STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G573	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	51778 TROWBRIDGE LN SOUTH BEND, IN 46637

(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
K 000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 03/26/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR Subpart 483.470(j). Survey Date: 05/14/15 Facility Number: 001087 Provider Number: 15G573 AIM Number: 100239960 At this PSR 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. This one story facility with a basement was fully 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. Calculation of the Evaluation Difficulty	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 3.4.			
K 130 Bldg. 01	Based on observation, record review and interview the facility failed to ensure monthly fire extinguisher inspections were documented, including the date and initials of the person performing the inspections for 2 of 2 portable fire extinguishers in the basement. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. This deficient practice could affect staff only. Findings include: Based on observation and record review	K 130	New inspection tags have been placed on all fire extinguishers in the basement of the home. These were signed and dated on the date of the survey re-visit. The Maintenance Coordinator has also verified that appropriate inspection tags are in place on every extinguisher throughout the facility.The Maintenance Coordinator, Program Director, and Lead DSP are all being re-trained on this standard to prevent recurrence of this deficiency. Going forward, compliance with this standard will be monitored through the monthly site risk management checklist.	06/13/2015

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	of the fire extinguisher inspection/maintenance tag with the Maintenance Coordinator on 05/14/15 at 1:08 p.m., there was no documentation on the tag to show the basement fire extinguisher and the main level fire extinguisher had received a monthly inspection since December of 2014. This was acknowledged by the Maintenance Coordinator at the time of observation and record review of the fire extinguisher. This deficiency was cited on 03/26/15. The facility failed to implement a systemic plan of correction to prevent recurrence			