observation revealed that the magnetic lock used to hold the door open was broken and the staff placed a dresser in front of the door to hold it open.</p> <p>2) Bedroom 2 door was released from the magnetic lock and swung closed. The latching mechanism failed causing door to not latch properly into the door frame The Lead DSP acknowledged the</p>		<p>bedroom #2 door was repaired. The door now latches properly into the door frame. This was verified by the maintenance supervisor and the Program Director / QIDP on 11/21/14. All staff working in the home will be retrained by 12/6/14 regarding this life safety code standard and the expectation that they are to report maintenance issues in a timely manner during their shift when the need is discovered. Going forward, the Lead Direct Support Professional will complete a monthly site risk checklist. The checklist involves conducting an environmental walk-thru of the facility, one area on the checklist is to ensure all doors properly latch and close. If a need for repair is identified, the Lead DSP is required to complete an immediate maintenance request and forward the request to the maintenance supervisor and Program Director/QIDP. The monthly site risk checklist is reviewed monthly by the Program Director /QIDP. It is also completed by the QIDP on a quarterly basis for ongoing quality assurance.</p>				

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K01S046	<p>aforementioned deficiencies.</p> <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, the facility failed to ensure 1 of 2 electrical outlets in the kitchen and 1 outlet in the basement bathroom were provided with working 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 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.</p> <p>Findings include:</p> <p>Based on observation on 11/6/14 between 1:05 p.m. and 1:45 p.m. with the Lead Direct Support Professional (LDSP), the</p>	K01S046	<p>On 11/7/14 the outlet on the left side of the kitchen sink and the outlet in the basement bathroom were replaced with working ground fault circuit interrupter (GFCI) protection receptacles. This was verified by the maintenance supervisor and the Program Director / QIDP on 11/21/14. All staff working in the home will be retrained by 12/6/14 regarding this life safety code standard and the expectation that they are to report maintenance issues in a timely manner during their shift when the need is discovered. Going forward, the Lead Direct Support Professional will complete a monthly site risk checklist. The checklist involves conducting an environmental walk-thru of the facility, one area on the checklist is to ensure all GFCI outlets are tested and reset. If a need for repair is identified, the Lead DSP is required to complete an immediate maintenance request and forward the request to the maintenance supervisor and Program Director/QIDP. The monthly site risk checklist is reviewed monthly by the Program Director /QIDP. It is also completed by the QIDP on a quarterly basis for ongoing quality</p>	12/06/2014

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K01S051	<p>following areas had sinks with an electric receptacle on the wall within three feet of the sink that was provided with a GFCI receptacle, when tested the GFCI receptacles failed to work.</p> <p>a) left side of kitchen sink; b) basement bathroom.</p> <p>The LDSP acknowledged the aforementioned defidencies.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6, 33.2.3.4.1.</p> <p>Exception No 1: Where there are interconnected smoke detectors meeting the requirements of 33.2.3.4.3 and there is not less than one manual fire alarm box per floor arranged to continuously sound the smoke detector alarms.</p> <p>Exception No. 2: Other manually activated continuously sounding alarms acceptable to the authority having jurisdiction.</p> <p>Based on observation, interview and record review, the facility failed to ensure 1 of 1 manual fire alarm systems was provided in accordance with Section 9.6. Section 9.6.2.1 requires activation of the complete fire alarm system by any or all of the following means: (1) manual fire alarm initiation, (2) automatic detection, (3) extinguishing system operation. This deficient practice could affect all client, visitors and staff.</p>	K01S051	<p>assurance.</p> <p>On 11/10/14, NOBI assessed the fire panel and pull stations of the facility. The system was reactivated. According to NOBI, a pull station needed to be reset. During a recent drill at the facility, the employee conducting the drill did not remember to reset the pull station. The maintenance supervisor and Program Director / QIDP verified that the fire panel was in proper working condition on 11/21/14. All staff working in the home will be retrained by 12/6/14 regarding this life safety</p>	12/06/2014			

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K01S147	<p>Findings include:</p> <p>Based on observation on 11/6/14 between 1:05 p.m. and 1:45 p.m. with the Lead Direct Support Professional (LDSP), the fire alarm control panel failed when 3 of 3 manual pull stations were activated and the fire alarm system did not go into alarm. Based on interview with the LDSP at the time of observation, the fire alarm system had just been worked on in the past week. Based on review of the facility's fire alarm inspection report, the fire alarm system was last inspected on 06/20/14. The LDSP acknowledged the aforementioned deficiency.</p> <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</p>		code standard and the expectation that they are to report maintenance issues in a timely manner during their shift when the need is discovered. In addition, all staff will also be retrained by 12/6/14 on the procedure for conducting an emergency fire drill. Going forward, the Lead Direct Support Professional will complete a monthly site risk checklist. The checklist involves conducting an environmental walk-thru of the facility, one area on the checklist is to test all smoke detectors and the fire system. If a need for repair is identified, the Lead DSP is required to complete an immediate maintenance request and forward the request to the maintenance supervisor and Program Director/QIDP. The monthly site risk checklist is reviewed monthly by the Program Director /QIDP. It is also completed by the QIDP on a quarterly basis for ongoing quality assurance.				

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	<p>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 observation, record review and interview, the facility failed to provide and to periodically instruct staff of a plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients in the home. Further, NFPA 101A, Guide on Alternative Approaches to Life Safety, 2001 edition at 6-5.2.1 says the protection plan should include the following features:</p> <p>(a) A description of all available evacuation, escape, and rescue routes and the procedures and techniques needed to evacuate all the residents using the various routes.</p> <p>(b) A fundamental knowledge of fire growth, containment, and extinguishment necessary to make reasonable judgments about action priorities and viable egress routes.</p> <p>This deficient practice could affect all staff and clients.</p> <p>Findings include:</p>	K01S147	<p>All staff that work in the facility will be retrained on the policy and procedure regarding Emergency situations and the facility specific emergency plan by 12/6/14. Going forward, copies of the policy and the plan will be kept in the facility Emergency Binder. The emergency binder contains the policy and procedure for emergency situations, copies of the training sign-in sheets and related staff training agendas, the facility emergency plan designed to ensure the safety of each individual in the home, fire watch protocol and worksheets, current F-1 worksheets, emergency drills, and recent NOBI inspections. The Program Director /QIDP will be retrained by 12/6/14 on the expectation of the contents of the facility emergency binder, and the expectation that routine staff instruction on the emergency plan should be provided to the facility staff at least every 60 days. To ensure staff are provided an opportunity for ongoing emergency procedure training, an area of the emergency plan will be a topic for review at the facility</p>	12/06/2014

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K01S155	<p>Based on interview on 11/6/14 between 12:35 p.m. and 1:05 p.m. with the Lead Direct Support Professional (LDSP), there was no documentation of a protection plan and there was no documentation of staff instruction on a protection plan located in the home at the time of this visit. The LDSP acknowledged the aforementioned deficiency</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8</p> <p>Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8.</p> <p>Findings include:</p> <p>Based on observation and record review on 11/6/14 between 12:35 p.m. and 1:05 p.m. with the Lead Direct Support Professional (LDSP), no documentation</p>	K01S155	<p>monthly staff meeting led by the Program Director / QIDP.</p> <p>All staff that work in the facility will be retrained on the Fire Watch Protocol as outlined in the facility specific emergency plan by 12/6/14. Going forward, copies of the emergency policy and the plan will be kept in the facility Emergency Binder. The emergency binder contains the policy and procedure for emergency situations, copies of the training sign-in sheets and related staff training agendas, the facility emergency plan designed to ensure the safety of each individual in the home, fire watch protocol and worksheets, current F-1 worksheets,</p>	12/06/2014

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	was found for: 1) written fire plan 2) fire watch The LDSP acknowledged the aforementioned deficiencies.		emergency drills, and recent NOBI inspections. The Program Director /QIDP will be retrained by 12/6/14 on the expectation of the contents of the facility emergency binder, and the expectation that routine staff instruction on the emergency plan should be provided to the facility staff at least every 60 days. To ensure staff are provided an opportunity for ongoing emergency procedure training, an area of the emergency plan will be a topic for review at the facility monthly staff meeting led by the Program Director / QIDP.		