

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2022
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
(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
E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 05/17/22</p> <p>Facility Number: 012557 Provider Number: 15G791 AIM Number: 201017960A</p> <p>At this Emergency Preparedness survey, Dungarvin Indiana, LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4.</p> <p>Quality Review completed on 05/18/22</p>	E 0000		
K 0000 Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.490(j).</p> <p>Survey Date: 05/17/22</p> <p>Facility Number: 012557 Provider Number: 15G791 AIM Number: 201017960A</p> <p>At this Life Safety Code survey, Dungarvin Indiana LLC was found not in compliance with</p>	K 0000		

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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PRINTED: 06/01/2022

FORM APPROVED
OMB NO. 0938-0391

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K S100 Bldg. 01	<p>Requirements for Participation in Medicaid, 42 CFR subpart 483.490(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 facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas, hard wired detectors in all resident sleeping rooms and heat detection in the attic. The facility has a capacity of 4 and had a census of 4 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.62.</p> <p>Quality Review completed on 05/18/22</p> <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation, records review, and interview, the facility failed to ensure 6 of 6 portable fire extinguisher located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions</p>	K S100	The Program Director will complete a maintenance request for maintenance to come to the home to inspect all the fire extinguishers in the home. All tags on the fire extinguishers will be updated to reflect the inspection.	06/10/2022

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	<p>of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Program Director and Direct Service Professional on 05/17/22 between 2:00 p.m. and 2:28 p.m., six of six fire extinguishers in the home had affixed inspection and maintenance tags that were not complete. The following fire extinguisher locations and monthly inspection were noted:</p> <ul style="list-style-type: none"> a) Dining room monthly inspection not documented since 1/5/2022 b) Garage monthly inspection not documented since 1/5/22 c) kitchen monthly inspection not documented since annual maintenance December 2021 d) Living room #1 monthly inspection not documented since 1/5/22 		<p>Going forward the Program Director will check the server monthly to ensure the monthly inspection were complete and all items met regulatory compliance.</p> <p>Going forward the Area Director will check the server quarterly to ensure the monthly inspection were complete and all items met regulatory compliance.</p>	

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K S353 Bldg. 01	<p>e) Living room #2 monthly inspection not documented since 1/5/22</p> <p>f) Office monthly inspection not documented since 1/5/22</p> <p>Based on records review, the annual fire extinguisher testing occurred December 2021, and no other documentation was provided to show the aforementioned fire extinguishers were inspected monthly.</p> <p>These findings were reviewed with the Program Director and Direct Service Professional at the time of discovery and again at the exit conference.</p> <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"> 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 			

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	<p>2. Gauges inspected monthly (NFPA 25, section 13.2.71).</p> <p>3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6).</p> <p>4. Alarm devices tested semiannually (NFPA 25, section 5.3.3).</p> <p>5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5).</p> <p>6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1).</p> <p>7. Visible pipe inspected annually (NFPA 25, section 5.2.2).</p> <p>8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3).</p> <p>9. Buildings inspected annually prior to 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&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> <p>_____</p> <p>B. Show who provided the service.</p> <p>_____</p>			

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	<p>C. Note the source of the water supply for the automatic sprinkler system.</p> <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 ensure 1 of 2 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all clients and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Program Director and Direct Service Professional during a tour of the facility from 2:00 p.m. to 2:28 p.m. on 05/17/22, one sprinkler gauge had a manufacture date of 2013 listed on the face of the sprinkler gauge and the second sprinkler system gauge had a manufacture date of 2021. Based on interview at the time of the observations, the Direct Service Professional agreed 1 of 2 sprinkler system gauges was more than five years old and no documentation of calibration of the 2013 gauge was provided.</p> <p>This finding was reviewed with the Program Director and Direct Service Professional at the</p>	K S353	<p>The Program Director will complete a maintenance request to have the sprinkler system calibration tested. If during the test it is determined it need to be replaced at that time the necessary, step will be taken to have it replaced.</p> <p>Going forward the Program Director will monitor the maintenance folder no less than quarterly to ensure all inspections are scheduled on the sprinkler system.</p> <p>Going forward the Area Director will monitor the maintenance folder no less than semiannually to ensure all inspections are scheduled on the sprinkler system.</p>	06/10/2022

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K S363 Bldg. 01	<p>exit conference.</p> <p>NFPA 101</p> <p>Corridor - Doors</p> <p>Corridor - Doors</p> <p>Doors shall meet all of the following requirements:</p> <ol style="list-style-type: none"> 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5. <p>Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 client sleeping room doors would latch into the door frame. This deficient practice could affect one client.</p> <p>Findings include:</p> <p>Based on observations on 05/17/22 between 2:00 p.m. and 2:28 p.m. during a tour of the facility with the Program Director and Direct Service Professional, AS's bedroom door would not latch into its door frame when tested several times. The plunger portion of the latching mechanism was missing, and the door was damaged around the doorknob, not letting the door latch into the door frame. Based on interview at the time of observation, the Program Director agreed AS's bedroom door did not latch</p>	K S363	<p>The Program Director will complete a maintenance request to have the doors accessed to determined level of repair needed. The maintenance department will ensure the door is repaired so it can latch.</p> <p>Going forward the Program Director will monitor all doors in the home no less than monthly to ensure they are functional in accordance with regulatory compliance.</p> <p>Going forward the Program Director will monitor all doors in the home no less than quarterly to</p>	06/10/2022

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	<p>when tested several times and said she would have a work order sent to maintenance to fix the door.</p> <p>This finding was reviewed with the Program Director and Direct Service Professional during the exit conference.</p>			<p>ensure they are functional in accordance with regulatory compliance.</p>	