An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475.

Survey Date: 02/28/18

Facility Number: 000974
Provider Number: 15G460
AIM Number: 100244830

At this Emergency Preparedness survey, Dungarvin Indiana, LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475

The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8.

Quality Review completed on 03/06/18 - DA

The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:

Based on record review and interview, the facility failed to develop an emergency preparedness program in accordance with 42 CFR 483.475 that includes the following elements:

a) An Emergency Plan
b) Policies and Procedures
c) A Communication Plan

The Dungarvin Emergency Plan policy was in place in the Emergency Binder at the site with accurate information about what to do in various emergencies, however, the form was not dated to indicate the last time it was completed on 03/30/2018.
d) Training and Testing
This deficient practice could affect all occupants.

Findings include:

Based on record review with the Lead Direct Support Professional on 02/28/18 between 1:30 a.m. and 2:18 a.m., no emergency preparedness documentation was available to review. Based on interview at the time of record review, the Lead Direct Support Professional confirmed no such documentation was available for review.

All Program Director/QIDPs and Area Directors attended the INARF Professional Development Training: Life Safety and Emergency Preparedness in Group Homes presented by Chris Greeney on 1/24/2018. The Area Directors have developed a committee to revise the current emergency plans to address all requirements of the Emergency Preparedness standards as presented in the training. At this time, the Program Director/QIDP will review the current emergency plan in place, ensure it is still accurate, dated, and has a supplemental page identifying the needs of the individuals currently residing at the facility in case of emergency. As soon as the revised plan is completed by the Area Directors and approved, it will be rolled out with training to all facility staff. The Lead DSP of this facility will be trained on all of the documents maintained in the Emergency Binder in order to be fully prepared to provide the documents requested by any state or federal surveyor.
A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j)

Survey Date: 02/28/18

Facility Number: 000974
Provider Number: 15G460
AIM Number: 100244830

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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, Existing Residential Board and Care Occupancies.

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 6 at the time of this survey.

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 1.3.

Quality Review completed on 03/06/18 - DA

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**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

**K S100**
- Bldg. 02

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**K 0000**
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.

Based on observation and interview, the facility failed to maintain latching hardware on 1 of 6 corridor doors in accordance with 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect all occupants.

Findings include:

Based on observation with the Lead Direct Support Professional on 02/28/18 at 2:01 p.m., bedroom #2 corridor door contained latching hardware. The door had a twelve inch crack near the latch and the latch was loose. Based on interview at the time of observation, the Lead Direct Support Professional confirmed the corridor does not always latch when fire drills were performed.

K S100

The door and the latch for bedroom #2 will be repaired by maintenance. All facility staff will be trained on the importance of reporting any door that does not fully latch during fire evacuation drills to the PRogram Director and to Maintenance for immediate repair.

Going forward, all staff are required to report any non-functioning doors or latches during fire evacuation drills. This will be reported on a Maintenance request form, and all Maintenance requests are tracked through the central office so that the Program Director and Area Director will be able to monitor the status of each pending work order for timely completion.

K S222

NFPA 101

Egress Doors

Egress Doors

2012 EXISTING (Prompt)

Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against
### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 02  
**Date Survey Completed:** 02/28/2018

**Name of Provider or Supplier:** DUNGARVIN INDIANA LLC  
**Address:** 55693 ASH RD, OSCEOLA, IN 46561

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Regulatory or LSC Identifying Information</th>
<th>(X7) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K</td>
<td>S222</td>
<td></td>
<td>Based on observation and interview, the facility failed to ensure 1 of 6 client rooms was arranged such that staff can rescue clients in an emergency if the rooms become locked. This deficient practice could affect at least 1 client. Findings include: We will either locate the key for the handle lock for bathroom #3 or we will replace the handle with one with a new key that will be kept in a secure location in the event that someone would be locked in the room and need assistance. The Program Director, Lead DSP, and Maintenance staff are being retrained on this standard so that they can monitor that all doors with the capability of being locked with a client inside the room have a key available to staff in the case of emergency. All facility staff will also be trained on this expectation and the requirement that they report immediately if these keys cannot be found.</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>S253</td>
<td></td>
<td>Based on observation with the Lead Direct Support Professional on 02/28/18 at 1:56 p.m., bathroom #3 door had a lock on the handle. Based on interview at the time of observation, the Lead Direct Support Professional was unable to provide a key to unlock the door.</td>
<td></td>
</tr>
</tbody>
</table>

**Regulatory or LSC Identifying Information:**  
- **NFPA 101 Number of Exits - Patient Sleeping and Non-SI**
Number of Exits - Patient Sleeping and Non-Sleeping Rooms

2012 EXISTING (Prompt)

Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside.

Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following:

1. It shall be a 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.

2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape.

3. It shall be 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 square feet. The width shall be not less than 20 inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable where one of the following criteria are met:

   a. The window shall be within 20 feet of finished ground level.
   b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.
c. The window or door shall open onto an exterior balcony.

4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria:
   a. The window well allows the window to be fully openable.
   b. The window is not less than 9 square feet with a length and width of not less than 36 inches.
   c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following:
      1. The ladder or steps do not extend more than 6 inches into the well.
      2. The ladder or steps are not obstructed by the window.

5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room.
   a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.
   b. Existing approved means of escape shall be permitted to continue to be used. 33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4

Based on observation and interview, the facility failed to ensure 3 of 6 clients sleeping rooms was provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary escape from each sleeping room with 33.2.2.3.1, 33.2.2.2, 33.2.2.3.1 through 33.2.2.3.4.

All client sleeping rooms have been rearranged in order to ensure unobstructed access to a secondary means of escape. All facility staff will be retrained on the
Findings include:

Based on observation with the Lead Direct Support Professional on 02/28/18 between 1:52 p.m. and 1:56 p.m., the following was discovered:

a) bedroom #6 secondary means of escape had a suit case, chair, and other personal items in front of the window
b) bedroom #5 secondary means of escape had a chair in front of the window
c) bedroom #3 secondary means of escape had a dresser in front of the window

Based on interview at the time of each observation, the Lead Direct Support Professional acknowledged each aforementioned condition and confirmed the means of escape were obstructed.

The latches for client rooms #5 and #6 are required to swing in the direction of egress travel and 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.

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

Based on observation and interview, the facility importance of maintaining this access at all times and their responsibility to redirect when an individual wants to rearrange their sleeping room in such a way that the furniture will block this access. Going forward, the Lead DSP and Program Director/QID are responsible to monitor that the secondary escape route in each bedroom is unobstructed during weekly inspections of the home. Maintenance staff are also responsible to monitor for this during monthly visits and the Area Director is responsible to ensure compliance during quarterly site visits.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th><strong>IDENTIFICATION NUMBER</strong></th>
<th><strong>DATE SURVEY COMPLETED</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>15G460</td>
<td>02/28/2018</td>
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</tbody>
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<tr>
<th><strong>NAME OF PROVIDER OR SUPPLIER</strong></th>
<th><strong>STREET ADDRESS, CITY, STATE, ZIP CODE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>DUNGARVIN INDIANA LLC</td>
<td>55693 ASH RD OSCEOLA, IN 46561</td>
</tr>
</tbody>
</table>

### Summary Statement of Deficiencies

**ID**: K S511  
**Prefix**: NFPA 101  
**Tag**: Utilities - Gas and Electric  
**Bldg.**: 02


Based on observation and interview, the facility failed to ensure 2 of 2 power cords was not used as a substitute for fixed wiring according to 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2

The surge protector plugged into another surge protector was removed immediately. If additional wiring is necessary at the dining room computer desk, this will be ordered to be installed through maintenance. All facility staff will be retrained on this standard and the importance of not using power cords as a substitute for fixed wiring.

### Deficiency

Failed to ensure 2 of 6 client room doors positively latched into the frame. This deficient practice could affect all occupants.

**Findings include:**

- Based on observation with the Lead Direct Support Professional on 02/28/18 at 1:52 p.m. then again at 1:53 p.m., bedroom #6 failed to latch into the frame when tested. Then again, bedroom #5 failed to latch into the frame when tested. Based on interview at the time of each observation, the Lead Direct Support Professional confirmed the corridor doors failed to latch.

- #6 are being repaired by Maintenance. All facility staff will be trained on the importance of reporting any door that does not fully latch during fire evacuation drills to the Program Director and to Maintenance for immediate repair.

- Going forward, all staff are required to report any non-functioning doors or latches during fire evacuation drills. This will be reported on a Maintenance request form, and all Maintenance requests are tracked through the central office so that the Program Director and Area Director will be able to monitor the status of each pending work order for timely completion.

**Correction:**

- Maintenance. All facility staff will be trained on the importance of reporting any door that does not fully latch during fire evacuation drills to the Program Director and to Maintenance for immediate repair.

**Completion Date:** 03/30/2018
Findings include:

Based on observation with the Lead Direct Support Professional on 02/28/18 at 1:44 p.m., a surge protector was powering another surge protector which was powering computer equipment in the Dining room. Based on interview at the time of observation, the Lead Direct Support Professional was unaware of the situation and acknowledged the interconnected surge protectors.

Going forward, the Lead DSP and Program Director/QIDP are responsible to ensure appropriate usage of surge protectors in the home through the Site Risk Management Checklist. Maintenance Staff are also aware of this standard and are to monitor for issues monthly. The Area Director is also responsible to check for this during quarterly site visits.