

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  12/31/2015
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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 Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/25/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/31/15</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>	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 S150 Bldg. 02	<p>Calculation of the Evacuation Difficulty 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 on 01/11/16 - DA</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 12/31/15 at 1:31 p.m., curtains were hung at the windows in bedroom #2. Based on an interview at</p>	K S150	<p>The curtains in the bedroom were treated, but it was on 12/31 after the surveyor had returned for the revisit. A copy of the product applied on 12/31 is attached with this response. A dated/signed copy of the product sheet is in the fire safety book at the facility for review. To prevent recurrence of this deficiency, the Lead DSPs were trained at our Lead meeting and all Program Director/QIDPs were trained on this at the Statewide Program Director meeting on 1/21/16. The Lead DSP, Program Director and Maintenance Director are all responsible to ensure that all new draperies purchased in the future are certified to be flame resistant or treated before being hung in the home going forward.</p>	01/30/2016

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K S152 Bldg. 02	<p>the time of observation, the Direct Support Staff confirmed that the bedroom decorations including curtains were new and were installed in May 2015, and no documentation was available for review.</p> <p>This deficiency was cited on 11/25/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD 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>				

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	<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 12/31/15 at 8:40 a.m., 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. Since the initial inspection, the most recent first shift fire drill took place on 8:40 a.m. Based on interview at the time of record review, the Direct Support Professional acknowledged the aforementioned condition.</p> <p>This deficiency was cited on 11/25/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p>	K S152	<p>The staff did submit one drill completed on 11/23/15 that was run at 8:15 a.m. That drill is attached with this submission. The Lead DSP is planning a weekend drill to occur later in the morning, and the Program Director is being instructed to go to the home between 6-8 am between now and January 30th to initiate an unscheduled drill. Going forward, we are creating a revised drill tracking worksheet to ensure that quarterly fire drills are occurring at unexpected times across the year on all shifts. This was reviewed with all Program Director/QIDPs at the Statewide Program Director meeting on 1/21/2016.</p>	01/30/2016	