STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G520	A. BUILDING -- B. WING	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	336 W 56TH AVENUE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 01/27/25 Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245230 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 conducted on 01/30/25	E 0000		
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Plan (EP) at least every two years in accordance with 42 CFR 483.475(a). This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., the facility failed to review and	E 0004	**The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an**	02/13/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annmarie Fanning	Area Director	02/26/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	update the EP every two years. The latest EP review and update was documented as April 8, 2021. The plan failed to have updated information regarding policies and procedures, contact information, and other elements affecting emergency preparedness. The Program Director stated she was currently working on reviewing and revising the plan. This finding was reviewed with the Program Director during the exit conference.		**emergency preparedness plan that must be [reviewed] and updated at least every 2 years.** **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics: The QIDP was trained on the specifics to be included within the Emergency Action and Communication Plan, on 02/04/2025. The QIDP will ensure updated Emergency Plan is in the facility site by 02/07/2025.The QIDP will ensure that the Emergency Plan book is regularly audited and contains all required elements of the emergency preparedness plan.The Quality Assurance Manager and Area Manager will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the plan includes a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.All facility staff to receive training on 02/07/2025, on the most recent Emergency Action and Communication Plan and the Emergency Plan D-01b policy and procedure. Documentation of training to be placed in**	

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			Emergency Plan binder and uploaded with this survey.<u>How facility will identify other residents potentially affected & what measures taken:</u>All residents potentially are affected, and corrective measures address the needs of all clients.During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff on the location of the Emergency plan as well as various elements of the Site-Specific Emergency Plan and the Emergency policies for staff to demonstrate continued competency. These visits are scheduled to take place 4 times per month 2 months and then monthly after that.Going forward, the QIDP is responsible to ensure that the emergency preparedness program is readily available at the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that all facility staff review the plan at staff meetings every other month to ensure ongoing comprehension and competency.Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director	

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E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Policies and Procedures at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., the facility failed to review and update the Emergency Preparedness Policies and Procedures every two years. The latest Emergency Preparedness Policies and Procedures review and update was documented as April 8, 2021. The plan failed to have updated information regarding policies and procedures, contact information, and other elements affecting emergency preparedness. The Program Director stated she was currently working on reviewing and revising the plan. This finding was reviewed with the Program Director during the exit conference.	E 0013	**Development of EP Policies and Procedures CFR(s): 483.475(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.** **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics:** **Dungarvin's Emergency Plan Policy and Procedure, Policy D-01b, was most recently revised on 08/14/2024. A current copy is submitted with this plan of correction. QIDP to ensure the current version is filed at the site by 02/07/2025 within the Life Safety Binder.** **All facility staff to receive training on 02/07/2025, on the most recent Emergency Action and Communication Plan and**	02/13/2025

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			the Emergency Plan D-01b policy and procedure. Documentation of training to be placed in Emergency Plan binder and uploaded with this survey. **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **The Quality Assurance Manager and Area Manager monitor the Emergency Plan Life Safety Binders monthly to ensure that all required components are current, present, and filed always.** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.1 Subsistence Needs for Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies	E 0015	**Subsistence Needs for Staff and Patients CFR(s): 483.475(b)**	02/13/2025

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	and procedures include at a minimum, (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., the emergency preparedness plan failed to address sewage and waste disposal whether they evacuate or shelter in place. The Program Director stated she was currently working on reviewing and revising the plan. This finding was reviewed with the Program Director during the exit conference.		**(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years.** **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621, will be fully implemented, including the following specifics:** **Dungarvin's Policy and Procedure for Emergency Situations (Policy D-01b, revised 08/14/2024) is attached for review and verification purposes. The policy outlines the provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: food, water, medical, and pharmaceutical supplies, alternate sources of energy to maintain - temperatures to protect resident health and safety and for the safe and sanitary storage of provisions;**	

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			emergency lighting; sewage and waste disposal. **Program Director/QIDP placed in the emergency book at the facility site 02/07/2025, Dungarvin's Policy and Procedure for Emergency Situations (Policy D-01b, revised 08/14/2024).** **All facility staff to receive training on 02/07/2025, on the most recent Emergency Action and Communication Plan and the Emergency Plan D-01b policy and procedure.** **Documentation of training to be placed in Emergency Plan binder and uploaded with this survey.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Program Director/QIDP will ensure copies of the policy are placed in the emergency book at the facility site on 02/07/2025, and whenever updates occur to the policy.** **Persons responsible: Program**	

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E 0025 Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., no policies and procedures which include the development of arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients was available for review. The Program Director stated she was currently working on reviewing and revising the plan. This finding was reviewed with the Program Director during the exit conference.	E 0025	**Director/QIDP, Quality Assurance Manager, Area Manager, Area Director** **Arrangement with Other Facilities CFR(s): 483.475(b)(7)** **[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.** **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621, will be fully implemented, including the following specifics:** **Dungarvin's Policy and Procedure for Emergency Situations (Policy D-01b, revised 08/14/2024) is attached for review and verification**	02/13/2025

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			purposes. The policy outlines the procedures and development of arrangements with other ICF/IDD facilities and other providers to receive residents in the event of limitation or cessation of operations to maintain the continuity of services to clients. **Program Director/QIDP placed in the emergency book at the facility site 02/07/2025, Dungarvin's Policy and Procedure for Emergency Situations (Policy D-01b, revised 08/14/2024).** **All facility staff to receive training on 02/07/2025, on the most recent Emergency Action and Communication Plan and the Emergency Plan D-01b policy and procedure.** **Documentation of training to be placed in Emergency Plan binder and uploaded with this survey.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:**	

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			Program Director/QIDP will ensure copies of the policy are placed in the emergency book at the facility site on 02/07/2025, and whenever updates occur to the policy. **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to review and update the Emergency Preparedness Communication Plan at least every two years in accordance with 42 CFR 483.475(c). This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., the facility failed to review and update the Emergency Preparedness Communication Plan every two years. The latest Emergency Preparedness Communication Plan review and update was documented as April 8, 2021. The plan failed to have updated information regarding policies and procedures, contact information, and other elements affecting emergency preparedness. The Program Director stated she was currently working on reviewing and revising the plan. This finding was reviewed with the Program	E 0029	**Development of Communication Plan CFR(s): 483.475(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years.** **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics:** **Dungarvin's Emergency Plan Policy and Procedure, Policy D-01b, was most recently revised on 08/14/2024. A current copy is submitted with this plan of correction. QIDP to ensure**	02/13/2025

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	Director during the exit conference.		**the current version is filed at the site by 02/07/2025 within the Life Safety Binder.** **All facility staff to receive training on 02/07/2025, on the most recent Emergency Action and Communication Plan and the Emergency Plan D-01b policy and procedure. Documentation of training to be placed in Emergency Plan binder and uploaded with this survey.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **The Quality Assurance Manager and Area Manager monitor the Emergency Plan Life Safety Binders monthly to ensure that all required components are current, present, and filed always.** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	

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E 0032 Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the Emergency Preparedness Communication Plan includes (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., the facility failed to provide documentation addressing primary and alternate means of communication within the Emergency Preparedness Communication Plan. The Program Director stated she was currently working on reviewing and revising the plan. This finding was reviewed with the Program Director during the exit conference.	E 0032	**Primary/Alternate Means for Communication [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years.** **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics:** **The QIDP was trained on 2/4/2025 to ensure the Emergency Preparedness Plan (EPP) addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility can provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3).** **Dungarvin's Policy and Procedure for Emergency Situations (Policy D-01b, revised 8/14/2024) and the site**	02/13/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			Emergency Action and Communication Plan are attached for review and verification purposes. Section G of the Emergency plan D-01b, outlines a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. **QIDP will ensure that the Emergency Plan book is audited and contains all required elements of the emergency preparedness plan.** **Facility staff were trained on the correct location of the binder and on the contents of the Emergency Plan on 02/07/2025.** **Copies of the Emergency Plan D-01b (revised 8/14/2024), Site and client specific Emergency Action & Communication Plan and staff training are uploaded with this survey.** **How facility will identify other residents potentially affected &**	

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			what measures taken: **All residents potentially are affected, and corrective measures address the needs of all clients.** **During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff on the location of the Emergency plan as well as various elements of the Site-Specific Emergency Plan and the Emergency policies for staff to demonstrate continued competency. These visits are scheduled to take place 4 times per month 2 months and then monthly after that.** **Going forward, the QIDP is responsible to ensure that the emergency preparedness program is readily available at the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that all facility staff review the plan at staff meetings every other month to ensure ongoing comprehension and competency.** **Persons responsible: Program Director/QIDP, Area Manager, Maintenance Manager, Area Director**	

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	15G520	A. BUILDING -- B. WING	01/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	336 W 56TH AVENUE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and update the Emergency Preparedness Training and Testing Program at least every 2 years in accordance with 42 CFR 483.475(d). This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., the facility failed to review and update the Emergency Preparedness Training and Testing Program every two years. The latest Emergency Preparedness Training and Testing Program review and update was documented as April 8, 2021. The plan failed to have updated information regarding policies and procedures, contact information, and other elements affecting emergency preparedness. The Program Director stated she was currently working on reviewing and revising the plan. This finding was reviewed with the Program Director during the exit conference.	E 0036	**EP Training and Testing CFR(s): 483.475(d) CF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).** **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics:** **Dungarvin's Emergency Plan Policy and Procedure, Policy D-01b, was most recently**	02/13/2025

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			revised on 08/14/2024. A current copy is submitted with this plan of correction. QIDP to ensure the current version is filed at the site by 02/07/2025 within the Life Safety Binder. **All facility staff to receive training on 02/07/2025, on the most recent Emergency Action and Communication Plan and the Emergency Plan D-01b policy and procedure. Documentation of training to be placed in Emergency Plan binder and uploaded with this survey.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **The Quality Assurance Manager and Area Manager monitor the Emergency Plan Life Safety Binders monthly to ensure that all required components are current, present, and filed always.** **Persons responsible: Program Director/QIDP, Quality**	

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			Assurance Manager, Area Manager, Area Director	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to provide documentation of conducting an annual emergency preparedness exercises to test the emergency plan, in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., the facility failed to provide documentation of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency, additionally no documentation was provided of an additional annual exercise. Based on interview at the time of record review, the Program Director stated she was not able to locate documentation of any exercises. This finding was reviewed with the Program Director during the exit conference.	E 0039	**EP Testing Requirements CFR(s): 483.475(d)(2) The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (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 full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A**	02/13/2025

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			mock disaster drill; or (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. (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. **<u>Corrective action for resident(s) found to have been affected</u>** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics:** **The facility staff, including the QIDP will review this finding and were trained on 02/07/2025 on the expectations regarding frequency and documentation of exercises to test the emergency plan annually and to place the training documentation into the Emergency Plan binder, as the facility training occurs.** **The facility staff will complete their exercise of a "facility-based functional**	

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K 0000 Bldg. 02			**exercise" to test the emergency plan on 02/07/2025. Copies of the facility-based functional exercise are uploaded with this survey.** **A table-top exercise was also completed last on 12/20/2023 and wasn't available in the Life Safety Binder at the time of the survey. It is uploaded here for reference and is now placed into the Life Safety Binder at the facility.** **-** **<u>How facility will identify other residents potentially affected & 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>:** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	

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	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in Accordance with 42 CFR 483.470(j). Survey Date: 01/27/25 Facility Number: 001034 Provider Number: 15G520 AIM Number: 100245230 At this Life Safety Code survey, 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. This one-story facility with a basement was fully sprinklered with heat detection in the attic area. This facility has a fire alarm system with hard wired smoke detectors in client sleeping rooms, the corridors, and common living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey. 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 .72. Quality Review conducted on 01/30/25	K 0000		
K S100 Bldg. 02	NFPA 101 General Requirements - Other Based on record review, observation, and interview; the facility failed to ensure 3 of 3 portable fire extinguishers located in the facility	K S100	**The facility failed to ensure 3 of 3 portable fire extinguishers located in the facility were**	02/13/2025

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	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 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 demonstrating that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., a document titled: "Fire Extinguisher Inspection List" 4 fire extinguishers were not tested and 3 were tested and none failed. Based on observation and interview with the Program Director on 01/27/25 between 1:57 p.m. and 2:35 p.m., 3 fire extinguishers in the facility were observed with inspection tags indicating an annual inspection had been completed on 10/4/24 and were dated and initialed on 10/4/24. No other monthly inspections were indicated on the tags or		**inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection.** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics:** **The QIDP was trained on 2/4/2025 to ensure the fire extinguisher tags are documented to include date and initials monthly by the person completing the fire extinguisher inspections. Maintenance Manager stated that the maintenance department will ensure the fire extinguishers are properly checked monthly and accurately documented going forward.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:**	

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	other documentation. Based on interview at the time of observation, the Program Director stated she had completed the inspection on 10/4/24 and stated she had not completed monthly inspections since 10/4/24. This finding was reviewed with the Program Director during the exit conference.		**A monitoring system is in place and delegated to our Quality Assurance Coordinator, to monitor compliance of the facility, including a look behind check and verify inspection documentation on the fire extinguisher tags, at the site during monthly visits. Area Manager and Area Director to further verify with a second look behind during regular site visits.** **Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director, Maintenance Manager**	
K S345 Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review, observation, and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections	K S345	**K0345** **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.**	03/07/2025

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	15G520	A. BUILDING 02 B. WING	01/27/2025

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	shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all staff and clients. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months. Based on interview at the time of record review, the Program Director provided a monthly checklist of tasks completed by the facility maintenance but there was no documentation of a semi-annual visual inspection of the fire alarm system. This finding was reviewed with the Program Director during the exit conference.		**No documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months. Based on interview at the time of record review, the Program Director provided a monthly checklist of tasks completed by the facility maintenance but there was no documentation of a semi-annual visual inspection of the fire alarm system.** Corrective action for resident(s) found to have been affected All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics: **The QIDP was trained on 2/4/2025 to ensure all inspection documentation is placed into the Life Safety Binder upon completion. Quality Assurance Manager will see that copies are taken to the facility of any inspections as they are performed.** **An annual test and inspection of the fire alarm system was conducted by contracted vendor on 6/04/2024; however, no documentation was available in the Life Safety Binder at the time of the survey. In the future, the facility will ensure that all the fire alarm inspections are available**	

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			within the home. Copy of the 06/04/2024, Fire Alarm and Life Safety System Inspection Certificate is uploaded with this plan of correction for reference. **The vendor that Dungarvin uses for our inspections, does not conduct semi-annual, visual fire alarm inspections. The contracted vendor only completes annual test and inspections of the fire alarm systems. Our Maintenance Manager has requested going forward for semi-annual, visual fire alarm inspections to also be completed in addition to our annual test and inspection of the fire alarm system by our contracted vendor.** **This facility is scheduled to have its "Semi-annual, visual fire alarm inspection" on 3/7/2025. See uploaded email correspondence, reflecting scheduling with FSS Technologies for the inspection, to be completed on 3/7/2025.** How facility will identify other residents potentially affected & what measures taken: **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure**	

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			no recurrence: **A monitoring system is in place and delegated to our Quality Assurance Coordinator, to monitor compliance of the facility, including a look behind check and verify inspection documentation at the site during monthly visits, to include reviewing the annual and semi-annual, visual fire alarm inspection test of the fire alarm system was conducted by contracted vendor and that the documentation was placed in the Life Safety Binder at the Facility. Area Manager and Area Director to further verify with a second look behind during regular site visits, to check and verify inspection documentation at the site during monthly visits, to include reviewing the annual and semi-annual, visual fire alarm inspection test of the fire alarm system was conducted by contracted vendor and that the documentation was placed in the Life Safety Binder at the Facility.** **Semi-annual, visual fire alarm inspections were not previously scheduled with our vendor, FSS Technologies. We are scheduled to have completed on 3/7/2025 and will schedule ongoing hereafter, along with**	

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			the regularly scheduled annual inspections. Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director, Maintenance Manager	
K S353 Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system was tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., a document titled: "Wet Fire Sprinkler System Inspection Report" dated 01/06/25 was provided stating a quarterly	K S353	**K0353** **Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems 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. Facility failed to ensure 1 of 1 sprinkler system was tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected**	02/26/2025

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	inspection had been completed. A second document with the same title was dated 07/01/24 also stating a quarterly inspection had been completed. A third document dated 01/04/24 was provided stating an annual inspection had been completed; however, no documentation of a quarterly inspection was provided for the quarter prior to 7/1/2024 or the quarter prior to 1/6/2025. Based on interview at the time of record review the Program Director stated she was not able to provide any additional documentation of sprinkler system inspections. 2. Based on record review, observation, and interview; the facility failed to ensure the sprinkler system would function as required by conducting the sprinkler test at 20-years old. Section 33.2.3.5.8.10 of NFPA 101 requires the testing of a representative sample of fast-response sprinklers in accordance with Section 5.3.1.1.1.3 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. If the sample fails the test, all of the sprinklers represented by that sample shall be replaced. If the sprinklers pass the test, the test shall be repeated every ten years thereafter. This deficient practice could affect all clients and staff in the facility. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., no documentation of the 20-year test or subsequent 10-year test of a representative sample of sprinklers was available at the time of survey. Based on record review, on page 3 of 4 of the document titled: "Wet Fire Sprinkler System Inspection Report" dated 01/04/24, that indicated it was an annual inspection, states: "i. Have all QR		**quarterly to verify that they are free of physical damage. Facility failed to ensure the sprinkler system would function as required by conducting the sprinkler test at 20-years old. Section 33.2.3.5.8.10 of NFPA 101 requires the testing of a representative sample of fast-response sprinklers in accordance with Section 5.3.1.1.1.3 of NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. If the sample fails the test, all the sprinklers represented by that sample shall be replaced. If the sprinklers pass the test, the test shall be repeated every ten years thereafter.** Corrective action for resident(s) found to have been affected All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics: **The QIDP was trained on 2/4/2025 to ensure all inspection documentation is placed into the Life Safety Binder upon completion. Quality Assurance Manager will see that copies are taken to the facility of any inspections as they are performed. The Life Safety Binder did**	

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	15G520	A. BUILDING 02 B. WING	01/27/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	heads been replaced or a sample tested based on the appropriate interval?". A box is checked as NA on this line. The next line on the same document states: "Install or last sample test date". The form states "UNKNOWN" to this question. Based on observation with the Program Director on 01/27/25 between 1:57 p.m. and 2:35 p.m., a QR sprinkler head was observed with a stamped date of 2001. No evidence that the sprinklers had been tested or replaced in the last 20 years was available. The Program Director acknowledged the date on the sprinkler head and stated she was not aware of any testing or replacement of the sprinklers. These findings were reviewed with the Program Director during the exit conference.		**have documentation titled, "Wet Fire Sprinkler System Inspection Report" from 1/4/2024, 7/1/2024 and 1/6/2025. It was missing from the quarter of April 2024 and October 2024. The missing quarters of April 2024 and October 2024 "Wet Fire Sprinkler System Inspection Report" dated 4/19/2024 and 10/24/2024 were completed and are uploaded with this plan of correction for reference.** In the future, the facility will ensure that all inspections are available within the home. Copy of the Wet Fire Sprinkler System Inspection Report will be placed in the Life Safety book by the QIDP, by 02/07/2025. Regarding testing of a representative sample of fast-response sprinklers once the sprinklers in the system are 20 years old – Maintenance has a "Monthly Sprinkler System Inspection" form, that is placed within all facilities, with sprinkler systems. Maintenance department, reviews monthly, the sprinkler system in each facility that has sprinklers, and will list the date reviewed, VALVE Position, SEALED, LOCKED or Supervised, VALVES and GUAGES ACCESSABLE, WATER PRESSURE, GUAGES	

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	15G520	A. BUILDING 02 B. WING	01/27/2025

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			within CALIBRATION and list any relative comments. Form is attached for reference. Form is also at the facility for the monthly maintenance check and review. **VFP Fire Systems of South Bend, IN completed a sampling of this facility's sprinklers in August of 2023. The sampling was received on 8/11/2023 and the report date was completed on 8/17/2023. The laboratory test results, and test result summary page are uploaded for reference. A copy of the VFP Fire Systems sampling test results, from 8/11/2023, are placed into the Life Safety Binder at the facility on 2/26/2025. How facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence: **A monitoring system is in place and delegated to our Quality Assurance Coordinator, to monitor compliance of the facility, including a look behind**	

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			check and verify inspection documentation at the site during monthly visits. Area Manager and Area Director to further verify with a second look behind during regular site visits. Maintenance Manager to follow up to ensure Monthly Sprinkler System Inspections are completed at all facilities with sprinklers. **Maintenance Manager will ensure all inspection reports are given to facility managers, to be placed into Life Safety Binders at facility sites promptly for reference.** How facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director, Maintenance and Maintenance Manager	
K S511 Bldg. 02	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure wet locations were provided with ground fault circuit interrupter (GFCI) protection	K S511	**Utilities - Gas and Electric** **Equipment using gas or related gas piping complies with NFPA**	02/13/2025

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	against electric shock. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). 210.8(B)(5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation and interview with the Program Director on 01/27/25 between 1:57 p.m. and 2:35 p.m., an electric receptacle located within eighteen inches of the bathroom sink of the first resident sleeping room was not provided with GFCI protection. The bathroom electric receptacle was a standard non-GFCI type; however, a GFCI protected breaker for the receptacle was located in the circuit breaker panel located in the basement. When tested more than three times the electrical receptacle failed to trip the breaker. The receptacle was loosely attached in the junction box. Based on interview at the time of observation, the Program Director acknowledged the electrical receptacle appeared to be faulty. This finding was reviewed with the Program Director during the exit conference.		**54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. Facility failed to ensure wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock.** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey 2LT621 will be fully implemented, including the following specifics:** **The QIDP was trained on 2/4/2025 to ensure all maintenance requests are submitted timely.** **Area Director submitted a maintenance request on 2/4/25, for the following items to be repaired:** **An electric receptacle located within eighteen inches of the bathroom sink of the first resident sleeping room was not provided with GFCI protection.** **Maintenance completed repair on 2/ /24.** **The bathroom electric receptacle was a standard non-GFCI type; however, a GFCI protected breaker for the receptacle was in the circuit breaker panel located in the basement. When tested more**	

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			than three times the electrical receptacle failed to trip the breaker. The receptacle was loosely attached in the junction box. The electrical receptacle appeared to be faulty. Maintenance completed repair on 2/ /24. **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Going forward, the QIDP will monitor for safety areas throughout the facility and report any maintenance needs immediately. QIDP will also document this on the Site Risk Management form.** **Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director, Maintenance**	
K S741 Bldg. 02	NFPA 101 Smoking Regulations			

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	Based on record review and interview, the facility failed to provide documentation of a smoking policy or smoking regulations adopted by the administration of the facility in accordance with LSC 33.7.4. 33.7.4.1 states smoking regulations shall be adopted by the administration of board and care occupancies. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review and interview with the Program Director on 01/27/25 between 11:55 a.m. and 1:57 p.m., no documentation of a facility smoking policy was available for review. The Program Director stated "All group homes are non-smoking." The Program Director stated she was not able to locate any smoking policy. This finding was reviewed with the Program Director during the exit conference.	K S741	**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. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2. The facility failed to provide documentation of a smoking policy, or smoking regulations adopted by the administration of the facility in accordance with LSC 33.7.4.** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey 2LT621, will be fully implemented, including the following specifics:** **The QIDP was trained on 2/4/2025 to ensure Dungarvin's Policy and Procedure E-12, regarding Smoking and Non-Smoking Areas is placed in the Life Safety Binder at the facility site by 02/07/2025.** **All facility staff to receive training on 02/07/2025, of Dungarvin's Policy and Procedure E-12, regarding Smoking and Non-Smoking Areas. Copies of the training and policy E-12 to be placed in Life Safety binder and uploaded with this survey.** **How facility will identify other**	02/13/2025

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			residents potentially affected & what measures taken: **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Program Director/QIDP will ensure copies of the policy E-12, regarding Smoking, are placed in the emergency book at the facility site on 02/07/2025, and whenever updates occur to the policy.** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	