

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G520	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/04/2015
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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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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: 12/04/15</p> <p>Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245230</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> <p>Calculation of the Evaluation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety,</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 S046 Bldg. 01	<p>Chapter 6, rated the facility Slow with an E-Score of 2.1.</p> <p>Quality Review completed 12/08/15 - DA</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 and interview, the facility failed to maintain an electrical outlet in 1 of 6 outlets in the basement. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff and clients.</p> <p>Findings include:</p> <p>Based on observations with the Program Director on 10/13/15 at 12:40 p.m., the outlet near the stairs was missing an outlet cover. Based on interview at the time of observation, the Program Director acknowledged the aforementioned condition.</p>			K S046	<p>The exposed electric outlet in the basement living room area was fastened with a cover plate before 12/18/15. This was verified by the Program Director/QIDP on 12/18/15. All staff working in the home will be retrained by 12/31/15 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 outlets have cover plates and that they are in good repair. 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</p>		12/18/2015

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K S155 Bldg. 01	<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 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 8 of 8 clients indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Program Director on 12/4/15 at 12:24 p.m., the facility's documentation provided for a plan of action when the fire alarm system</p>	K S155	<p>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. The checklist will be completed by the Program Director/QIDP by 12/31/15 for the month of December.</p> <p>The emergency plan which includes the fire watch protocol is located in two binders in the home; the policy and procedure manual as well as the Emergency Drill Binder, respectively. All staff at the facility have been trained on the location of the fire watch protocol, however, it is apparent that a refresher training is needed. All staff will be retrained by 12/31/15 on the location of the fire watch protocol and the procedure for completing a fire watch and how to document the fire watch. Going forward, the Program Director/QIDP will include the emergency plan and fire watch protocol as a topic in the Emergency Safety trainings which are held a</p>	12/31/2015	

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	was out of service for more than four hours in a twenty four hour period was not available for review. Based on interview at the time of record review, the Program Director acknowledged the aforementioned condition.		minimum of every 60 days for the facility.		