

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G573	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 51778 TROWBRIDGE LN SOUTH BEND, IN 46637		
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E 0000  Bldg. --	<p>A Post Survey Revisit (PSR) for the Emergency Preparedness Survey that exited on 04/02/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73</p> <p>Survey Date: 05/29/24</p> <p>Facility Number: 001087 Provider Number: 15G573 AIM Number: 100239960</p> <p>At this Emergency Preparedness PSR, Dungarvin Indiana LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds. All 8 beds are certified for Medicaid/Medicare. At the time of the survey, the census was 8</p> <p>Quality Review completed on 05//3124</p>	E 0000		
E 0039  Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2).</p> <p>EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727,</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Greta Goins

Area Director

06/14/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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	<p>CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> <li>(i) Participate in a full-scale exercise that is community-based every 2 years; or <ul style="list-style-type: none"> <li>(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or <ul style="list-style-type: none"> <li>(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</li> </ul> </li> </ul> </li> <li>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: <ul style="list-style-type: none"> <li>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or <ul style="list-style-type: none"> <li>(B) A mock disaster drill; or <ul style="list-style-type: none"> <li>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</li> </ul> </li> </ul> </li> <li>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</li> </ul> </li></ul>			

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	<p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p>			

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	<p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p>			

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	<p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p>			

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	<p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an</p>			

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	<p>actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> <li>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</li> <li>(B) A mock disaster drill; or</li> <li>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</li> </ul> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <ul style="list-style-type: none"> <li>(i) Participate in an annual full-scale exercise that is community-based; or</li> <li>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</li> <li>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required</li> </ul>			

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	<p>full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> <li>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</li> <li>(B) A mock disaster drill; or</li> <li>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</li> </ul> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <ul style="list-style-type: none"> <li>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</li> <li>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</li> </ul>			

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	<p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <ul style="list-style-type: none"> <li>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</li> <li>(B) A mock disaster drill; or</li> <li>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</li> </ul> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop</p>			

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	<p>exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.</p> <p>*[ RNHCl's at §403.748]:</p> <p>(d)(2) Testing. The RNHCl must conduct exercises to test the emergency plan. The RNHCl must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(ii) Analyze the RNHCl's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCl's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p>	E 0039	<p><u>Corrective action for resident(s) found to have been affected</u></p> <p>All parts of the POC for the survey with event ID I3I722 will be fully implemented, including the following specifics:</p> <p>The emergency preparedness plan tabletop exercise was completed on 5/31/24. It is filed in the Life Safety binder at the home and uploaded with this submission.</p> <p>The emergency preparedness community-based exercise was completed on 5/31/24. It is filed in the Life Safety binder at the home and uploaded with this submission.</p> <p><u>How facility will identify other residents potentially affected &amp; what measures taken</u></p>	06/14/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G573	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2024
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 51778 TROWBRIDGE LN SOUTH BEND, IN 46637		
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K 0000  Bldg. 01	<p>This finding was review with the LDSP during the exit conference. This deficiency was cited on 04/02/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/02/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 05/29/24</p> <p>Facility Number: 001087 Provider Number: 15G573 AIM Number: 100239960</p> <p>At this Life Safety Code PSR, 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 2012 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 building, with a basement, was determined to be fully sprinklered with heat detection in attic spaces. The facility has a fire alarm system with smoke detection in corridors, in client sleeping rooms and all 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 Evacuation Difficulty Score</p>	K 0000		

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K S345 Bldg. 01	<p>(E-Score) using NFPA 101A, Alternative Approaches of Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.84.</p> <p>Quality Review completed on 05/31/24</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction.</p> <p>NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect approximately all occupants.</p> <p>Findings include:</p>	K S345	<p><u>Corrective action for resident(s)</u> <u>found to have been affected</u></p> <p>All parts of the POC for the survey with event ID I3I722 will be fully implemented, including the following specifics:</p> <p>The maintenance manager contacted VFP about the sensitivity testing documentation. VFP stated that the sensors in the smoke detectors do not require sensitivity testing and provided the sensor specifications. They are uploaded with the original submission.</p> <p>The maintenance manager is working with VFP to get additional documentation for sensitivity testing, but it has not been</p>	06/28/2024

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	<p>Based on record review from with the Lead Direct Support Professional (LDSP) between 09:15 a.m. and 10:15 a.m. on 05/29/24, no documentation was available for review to show if the smoke detector sensitivity had been tested with in the last two years. Based on interview at the time of record review, the LDSP did not know where the proper documentation could be except for in the binder provided.</p> <p>Findings were discussed with the LDSP at exit conference. This deficiency was cited on 04/02/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.</p>		<p>provided at the time of this submission. Follow up will occur weekly until appropriate sensitivity testing documentation is received.</p> <p>Going forward, the Quality assurance coordinator will monitor all VFP documentation to ensure that all aspects of testing and inspections are complete, any follow-up for deficiencies is completed timely, and work orders are received and filed.</p> <p><u>How facility will identify other residents potentially affected &amp; what measures taken</u></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes facility put in place to ensure no recurrence:</u></p> <p>Area Director will work with the Senior Director and Maintenance Dept to ensure that all facilities meet State standards for sprinkler systems and sensitivity testing.</p> <p>Area Director is developing a monitoring system in conjunction with the Maintenance Dept and new Quality Assurance Coordinator to monitor the Life Safety books monthly to ensure that all required inspections are present and always filed.</p> <p>Persons responsible:</p> <p>Maintenance manager, QA coordinator</p>	

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K S353  Bldg. 01	<p>NFPA 101</p> <p>Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing</p> <p>2012 EXISTING (Prompt)</p> <p>NFPA 13 and 13R Systems</p> <p>All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System.</p> <p>NFPA 13D Systems</p> <p>Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25:</p> <ol style="list-style-type: none"> <li>1. Control valves inspected monthly (NFPA 25, section 13.3.2).</li> <li>2. Gauges inspected monthly (NFPA 25, section 13.2.71).</li> <li>3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6).</li> <li>4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).</li> <li>5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5).</li> <li>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1)).</li> <li>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).</li> <li>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).</li> <li>9. Buildings inspected annually prior to</li> </ol>			

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	<p>freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5).</p> <p>10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2).</p> <p>11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15).</p> <p>12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).</p> <p>13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1).</p> <p>14. Operating stems of OS&amp;Y valves are lubricated annually (NFPA 25, section 13.3.4).</p> <p>15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <hr/> <p>B. Show who provided the service.</p> <hr/> <p>C. Note the source of the water supply for the automatic sprinkler system.</p> <hr/> <p>(Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.)</p> <p>33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall</p>	K S353	<p><u>Corrective action for resident(s)</u> <u>found to have been affected</u></p> <p>All parts of the POC for the survey with event ID I3I722 will be fully implemented, including the following specifics:</p>	06/28/2024

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	<p>be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately all staff and residents.</p> <p>Findings include:</p> <p>Based on observation with the Lead Direct Support Professional (LDSP) on 05/29/24 between 09:15 a.m. and 10:15 a.m., one sprinkler head located within the garage next to the overhead door had an approximatel 1/4" of annular space around the sprinkler head. Based on interview at the time of observation, the LDSP acknowledged the open space between the ceiling and sprinkler heads in the garage.</p> <p>Findings were discussed with the LDSP at exit conference. This deficiency was cited on 04/02/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.</p>		<p>The maintenance manager is working with VFP to resolve the annular space around the sprinkler heads in the garage and bedroom #5. It is still pending at the time of this submission and no resolution date has been determined.</p> <p>Going forward, the Quality assurance coordinator will monitor all VFP documentation to ensure that all aspects of testing and inspections are complete, any follow-up and/or work related to deficiencies is completed timely, and work orders are received and filed.</p> <p><u>How facility will identify other residents potentially affected &amp; what measures taken</u></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes facility put in place to ensure no recurrence</u></p> <p>Maintenance Manager in conjunction with the Area Director and the Quality Assurance Coordinator is developing a monitoring system to review all VFP inspections and approve work orders with VFP to resolve any noted deficiencies on annual and or quarterly inspections. The Quality Assurance Coordinator is tracking all VFP inspections to ensure all paperwork is in life safety binders as soon as possible.</p>	

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K S741  Bldg. 01	<p>NFPA 101</p> <p>Smoking Regulations</p> <p>Smoking Regulations</p> <p>Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations.</p> <p>32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2</p> <p>Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately all staff and residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Lead Direct Support Professional (LDSP) on 05/29/24 between 09:15 a.m. and 10:15 a.m., approximately fifteen cigarette butts were discarded on the ground within the enclosed back patio and around the smoking area. Based on interview at the time of observation, the LDSP stated that one client likes to discard the cigarette butts on the ground and staff does try and clean the smoking area, however she acknowledged that there were still cigarette butts on the ground improperly disposed of.</p> <p>This finding was reviewed with the LDSP during the exit conference. This deficiency was cited on 04/02/24. The facility failed to implement a systemic plan of correction to prevent</p>	K S741	<p>Persons responsible: Maintenance manager, QA coordinator</p> <p><u>Corrective action for resident(s) found to have been affected</u></p> <p>All parts of the POC for the survey with event ID I3I722 will be fully implemented, including the following specifics:</p> <p>All facility staff were trained on 05/31/24 on the designated smoking area per Dungarvin policy and how to properly dispose of cigarette butts, in addition to assisting individuals with cleaning up their cigarette butts if the receptacle is not utilized.</p> <p>Going forward the QIDP will observe the designated smoking area and the perimeter around the facility during weekly site visits to ensure staff and supported individuals are following Dungarvin policy for smoking. Coaching will be provided immediately for anyone in non-compliance with policy and disciplinary action as needed.</p> <p><u>How facility will identify other</u></p>	06/14/2024

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	reoccurrences.		<u>residents potentially affected &amp; what measures taken</u> All residents potentially are affected, and corrective measures address the needs of all clients.  <u>Measures or systemic changes facility put in place to ensure no recurrence</u> All facility staff are trained on designated smoking areas upon hire and as needed. All supported individuals are able to smoke in designated areas. All QIDPs are trained on Dungarvin policy pertaining to designated smoking areas upon hire and as needed. QIDP, Area Manager, and Area Director or other designated supervisory staff will monitor smoking areas during site visits to ensure staff and supported individuals are utilizing it appropriately.  <u>Persons responsible:</u> QIDP, Lead DSP, QA Coordinator, Area Manager, Area Director	