

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

PRINTED: 03/03/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15G573</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b>  <b>03/01/2023</b>	
NAME OF PROVIDER OR SUPPLIER  <b>DUNGARVIN INDIANA LLC</b>				STREET ADDRESS, CITY, STATE, ZIP CODE  <b>51778 TROWBRIDGE LN</b> <b>SOUTH BEND, IN 46637</b>			
(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
{K 000}	<p>INITIAL COMMENTS</p> <p>A 2nd Post Survey Revisit (PSR) to the 1st PSR visit that exited on 12/30/22 for the Life Safety Code Recertification and State Licensure Survey that exited on 11/04/22 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 03/01/23</p> <p>Facility Number: 001087 Provider Number: 15G573 AIM Number: 100239960</p> <p>At this PSR, Dunganvin Indiana LLC was found 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. The facility has a monitored fire alarm system with smoke detection in corridors, in client sleeping rooms and all living areas and heat detection in attic spaces. The facility has a capacity of 8 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.2</p> <p>Quality Review completed on 03/02/23</p>			{K 000}			

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.