

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/25/2015
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561
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K 0000  Bldg. 02	<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: 11/25/15</p> <p>Facility Number: 000974 Provider Number: 15G460 AIM Number: 100244830</p> <p>At this Life Safety Code survey, Dungarvin Indiana, LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CRF 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 a basement was not sprinklered. The facility has a monitored fire alarm system with smoke detection on all levels including in the corridors, client sleeping rooms and common living areas. The facility has a capacity of 8 and had a census of 7 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 S043 Bldg. 02	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 4.7.</p> <p>Quality Review completed 12/01/15 - DA</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observation, the facility failed to ensure 2 of 3 exit doors was provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4 requires that where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is that the method of release be one that is familiar to the average person. Generally, a two-step release such as a knob and independent dead-bolt is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect staff and all the clients.</p>	K S043	The two doors cited under this deficiency will either be replaced or the dead bolt function on each door will be disabled so that each exit door at the facility will comply with LSC 7.2.1.5.4. This standard will be reviewed with the Maintenance Director, Area Director, Program Director and Lead DSP in order to ensure that this deficiency does not recur at this facility or at any Dungarvin Indiana ICF.	12/25/2015

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K S046  Bldg. 02	<p>Findings include:</p> <p>Based on observation with the Direct Support Professional on 11/25/15 at 1:23 p.m., then again at 1:26 p.m., the "back" exit door had a deadbolt and a lock on the door knob on the same door. Then again the "office" exit door had a deadbolt and a lock on the door knob on the same door. Based on interview at the time of each observation, the Direct Support Professional acknowledged each aforementioned condition and confirmed both exit doors were shown on the evacuation map.</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 1 of 1 electrical outlet in the stairway. 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 up to 5 residents who use the basement.</p> <p>Findings include:</p>	K S046	<p>The electrical outlet located in the stairway will have a new outlet cover put in place. All electrical outlets in the facility are being checked to ensure that none of the other outlets in the facility have damaged or missing covers. Going forward, the Lead DSP completes a site risk management checklist which is reviewed by the Program Director on a monthly basis. One item on this checklist asks if any electrical plates are missing or cracked. The Lead DSP will be responsible</p>	12/25/2015
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K S120 Bldg. 02	<p>Based on observations with the Direct Support Professional on 11/25/15 at 1:24 p.m., the outlet in the stairwell was missing an outlet cover. Based on interview at the time of observation, the Direct Support Professional acknowledged the aforementioned condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD In addition to the primary route, each sleeping room in facilities that use Exception No. 1 to 32.2.3.5.1 has a second means of escape that consists of one of the following:</p> <p>(d) It is door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape.</p> <p>(e) It is a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape.</p> <p>(f) It is an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 sq. ft. The width is not less than 24 inches. The bottom of the opening is no more than 44 inches above the floor. Such means of escape is acceptable where one of the following criteria are met:</p>		to notify Maintenance when any needed repair such as the missing outlet cover is noted. The Program Director and Maintenance Director will be responsible to ensure that Maintenance requests are acted upon in a timely fashion. The Maintenance Director, Area Director, Program Director, and Lead DSP will review this standard in order to ensure that this deficient practice does not recur.	

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	<p>(1) The window is within 20 ft of grade.</p> <p>(2) The window is directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>(3) The window or door opens onto an exterior balcony. 33.2.2.3</p> <p>Exception: If the sleeping room has a door leading directly to the outside of the building with access to grade or to a stairway that meets the requirements of exterior stairs in 32.2.3.1.2, that means of escape is considered as meeting all the escape requirements for the sleeping room.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 5 client sleeping rooms was provided with a secondary means of escape. This deficient practice could affect 4 of 8 clients.</p> <p>Findings include:</p> <p>Based on interview and observation, the Direct Support Professional on 11/25/15 at 1:14 p.m. then again at 1:15 p.m., there was a dresser blocking the window in Bedroom #3. Then again, there was a dresser blocking the window in Bedroom #4. This facility is non-sprinklered. Based on interview at the time of observation, the Direct Support Professional acknowledged each aforementioned</p>	K S120	The dressers located in bedrooms #3 and #4 are being moved so that there is clear access to the windows that are considered a secondary means of escape. The Maintenance Director, Area Director, Program Director, Lead DSP and all facility DSPs are being retrained on this standard in order to monitor that this deficiency does not recur at the facility.	12/25/2015	

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K S150 Bldg. 02	<p>condition.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities are in accordance with the provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>Based on interview and observation, the facility failed to ensure new draperies and curtains in 1 of 1 sleeping rooms were flame resistant. LSC Section 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Method of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice affects 1 client.</p> <p>Findings include:</p> <p>Based on observations with the Direct Support Staff on 11/25/15 at 1:11 p.m., curtains were hung at the windows in bedroom #2. Based on an interview at the time of observation, the Direct Support Staff confirmed that the bedroom decorations including curtains was new, and was installed in May 2015.</p>	K S150	The maintenance department stated that all curtains in the home are flame resistant. This should be indicated on the tags on the curtains themselves. By 12/25/15, The maintenance department will assess all of the curtains in the home to ensure the proof of flame resistant treatment is present. For any curtains in the home, including the curtains in all sleeping rooms, if proof or documentation is unable to be located, new curtains with the appropriate flame resistant rating will be purchased for the home. Going forward, the maintenance department will ensure the curtains of the home meet the LSC standard 10.3.1 during their monthly reviews of the facility.	12/25/2015			

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K S152  Bldg. 02	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; and ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities; (iii) File a report and evaluation on each drill; (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>Facilities meet the requirements of paragraphs (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times for 3 of 4 quarters. This deficient practice affects all staff and clients.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Record" forms with the Direct Support Professional on 11/25/15 at 1:00 p.m.,</p>	K S152	The Program Director will audit all drills completed in the past year and will ensure that fire drills are completed this month during times that are unexpected according to the last three quarters of data. Going forward, the Program Director will be responsible to create a tracking system to ensure that quarterly drills are completed at unexpected times each quarter in order to provide an opportunity for	12/25/2015	

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	three sequential first shift fire drills took place between 8:45 a.m. and 8:50 p.m. for three of the last four quarters. Based on interview at the time of record review, the Direct Support Professional acknowledged the aforementioned condition.		the individuals to learn related safety skills at different times and during different scenarios. The Program Director, Area Director, Lead DSP, and all facility DSPs will be trained on this standard in order to prevent recurrence of this deficiency.		