

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929
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(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
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K 0000 Bldg. 01	<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: 06/25/15</p> <p>Facility Number: 011817 Provider Number: 15G757 AIM Number: 200940180</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 32, New Residential Board and Care Occupancies.</p> <p>This one story facility with basement was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired detectors in all resident sleeping rooms. The facility has a capacity of four and had a census of four at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K 0000		
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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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K S051 Bldg. 01	<p>Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.8.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD A manual fire alarm system is provided in accordance with Section 9.6. 32.2.3.4.1. Based on observation and interview, the facility failed to ensure 1 of 2 levels was provided with manual fire alarm boxes. LSC 9.6.2.3 requires manual fire alarm boxes shall be provided near the natural path to exit an area. This deficient practice affects all clients as well visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/25/15 at 1245 p.m., the basement where three clients have sleeping rooms was not provided with a manual fire alarm box. The basement was provided with hard wired smoke detector protection and was sprinklered. Based on interview with the House Manager on 06/25/15 concurrent with the observation it was acknowledged</p>	K S051	<p>K0051 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The House Manager, QIDP, Area Director, and Maintenance Coordinator have reviewed this Standard. A manual pull station for the fire alarm system was installed in the basement of the home on 7/1/15.</p> <p>Ongoing, and at least monthly, the House Manager, QIDP, and/or Maintenance department will ensure all required areas of home have manual pull stations for the fire alarm system and that the fire alarm system is inspected as required, at least every year, by ensuring the inspection report is complete and available for review in the home's Life Safety binder.</p> <p>Completed 7/1/15</p>	07/01/2015

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	a manual fire alarm box was not provided for the basement.		Persons Responsible: Maintenance Coordinator, House Manager, and QIDP		