STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G452	A. BUILDING -- B. WING	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	52812 HIGHLAND DR SOUTH BEND, IN 46635

(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: 10/04/24 Facility Number: 000966 Provider Number: 15G452 AIM Number: 100244770 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 7. Quality Review completed on 10/07/24	E 0000		
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness	E 0037	**E 037** **Governing Body (Standard):** **The facility must do the following emergency preparedness policy and procedure training with all new and existing staff. Provide emergency preparedness training at least annually. Maintain documentation of all emergency preparedness**	10/15/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annmarie Fanning	Area Director	10/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on records review with the Direct Support Professional (DSP) on 10/04/24 between 12:03 p.m. and 12:44 p.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of record review, the DSP acknowledged the missing documentation and further stated that she remembers going over the EPP and being trained on it, however she was unaware where the documentation could be at as it wasn't in the life safety binder. The finding was reviewed with the DSP during the exit conference.		**training. Demonstrate staff knowledge of emergency procedures.** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey ID6DPT21 will be fully implemented, including the following specifics:** **All facility staff received training on 10/15/2024, regarding the most recent Emergency Preparedness policy and procedure. Documentation of training to be placed in Emergency Plan binder. Copy of training is uploaded 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, Area Manager, Area Director**	
E 0039	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements			

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	15G452	A. BUILDING -- B. WING	10/04/2024

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Bldg. --	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: (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. 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. (ii) Conduct an additional 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. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes 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. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support	E 0039	**On 10/24/2024, the facility met for an additional table-top exercise to review, and training occurred of an elopement and the procedure of a missing facility person in the community or from the site. An individual from the site has a plan in place for elopement and this was reviewed as well. Documentation from the staff training on 10/24/2024 was placed in the Life Safety Binder at the facility.** **E 039** **Governing Body (Standard): The facility must participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based, or a second full-scale exercise that is community-based or individual, facility-based or tabletop exercise that includes a group discussion led by a facility, using a narrate, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge and emergency plan.Corrective action for resident(s) found to have been affected:All parts of the POC for the survey**	10/24/2024

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	Professional (DSP) on 10/04/24 between 12:03 p.m. and 12:44 p.m., the following was not available for review: a) No 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. b) No documentation of an additional annual exercise of choice: a second full-scale exercise that is community-based, a facility-based functional exercise, a mock disaster drill, a tabletop exercise, or a workshop. Based on interview at the time of record review, the DSP acknowledged the lack of documentation and further stated that the group home does do emergency exercieses and are documented, however they were unaware where the documentation would be. This finding was reviewed with the DSP during the exit conference.		**ID6DPT21, will be fully implemented, including the following specifics:** **On 9/24/ 2024, a natural emergency event occurred at the facility and surrounding community area, of strong winds, power outages and local severe weather sirens throughout the surrounding area. The facility completed an emergency Tornado drill during the sirens sounding. The clients did not require to be evacuated. Copies of the tornado drills are attached for reference and placed in the Life Safety Binder at the facility as well. Staff have been reminded during 10/15/2024 training, that any drills need to be documented and available in the Life Safety Binder for reference.** **On 10/15/2024, staff met with their Program Director/QIDP and the Area Director for a complete training and review of the Community Based event that occurred on 9/24/2024, with discussion of what happened during the event along with ways to improve for future events. A table-top exercise was done to discuss the event, along with regards to a tornado and power outage. Training included the review of our Life Safety Binder, F-1 forms, Emergency Preparedness**	

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			Policy D-01b, along with the Emergency Community Action Plan for the facility. Documentation from the staff training on 10/15/2024 and are attached for reference and placed in the Life Safety Binder at the facility as well. <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. Quality Assurance Manager will review the Life Safety Binder at the facility monthly to assure drills are completed as scheduled and documentation is placed in the binder once finished, to follow up after the Program Director/QIDP completes tasks. Area Manager and Area Director will also review the Life Safety Binder minimally monthly upon their visits at the facility.Persons responsible: Program Director/QIDP, Area Manager, Quality Assurance Coordinator, Area Director	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 10/04/24	K 0000		

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	Facility Number: 000966 Provider Number: 15G452 AIM Number: 100244770 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 was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in common living areas with battery-smoke detectors in all client rooms. The facility has a capacity of eight and had a census of seven 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, could not be determined at this time because no F-1's were provided. LSC Chapter 32.2.1.2.2 states where such documentation is not furnished, the evacuation capability shall be classified as Impractical. Quality Review completed on 10/07/24			
K S100 Bldg. 01	NFPA 101 General Requirements - Other Based on record review and interview, the facility failed to provide 6 of 7 F-1 work sheets to the authority having jurisdiction to be able to determine an evacuation assistance score in accordance with LSC 33.2.1.2.2 which states that	K S100	**On 10/24/2024, F-1's was completed for the 4 of 7 individuals that were calculated incorrectly and placed into the Life Safety**	10/24/2024

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	facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional (DSP) on 10/04/24 between 12:03 p.m. and 12:44 p.m., documentation of F-1's were produced, however only one client had a fully documented F-1 sheet. Two other F-1 forms were produced, however they were not labeled to indicate which client they belonged to. Based on interview at the time of record review, the DSP confirmed that the forms were missing or incomplete. The finding was discussed with the DSP at exit conference.		**Binder at the facility. The updated F-1 forms are uploaded for reference.** **KS100** **Governing Body (Standard):** **The facility management shall furnish to the authority having jurisdiction where such documentation is not furnished; the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants. (failed to provide 6 of 7 F-1's)Corrective action for resident(s) found to have been affectedAll parts of the POC for the survey ID6DPT21 will be fully implemented, including the following specifics:** **On 10/15/2024, F-1's was completed for the 6 of 7 missing individuals and placed into the Life Safety Binder at the facility. In the future the QIDP, Area Manager and Area Director will assure timely completion of F-1's for all individuals in the home.** **All staff in the home were retrained on 10/15/2024, regarding the standard that F1 forms be provided to the surveyor upon opening a Life Safety survey, as well as the designated location of the worksheets. Copy of staff training and the F-1 forms are**	

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			uploaded 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.Measures or systemic changes facility put in place to ensure no recurrence:** **Going forward, it is the responsibility of the Program Director / QIDP to ensure the F-1 worksheets are completed and updated as necessary. The Program Director/QIDP is also responsible to ensure that the worksheets are present in the home and filed and organized in a designated location, in order to ensure that they are available for review by any agency management or any authorized regulatory agent.** **Persons responsible: Program Director/QIDP, Area Manager, Quality Assurance Coordinator, Area Director**	
K S300 Bldg. 01	NFPA 101 Protection - Other Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 3 of 3 battery operated smoke alarms in client rooms were complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public,	K S300	**K0300** **Governing Body (Standard): Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published**	10/15/2024

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	if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all clients, staff, and visitors. Findings include: During a tour of the facility with the Direct Support Professional (DSP) on 10/04/24 between 1:09 p.m. and 1:24 p.m., battery operated smoke alarms were observed in each sleeping room. During record review with the DSP between 12:03 p.m. and 12:44 p.m., documentation titled "Monthly Site Risk Management Checklist" showed that each month battery smoke detectors had been inspected, however documentation for the months between October 2023 and December 2023 could not be found during the survey. Based on interview at the time of record review, the DSP agreed there were single-station smoke alarms and acknowledged the lack of documentation. The finding was reviewed with the DSP during the exit conference.		**instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all clients, staff, and visitors.** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey ID6DPT21, will be fully implemented, including the following specifics:** **During record review, documentation titled "Monthly Site Risk Management Checklist" showed that each month battery smoke detectors had been inspected, however documentation for the months between October 2023 and December 2023 could not be found during the survey.** **The October 2023 through December 2023, Monthly Site Risk Management Checklists were pulled and placed into overflow at the beginning of 2024. The documents are out of overflow and placed back into the Life Safety Binder for the facility. Copies of the**	

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			October 2023 through December 2023 are uploaded for reference. **The house Lead was reminded to keep a rolling years' worth of documentation available in the Life Safety binder.** **<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>** **A monitoring system is in place and delegated to our Quality Assurance Coordinator, to monitor the Life Safety compliance of the facility, including a look behind check of this documentation during monthly visits. Area Manager and Area Director to further verify with a second look behind during regular site visits.** **Persons responsible: House Lead, Program Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director, Maintenance**	

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K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 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. 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 all occupants. Findings include: Based on record review from with the Direct Support Professional (DSP) between 12:03 p.m. and 12:44 p.m. on 10/04/24, no documentation for the smoke detector sensitivity has been tested within the past two years. Based on interview at the time of record review, the DSP acknowledged the missing documentation and further stated she does not know if that type of inspection has been done recently. The finding was discussed with the DSP at exit conference.	K S345	**FSS Technologies emailed on 10/24/2024 and stated: The fire panel at Highland is a conventional panel, which doesn't allow sensitivity testing. Attached is the install guide of the smoke detectors that state why there is no sensitivity.** **Documentation of the FSS sensitivity email from 10/24/2024 and the install guide of the smoke detectors, is attached for reference and is placed in the Life Safety Binder at the facility.** **K0345** **Governing Body (Standard): 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 Signaling Code. Records of system acceptance, maintenance and testing are readily available.Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey ID6DPT21, will be fully**	10/24/2024

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			implemented, including the following specifics: The fire alarm inspection, by FSS, was completed on 06/3/2024. FSS Technologies forward their Sensitivity Report that was completed on 6/3/2024. FSS reported our smoke detectors do not have sensitivity testing; due to the type of smoke detector they are. **Documentation of the FSS sensitivity report from 6/3/2024 is attached for reference and is placed in 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>** **A monitoring system is in place and delegated to our Quality Assurance Coordinator, to monitor the Life Safety compliance of the facility, including a look behind check of this documentation during monthly visits. Area Manager and Area Director to further verify with a second look behind during regular site visits.** **Persons responsible: Program**	

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K S359 Bldg. 01	NFPA 101 Sprinkler System - Installation Based on record review and interview, the facility failed to install a 1 of 1 approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. LSC 33.2.3.5.3 requires facilities with an impractical evacuation capability to be sprinklered in accordance with NFPA 13D. LSC 33.2.1.2.2 states that facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants. Findings include: Based record review with the Direct Support Professional (DSP) on 10/04/24 between 12:03 p.m. and 12:44 p.m., the facility was unable to provide the F1 worksheets used to rate the resident and determine the resident's overall need for assistance when requested for 6 of the 7 clients. Due to the lack of furnished F1 forms, the facility was classified as "Impractical" and was not provided with an approved, supervised automatic sprinkler system. Based on interview at the time of observation, the DSP acknowledged the aforementioned issue and further stated that she was unaware where the current F-1 forms could be located.	K S359	**Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director, Maintenance** **K0359** **Governing Body (Standard): All Impractical Evacuation Capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3.** **("impractical due to lack of F-1's)** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey will be fully implemented, including the following specifics:** **This citation states that the home was assessed as "impractical" due to the failure to provide F-1 worksheets. All staff in the home were retrained on 10/15/2024, regarding the standard that F-1 forms be provided to the surveyor upon opening a Life Safety survey, as well as the**	10/15/2024

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	15G452	A. BUILDING 01 B. WING	10/04/2024

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	The finding was discussed with the DSP at exit conference.		**designated location of the worksheets. Copies of the missing F-1 forms were placed in the Life Safety Binder at the facility on 10/15/2024.** **<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>** **Going forward, it is the responsibility of the Program Director / QIDP to ensure the F-1 worksheets are completed and updated as necessary. The Program Director/QIDP is also responsible to ensure that the worksheets are present in the home and filed and organized in a designated location, in order to ensure that they are available for review by any agency management or any authorized regulatory agent.** **Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director**	

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K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately all clients and staff. Findings include: Based on observation during a tour of the facility with the Direct Support Professional (DSP) on 10/04/24 between 1:09 p.m. and 1:24 p.m., two refrigerators (high power draw equipment) were plugged into and supplied power by a multi-plug adapter in the garage. Based on interview at the time of observation, the DSP confirmed the aforementioned issue and did confirm that the two refrigerators were plugged into a multi-plug adapter. The finding was discussed with the DSP at exit conference. 2. Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed	K S511	**K 0511** **Governing Body (Standard):** **The facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. The facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel.** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey ID6DPT21, will be fully implemented, including the following specifics:** **The power strip cord was removed by facility maintenance manager on 10/15/2024, and the refrigerators are now plugged into the wall outlet, picture provided for reference.** **A lock has been placed on the electrical panel by facility maintenance manager on 10/15/2024, picture provided for reference.** **Going forward, the Lead DSP and PD are to monitor that no extension cords are in use as a substitute for fixed wiring in**	10/15/2024

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	so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all clients and staff. Findings include: Based on observation with the Direct Support Professional (DSP) on 10/04/24 during a facility tour between 1:09 p.m. and 1:24 p.m., the main electrical panel for the home was located in the garage unlocked. When questioning staff on access of the garage, the DSP stated that all clients have access to the garage area as that is where they access food and other supplies that may be needed for them and don't need supervision. This leaves the electrical panel exposed and able to be accessed by unauthorized personnel. Based on interview at the time of observation, the DSP acknowledged the electrical panel not being able to be secured. The finding was discussed with the DSP at exit conference.		**the home on a monthly basis and document this on the Site Risk Management form and will report and safety related maintenance needs to maintenance immediately.** **<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>** **A monitoring system is in place and delegated to our Quality Assurance Coordinator, to monitor the Life Safety compliance of the facility, including a look behind check of this documentation 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 Manager, Area Manager, Area Director, maintenance.**	

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K S751 Bldg. 01	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Based on observation, record review, and interview the facility failed to ensure 1 of 1 sets of new curtains were in compliance with provisions of LSC 10.3.1., which states where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall meet the flame propagation performance criteria contained in NFPA701. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation during a tour of the facility with the Direct Support Professional (DSP) on 10/04/24 between 1:09 p.m. and 1:24 p.m., there was one set of window curtains within the employee desk area within the first living area which was near the front door. Based on record review between 12:03 p.m. and 12:44 p.m., the label on the curtains did dot provide the flame propagation performance criteria and no other documentation could be provided to show the flame propagation performance criteria. Based on interview at the time of the observation, the DSP stated that the window curtains were put up a few weeks prior to the survey and to their knowledge, the window curtains had not been treated. The finding was discussed with the DSP at exit conference.	K S751	**K0751** **Governing Body (Standard):** **Draperies, Curtains, and Loosely Hanging Fabrics and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with provisions of 10.3.1.** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey ID6DPT21, will be fully implemented, including the following specifics:** **There was one set of window curtains within the employee desk area within the first living area, which was near the front door. The label on the curtains did not provide the flame propagation performance criteria and no other documentation could be provided to show the flame propagation performance criteria.** **Maintenance manager provided documentation showing the fabric was treated with flame retardant on 1/08/2024. A picture of documentation is uploaded for reference and will be placed into the Life Safety Binder.**	10/25/2024

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			Facility staff reported to surveyor, that the curtains were put up a few weeks prior and it was unknown if they were treated. Facility staff Lead stated that they were purchased early in the year but could not remember when. Maintenance manager has ordered more Fabric Fire Protectant, to ensure that the specific curtains currently hung are protected. Maintenance manager reported his Fabric Fire Protectant is due to arrive on 10/23/2024 and he will go and apply the protectant, once receiving the order. This way it will be ensured that the curtains have the Fabric Fire Protection. **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:** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director, Maintenance**	

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