

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G750	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 60680 LILAC RD SOUTH BEND, IN 46614
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K 000 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: 05/07/15</p> <p>Facility Number: 011765 Provider Number: 15G750 AIM Number: 200908290</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 was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, in client sleeping rooms and in common living areas. The facility has a capacity of 4 and had a census of 4 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 000		
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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 130 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.22.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguishers in the garage was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, Section 1-6.3 requires that fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect staff.</p> <p>Findings include:</p> <p>Based on observation with the Direct Support Staff on 05/07/15 at 1:29 p.m., access to the fire extinguisher located in the garage was obstructed by storage of clothes. Based on interview at time of observation, the Direct Support Staff acknowledged the aforementioned condition.</p>	K 130	The items stored in the garage have been re-arranged to ensure that the fire extinguisher is readily accessible and immediately available in case of an emergency. We have reviewed the placement of all fire extinguishers in the facility to ensure that all locations meet this requirement. The Maintenance Director and all facility staff are receiving retraining on this standard. Going forward, the Maintenance Director and Lead DSP will be responsible to monitor compliance with this standard through the monthly site risk management checklist.	06/06/2015	
K 051 Bldg. 01	<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.</p>				

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	<p>1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was provided in accordance with Section 9.6. Section 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, Section 2-8.2.1 manual fire alarm boxes shall be located throughout the protected area so that they are unobstructed and accessible. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation on 05/07/15 at 1:20 p.m. a manual fire alarm box was observed obstructed by a television cabinet. Based on interview at the time of observation, the Direct Support Staff acknowledged for the aforementioned condition.</p> <p>2. Based on record review, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. LSC 9.6.1.4 requires fire alarm systems to be maintained in accordance with NFPA 72. NFPA 72, 7-3.2 requires that testing shall be performed in accordance with the schedules in Chapter 7 or more often if required by the authority having jurisdiction. Table 7-3.2 shall apply.</p>	K 051	<p>We reviewed this deficiency to determine the cause for the error. The monitoring company had scheduled an annual review for July 2015 based on an error - the clerk entering the due date had read the 2/27/14 date as 7/27/14 on the first page of the report, though it clearly read as 2/27/14 on the following pages of the report. Dungarvin's internal tracking also did not catch the error. The Program Director and Maintenance Director are being retrained on the expectation that they will track the due dates for the required annual and quarterly inspections and ensure that proof of those inspections are located in the binder at the facility for review as soon as the reports are received. The monitoring company has scheduled an inspection in the next week, and the report will be on file and available for review at the home by 6/6/15.</p>	06/06/2015			

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	<p>Table 7-3.2 "Testing Frequencies" requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all clients, staff, and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of fire alarm inspection report with the Direct Support Staff on 05/07/15 at 1:30 p.m., the most recent fire alarm system inspection documentation available for review indicated the inspection occurred on 02/27/14. Based on interview at the time of review, the Direct Support Staff acknowledged the lack of documentation.</p>						