	D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 CO		(X3) DATE SURVEY  COMPLETED  12/20/2022		
	PROVIDER OR SUPPLIER		422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W 0000					
Bldg. 00		pre-determined full tate licensure survey.	W 0000		
	accordance with 460	5G479 244950 also reflect state findings in			
W 0104 Bldg. 00	policy, budget, and the facility.	dy must exercise general d operating direction over			
	sampled clients (#1, clients (#4, #5, #6, # failed to exercise ge	on and interview for 3 of 3 , #2 and #3), plus 5 additional #7 and #8), the governing body eneral policy, budget, and over the facility to ensure the epair.	W 0104	W 104 Governing Body (Standard) – governing body failed to exerce general policy, budget, and operating direction over the fa to ensure the home was in government.	cility
	Observations were of 3:40 pm to 5:45 pm 8:18 am. Clients #1 were present throug	conducted on 12/12/22 from and 12/13/22 from 6:28 am to ,#2, #3, #4, #5, #6, #7 and #8 hout the observation period.  de client #3's bed, the paint was all was not fully painted.		Corrective action for resident(s) found to have been affected All parts of the POC for the su with event ID C5YS11 will be simplemented, including the following specifics:  - All facility staff re-trained the importance of reporting all	d on

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: C5YS11 Facility ID: 000993 If continuation sheet Page 1 of 17

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G479	B. W	NG		12/20/	2022
		<u> </u>	1	CTDEET	ADDRESS CITY STATE ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL		
DUNGAE	RVIN INDIANA LLC				SAN CITY, IN 46360		
				WHOTH	, ar on i, ar <del>1</del> 0000		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	· ·	on the left side of the hallway,			maintenance concerns		
	the shower bar was	rust colored and deteriorating.			immediately via the Maintena		
	2) In the (1				Request forms. All maintenan	ce	
		ere was a freezer not plugged in.  In the drawers and bottom there			concerns reported are being	nina	
	was a black substar				addressed through deep clear	ning	
	was a black substat	ICC.			as well as the completion of		
	4) Leading into the kitchen the half door frame of the door was rough and missing pieces of wood.				needed repairs by the Maintenance department.		
					Maintenance department.  Lead DSP and QIDP at	r <u>o</u>	
	are door was rough	and missing pieces of wood.			responsible to note any broke		
	An interview with staff #4 was conducted on				items or maintenance needs	••	
	12/13/22 at 11:21 am. Staff #4 stated, "I don't				during daily and weekly		
	know what happened to the wall in [client #3's]				observations at the home. Lea	ad	
		sure why the curtain rod looks			DSP is to document concerns		
		use shower curtains.			monthly Site Risk Manageme		
	·	posed to take the freezer in the			Checklist. Maintenance		
	garage and get rid				Department is required to con	duct	
					a monthly inspection and note		
	An interview with	the Program Director (PD) was			needed repairs or safety cond		
		5/22 at 12:54 pm. The PD			QIDP visits several times per	week	
	•	should be clean. The half door			and is to report these concerr	is to	
		ld not be rough, it is not as			Maintenance as needed. Area		
		be. Maintenance did a cheap			Director is also to visit at leas		
	_	ent #3's] bedroom is from him			quarterly to ensure that conce		
		ainst the wall. The freezer in the			are being reported as needed		
	~ ~	iscarded. We are waiting for					
	•	k it up. We are not using it.			How facility will identify other		
		ive rusted, they should be			residents potentially affected	<u>&amp;</u> _	
	taken down."				what measures taken		
	An intervious with	the Area Director (AD) was			All residents potentially are	uroo	
		5/22 at 2:00 pm. The AD stated,			affected, and corrective meas address the needs of all clien		
		be kept in good condition and			address the needs of all clien	io.	
		ded. Paint should not be off			Measures or systemic change	76	
	_	rain rods in the shower should			facility put in place to ensure		
					recurrence	10	
	not be rusty. If the freezer in garage is not being used it needs to be removed. The wood around				Going forward, the QIDP is to		
		uld not be rough or dangerous			maintain a regular presence in		
	to anyone."	<i>6</i> <b>6</b>			home through scheduled and		
					unscheduled visits multiple tir	nes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 12/20/2022
	PROVIDER OR SUPPLIER	<u>I</u>	422 N	F ADDRESS, CITY, STATE, ZIP COD IARQUETTE TRAIL IGAN CITY, IN 46360	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG W 0226 Bldg. 00	9-3-1(a)  483.440(c)(4) INDIVIDUAL PROWithin 30 days affi		TAG	per week, to monitor for the or quality of the maintenance and cleanliness of the home. In addition, Maintenance is to to the home monthly for any concerns and the Area Direct to conduct look behind visits a verify that concerns are being reported appropriately and the staff demonstrate competence monitoring the cleanliness and safety of the home.	DATE  overall  nd  our  tor is  to  g  at  y in
	client, an individual Based on record recollents in the sample ensure client #1 had Plan (ISP) prepared within 30 days of a Findings include:  Client #1's record was pm. During the recollent and admitted to An interview with the conducted on 12/15 "The ISP should be admission." The PI meeting was held of approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved on 12/14/An interview with the conduction of the provided approved approved on 12/14/An interview with the conduction of the provided approved ap	view and interview for 1 of 3 e (#1), the facility failed to d an Individualized Support d, completed, and implemented dmission.  vas reviewed on 12/13/22 at 3:10 ord review, there was no ort Plan (ISP) to review. Client the group home on 10/28/22.  the Program Director (PD) was //22 at 12:54 pm. The PD stated, completed within 30 days of 0 indicated client #1's ISP in 11/29/22. The ISP was	W 0226	W 226 Individual Program Plan (State – Failed to ensure client #1 h Individualized Support Plan (I prepared, completed, and implemented within 30 days of admission.  Corrective action for resident found to have been affected All parts of the POC for the state with event ID C5YS11 will be implemented, including the following specifics:  The ISP for client #1 has be completed and entered into the client file. Further, the ISPs for other individuals residing at the facility have also been audite ensure completion and implementation.  The QIDP is being retrained this standard and on the	ad an ISP)  of  (s)  urvey fully  eeen ne or all ne d to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C5YS11 Facility ID: 000993

If continuation sheet Page 3 of 17

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

PRINTED: 02/02/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED.
		15G479	B. W	ING		12/20/	/2022
NAME OF I	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
DUNGAE	N/IN INIDIANA I I O				RQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC			MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG		h -	DATE
	in place."	completed within 30 days and			expectation that the ISP must developed and implemented for		
	in place.				newly admitted individual with		
	9-3-4(a)				the first 30 days of admission.		
					The QIDP is also being		
					retrained on the Dungarvin		
					Pre/Post Admission Checklist	in	
					place to assist the QIDP in		
					ensuring that all requirements		
					met before and immediately a	iter a	
					new admission.		
					How facility will identify other		
					residents potentially affected &	ζ.	
					what measures taken	_	
					All residents potentially are		
					affected, and corrective meas	ures	
					address the needs of all client	S.	
					Measures or systemic change	<u>s</u>	
					facility put in place to ensure r	10	
					recurrence		
					On a quarterly basis, file audit		
					are to be completed by the QI in conjunction with the Area	ן אט	
					Director to ensure compliance	with	
					this standard. A checklist for		
					items required within the first 3		
					days of admission is in place a		
					all Program Director/QIDPs ar		
					trained on this checklist.		
W 0227	483.440(c)(4)						
VV UZZI	INDIVIDUAL PRO	GRAM PLAN					
Bldg. 00		gram plan states the					
3	-	necessary to meet the					
	client's needs, as						
		ssessment required by					
	paragraph (c)(3) c						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

C5YS11

Facility ID: 000993

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		r í	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  12/20/2022	
	PROVIDER OR SUPPLIER		42	REET ADDRESS, CITY, STAT 2 MARQUETTE TRAIL ICHIGAN CITY, IN 4636	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	II PRE TA	PROVIDER'S PLA (EACH CORRECTIVE A CROSS-REFERENCED	IN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
	Based on interview sample clients (client ensure client #1's In included training prhis needs.  Findings include:  Client #1's record wpm.  Client #1's ISP (Indiated 11/29/22 did not be a stated).  An interview with the conducted on 12/15 stated, "Goals should days of admission. I goals."  An interview with the conducted on 12/16	and record review for 1 of 3 and #1), the facility failed to dividual Support Plan (ISP) ograms and goals to address are reviewed on 12/13/22 at 3:10 ividual Program Plan Summary) not include any goals.  The Program Director (PD) was /22 at 12:54 pm. The PD d be completed within 30 include #1] does not have the Area Director (AD) was /22 at 2:00 pm. The AD stated, place by the 30-day mark."	W 0227	M 227 Individual Progra - Facility failed to #1's Individual S included training goals to address  Corrective action found to have be All parts of the P with event ID C5 implemented, inc following specific All ICF/I-D retrained on the all ISPs must ou objectives neces client's needs, a CFA. Goals imp client A in conjuit completed CFA. Audit com individuals residit to ensure that ar are in place in the individual.  How facility will i residents potent what measures of All residents pote affected, and con address the nee  Measures or syst facility put in place recurrence On a quarterly b	support Plan (ISP) I programs and Is his needs.  In for resident(s) I programs and Is his needs.  In for resident(s) I programs and I program	01/20/2023

02/02/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G479 B. WING 12/20/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **422 MARQUETTE TRAIL DUNGARVIN INDIANA LLC** MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE in conjunction with the Area Director to ensure compliance with this standard. A simplified audit form was created to assist the QIDP in completing this audit and reviewing that all basic domains are addressed in the ISP. W 0249 483.440(d)(1) PROGRAM IMPLEMENTATION Bldg. 00 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and W 0249 W 249 01/20/2023 interview for 1 of 3 sampled clients (#3), the Program Implementation facility failed to implement client #3's goal to feed (Standard) - Facility failed to himself. implement client #3's goal to feed himself. Findings include: Corrective action for resident(s) Observation was conducted in the group home on found to have been affected 12/12/22 from 3:40 pm to 5:45 pm. All parts of the POC for the survey At 4:39 pm the Program Director (PD) asked the with event ID C5YS11 will be fully clients to go and wash their hands. Staff #1 and implemented, including the #2 were in the kitchen dishing out bowls of food following specifics: for the individuals. ·All facility staff retrained on At 4:49 pm the PD began feeding client #3 his dining risk plan and self feeding bowl of chicken and dumplings. The PD goal for client #3. stated,"[Client #3] can eat cold food himself but The QIDP, Nurse, Area not hot food." Director or other qualified At 5:05 pm the PD gave client #3 his bowl of fruit designated staff are responsible to

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(PD).

and let him feed himself. During the dinner meal

client #3 was fed his meal by the Program Director

Event ID:

C5YS11

Facility ID: 000993

If continuation sheet

conduct active treatment

observations at varying mealtimes

of the day to ensure that facility staff demonstrate competency on

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G479	B. W	ING	_	12/20/	2022
	PROVIDER OR SUPPLIER		<u> </u>	422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWNERS N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Client #3's record w	vas reviewed on 12/13/22 at 3:45			implementing the self feeding		
	pm.				goals at mealtimes. Initially the	ese	
	Client #3's Individu	al Support Plan (ISP) dated			observations will be conducted	d 4	
	5/26/22 indicated th	ne following: "[Client #3] will			times per week for the first two	0	
	eat using utensils. I	SP Program Name:			weeks. If competency is show	n in	
	Self-Feeding, Goal	or Service: 1. At mealtimes,			that time, observations may		
	Staff will provide [client #3] with utensils. 2.				reduce to 3 times per week for	r the	
	[Client #3] will eat using his utensils as the meal				next two weeks and then titrat		
	permits. 3. Staff will redirect [client #3] to use				2 times per week for two week		
	utensils and not fingers unless it is finger foods.				Any observed concerns will be		
	3. (sic) Staff will monitor [client #3] as he eats to				addressed through immediate		
	assure his safety and assure, he is using his				retraining and coaching.		
	utensils. 4. Staff will provide prompting as needed						
		e prompting first. 5. If [client					
		nen (sic) 1 physical prompts			How facility will identify other		
	1 1	sils during a meal he will not			residents potentially affected &	<u>&amp;</u>	
		nis goal. 6. [Client #3] will be			what measures taken		
	praised for all effor				All residents potentially are		
		licate client #3 needed to be			affected, and corrective meas		
	fed hot foods.				address the needs of all client	S.	
	An interview with t	he PD was conducted on			Measures or systemic change	ie.	
		m. The PD stated, "We have			facility put in place to ensure r		
	_	3], depending on what food he			recurrence	10_	
		im to prevent him from spilling			QIDP to maintain a very regula	ar	
		floor. So, we assist him with			presence in the facility in orde		
	eating properly."	,			monitor continuous active		
					treatment, coach staff on plan		
	An interview with t	he Area Director (AD) was			implementation and review sta		
		/22 at 2:00 pm. The AD			competency on providing activ		
	indicated she was a	ware staff are concerned about			treatment during family style		
	client #3 burning hi	mself if the food is hot. The			dining.		
	AD stated, "We nee	ed to make sure food is at a					
	safe temperature. I	f he needs to be fed, then it					
	should be in his pla	n."					
	9-3-4(a)						
W 0322	483.460(a)(3)						
	PHYSICIAN SER	VICES					

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Event ID:

C5YS11 Facility ID: 000993

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G479	B. WI	NG		12/20/2	2022
NAME OF I	DROVIDED OD GUDDI IEI			STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
	PROVIDER OR SUPPLIEI				ARQUETTE TRAIL		
DUNGA	RVIN INDIANA LLC			MICHIO	GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
Bldg. 00		R LSC IDENTIFYING INFORMATION provide or obtain preventive		TAG	BEITELENETY		DATE
Diag. 00	and general medi						
		view and interview for 1 of 3	$\mathbf{w}_0$	322	W 322		01/20/2023
	sampled clients (cli	ent #1), the facility failed to			Physician Services (Standard)	<u>)</u> -	
	ensure client #1 had	d a physical exam within 30			Facility failed to ensure client	#1	
	days of admission.				had a physical exam within 30	)	
					days of admission.		
	Findings include:				Compositive action for resident/	-\	
	Client #1's record v	vas reviewed on 12/13/22 at 3:10			Corrective action for resident(s	<u>s)</u>	
		xamination was available for			All parts of the POC for the su	rvev	
		vas admitted to the group home			with event ID C5YS11 will be	· ·	
	on 10/28/22.	& 1			implemented, including the	,	
					following specifics:		
	An interview with t	the Program Director (PD) was					
	conducted on 12/15	5/22 at 12:54 pm. The PD			·Client #1 saw his primary c	are	
	_	t world we would have the			physician on 1/9/2023.		
		in 30 days." The PD indicated			Documentation of the appoint		
		ndicated they would complete			will be placed in the medical fi		
	appointments prior	to admission.			·Facility nurse and QIDP are		
		1			being retrained on the Dungar		
		the Area Director (AD) was			Pre/Post Admission Checklist		
		6/22 at 2:00 pm. The AD stated,			place to assist the oversight to		
		be completed annually and Ve should have written proof			in ensuring that all requiremen		
	that annual was cor	-			are met before and immediate after a new admission, includi	-	
	linat annuar was cor	npieted.			obtaining proof of all required	ing	
	9-3-6(a)				medical		
					assessments/appointments.		
					<u>-</u>		
					_		
					How facility will identify other		
					residents potentially affected &	<u> </u>	
					what measures taken		
					All residents potentially are		
					affected, and corrective meas		
					address the needs of all client	ა.	
					Measures or systemic change	s	
					facility put in place to ensure r		

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Event ID:

C5YS11 Facility ID: 000993

If continuation sheet Page 8 of 17

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G479	B. WING		12/20/2022
DUNGAF	PROVIDER OR SUPPLIER		422 MA MICHIO	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
W 0323 Bldg. 00	physical examinat	/ICES rovide or obtain annual ions of each client that at a an evaluation of vision and		recurrence Going forward, the nurse and Program Director/QIDP will util the Pre/Post Admission Check in conjunction with the Master Medical Schedule to ensure the all required appointments are scheduled, completed, and documented in the Medical Fill within prescribed timeframes. team of Nurse, PD/QIDP, Med DSP and Lead DSP are to me weekly to review compliance wappointments, paperwork, and filling, as well as discussing the overall health and safety need the home.	klist nat  le The d eet with d
	Based on record rev sampled clients (cli- ensure client #1 had within 30 days of ad	riew and interview for 1 of 3 ent #1), the facility failed to 1 vision and hearing exams dmission.	W 0323	W 323 Physician Services (Standard) Facility failed to ensure client; had vision and hearing exams within 30 days of admission.	#1
	pm. No vision and available for review group home on 10/2			Corrective action for resident(s found to have been affected All parts of the POC for the su with event ID C5YS11 will be simplemented, including the following specifics:	ırvey
	conducted on 12/15	he Program Director (PD) was /22 at 12:54 pm. The PD world we would have the		·Client #1 had an eye appointment on 12/22/2022.	

appointments done in 30 days." The PD indicated

Documentation of the appointment

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G479	B. W	ING		12/20/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			RQUETTE TRAIL		
DUNGAR	RVIN INDIANA LLC	:	_		GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		ndicated they would complete			will be placed in the medical f		
	appointments prior	to admission.			·The referral for the audiolog	•	
	An interview with	the Area Director (AD) was			was requested from the PCP		
	An interview with the Area Director (AD) was conducted on 12/16/22 at 2:00 pm. The AD stated, "A hearing exam is completed within the first 30 days unless we have proof of prior visit and then				we are working to schedule at	uie	
					first available appointment.  ·Facility nurse and QIDP are	_	
					being retrained on the Dungar		
		ion exams are completed within			Pre/Post Admission Checklist		
		d then annually or as			place to assist the oversight to		
	recommended."				in ensuring that all requiremen		
					are met before and immediate		
	9-3-6(a)				after a new admission, includi	•	
	` ,				obtaining proof of all required	5	
					medical		
					assessments/appointments.		
					  -		
					_		
					How facility will identify other		
					residents potentially affected	<u>&amp;</u>	
					what measures taken		
					All residents potentially are		
					affected, and corrective meas		
					address the needs of all client	ts.	
					Measures or systemic change	es	
					facility put in place to ensure		
					recurrence	<u></u>	
					Going forward, the nurse and		
					Program Director/QIDP will ut	ilize	
					the Pre/Post Admission Chec		
					in conjunction with the Master		
					Medical Schedule to ensure the	nat	
					all required appointments are		
					scheduled, completed, and		
					documented in the Medical Fi		
					within prescribed timeframes.		
					team of Nurse, PD/QIDP, Med		
					DSP and Lead DSP are to me		
					weekly to review compliance		
					appointments, paperwork, and	d	

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Event ID:

C5YS11

Facility ID: 000993

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G479	B. W	NG		12/20/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ARQUETTE TRAIL		
DUNGAR	RVIN INDIANA LLC				GAN CITY, IN 46360		
			1		T		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
					filing, as well as discussing the overall health and safety need		
					the home.	3 01	
					the nome.		
W 0351	483.460(f)(1)						
	COMPREHENSIV	/E DENTAL DIAGNOSTIC					
Bldg. 00	SERVICE						
	Comprehensive d	ental diagnostic services					
	-	e extraoral and intraoral					
		g all diagnostic aids					
		erly evaluate the client's					
		than one month after					
	admission to the f						
		completed within twelve					
	months before add	view and interview for 1 of 3	w	251	W 351		01/20/2022
		ent #1), the facility failed to	I w c	351	Comprehensive Dental Diagno	octic	01/20/2023
		d a dental exam within 30 days			Service (Standard) - Facility fa		
	of admission.				to ensure client #1 had a dent		
					exam completed within 30 day		
	Findings include:				admission.		
	_						
	Client #1's record w	vas reviewed on 12/13/22 at 3:10			Corrective action for resident(s	<u>s)</u>	
	pm. No dental exar	n was available for review.			found to have been affected		
		tted to the group home on			All parts of the POC for the su	-	
	10/28/22.				with event ID C5YS11 will be	fully	
		1 D D: (75)			implemented, including the		
		he Program Director (PD) was			following specifics:		
		3/22 at 12:54 pm. The PD			·Client #1 has a dental		
	-	world we would have the			appointment re-scheduled on		
		in 30 days." The PD indicated dicated they would complete			2/15/23. He had an earlier appointment, but completely		
		to admission. The PD stated,			refused to allow the tech to sta	art	
		lental appointment scheduled			the exam and the appointmen		
		alked out of the appointment.			had to be rescheduled.		
		nent has been rescheduled to			·Facility nurse and QIDP are	<b>;</b>	
	February."				being retrained on the Dungar		
	-				Pre/Post Admission Checklist		
	An interview with t	he Area Director (AD) was			place to assist the oversight to		

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Event ID:

C5YS11 Facility ID: 000993 If continuation sheet Page 11 of 17

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

PRINTED: 02/02/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479				(X3) DATE SURVEY COMPLETED 12/20/2022	
	RVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	conducted on 12/16	/22 at 2:00 pm. The AD stated, uld be completed within the			in ensuring that all requirement are met before and immediate after a new admission, includir obtaining proof of all required medical assessments/appointments.  How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures the needs of all clients.  Measures or systemic change facility put in place to ensure in recurrence Going forward, the nurse and Program Director/QIDP will util the Pre/Post Admission Check in conjunction with the Master Medical Schedule to ensure the all required appointments are scheduled, completed, and documented in the Medical Fill within prescribed timeframes. It team of Nurse, PD/QIDP, Medical DSP and Lead DSP are to me weekly to review compliance wappointments, paperwork, and filing, as well as discussing the overall health and safety need the home.	ly ng ures s. so lize dist e The et vith	
W 0382	483.460(I)(2) DRUG STORAGE	E AND RECORDKEEPING					
Bldg. 00	The facility must k	eep all drugs and except when being					

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Event ID: C5YS11 Facility ID: 000993

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SUR	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETE	ED
		15G479	B. W	ING		12/20/202	22
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			ARQUETTE TRAIL		
DUNGAE	RVIN INDIANA LLC				GAN CITY, IN 46360		
D0110/11				Willoring			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE CO	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on and interview for 3 of 3	W (	)382	<u>W 382</u>		1/20/2023
		, #2 and #3) plus 4 additional			Drug Storage and Recordkee	oing_	
	· ·	and #8), the facility failed to			(Standard) - Facility failed to		
		nedications were stored in a			ensure clients' medications we	∍re	
	secure manner.				stored in a secure manner.		
	Findings include:				Corrective action for resident(	<u>s)</u>	
	01 1 1 12/12/22 5 (29)				found to have been affected		
		onducted on 12/13/22 from 6:28			All parts of the POC for the su	rvey	
		ents #1, #2, #3, #4, #5, #7 and #8			with event ID C5YS11 will be	fully	
		ghout the observation period.			implemented, including the		
		resent during observation.			following specifics:		
	Client #6 was on a	-			· All facility staff were		
		lication room door was			retrained on the expectation the		
	· ·	nedication cart was unlocked			all medications must be secur		
	1	cart lying on top of the cart.			in a locked cabinet at all times	l	
		bathroom assisting client #1			· QIDP and nurse will be		
		he cart was left unlocked until			responsible to verify that		
		m staff #3 stated, "The			medication is stored in a locke	I	
	medication cart is s	tored locked all the time."			cabinet during regular, freque	nt	
					visits in the home.		
		walked out of the medication			Staff who were respons	l l	
	_	edication cart unlocked with			to have locked the med cabine	et on	
		lying on top of the cart. Staff			the date of the observation	.	
		ner room and brought back			receiving employee counseling		
	client #4.				addition to the retraining for al		
	A into	ha Dua anoma Dina at - : (DD)			staff. Similarly, any staff found	ιο	
		the Program Director (PD) was			have left the medications		
		5/22 at 12:54 pm. The PD			unsecured during an observat		
		s should be stored in the cart and keys should be on			will receive corrective action a	nu/or	
	staff or hanging on				retraining in accordance with		
	starr or nanging on	KEY IAUK.			Dungarvin policy.		
	An interview with t	he Area Director (AD) was			How facility will identify other		
	conducted on 12/16	5/22 at 2:00 pm. The AD stated,			residents potentially affected 8	<u> </u>	
		d be stored in the locked			what measures taken		
	medication cart and	l narcotics double locked.			All residents potentially are		
	Keys should be kep	ot on staff or on the high shelf			affected, and corrective meas	ures	
	-	not accessible to individuals."			address the needs of all client	l l	

AND PLAN OF CORRECTION IDENTI		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/20/2022	
	PROVIDER OR SUPPLIER		422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL BAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
W 0383 Bldg. 00	Only authorized pothe keys to the drubased on observation sampled clients (#1, clients (#4, #5, #7 a ensure clients did not medication room keeps to be servation was compared to a servation was compared to the servat	on and interview for 3 of 3 #2 and #3) plus 4 additional and #8), the facility failed to be thave access to the eys.  Inducted on 12/13/22 from 6:28 ants #1, #2, #3, #4, #5, #7 and #8 hout the observation period.	W 0383	Measures or systemic change facility put in place to ensure recurrence All new employees are trained the policy on drug storage and transference as part of new storientation. All staff are require complete annual retraining on Medication Administration whi covers med storage. QIDP is to maintain a regular, frequent presence in the home and prodirect coaching and redirection any staff who leave the medicursecured. Nurse will also repany violations to the PD/QIDP follow up.  W 383  Drug Storage and Recordkeer (Standard) - Facility failed to ensure clients did not have act to the medication room keys.  Corrective action for resident(stound to have been affected) All parts of the POC for the sure with event ID C5YS11 will be implemented, including the following specifics:  All facility staff will be retrained on the expectation the keys to the medication from are to be sto securely where the clients do have access to them.	d on d aff ed to ch to c	

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Event ID:

C5YS11 Facility ID: 000993

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
15G479		B. WING 12/20			12/20/2	2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					RQUETTE TRAIL		
DUNGARVIN INDIANA LLC				MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	+	DATE
	6:48 am. At 6:48 am staff #3 stated, "The medication cart is stored locked all the time."				· QIDP and nurse will be		
	medication cart is s	tored locked all the time.			responsible to verify that keys		
	At 7:22 am staff #3 walked out of the medication			secured safely at all times duri regular, frequent visits in the		ing	
		edication cart unlocked with			home.	iii uic	
	_	lying on top of the cart. Staff			Staff who were respons	ible	
		ner room and brought back			to have secured the med roon		
	client #4.	S			keys on the date of the		
					observation receiving employe	ee	
	An interview with t	he Program Director (PD) was			counseling in addition to the		
		/22 at 12:54 pm. The PD			retraining for all staff. Similarly	/,	
	· · · · · · · · · · · · · · · · · · ·	s should be stored in the			any staff found to have left the	,	
		eart and keys should be on			med room keys unsecured du	ring	
	staff or hanging on	key rack."			an observation will receive		
					corrective action and/or retrain	ning	
	An interview with the Area Director (AD) was				in accordance with Dungarvin		
		/22 at 2:00 pm. The AD stated,			policy.		
		d be stored in the locked					
		narcotics double locked.			How facility will identify other	_	
		t on staff or on the high shelf			residents potentially affected 8	<u> </u>	
	in the dining room,	not accessible to individuals."			what measures taken		
	9-3-6(a)				All residents potentially are affected, and corrective meas	uraa	
	9-3-0(a)				address the needs of all client		
					address the needs of all client	.s.	
					Measures or systemic change	<u>s</u>	
					facility put in place to ensure r		
					<u>recurrence</u>		
					All new employees are trained	d on	
					the policy on drug storage and		
					transference as part of new st		
					orientation. All staff are require		
					complete annual retraining on		
					Medication Administration whi	1	
					covers med storage. QIDP is t	to	
					maintain a regular, frequent	l	
					presence in the home and pro		
					direct coaching and redirection		
					any staff who leave the med c		
				unsecured. Nurse will also rep	ort		

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/20/2022	
	PROVIDER OR SUPPLIEI		422 M	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL IGAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 3 of 3 sampled clients (clients #1, #2, and #3) plus 4 additional clients (clients #4, #5, #7 and #8), the facility failed to ensure the clients assisted with meal preparation and served themselves at dinner.		W 0488	any violations to the PD/QIDP follow up.  W 488  Dining Areas and Service (Standard) - Facility failed to ensure the clients assisted with meal preparation and served themselves t dinner.	01/20/2023	
	12/12/22 from 3:40 #3, #4, #5, #7 and # observation period. At 4:39 pm the Pro clients to go and we Staff #1 and #2 we bowls of food for c #8. Staff #1 and #2 and dumplings and for each client. At 4:49 pm staff #1 a bowl of fruit and gave each client at Clients #1, #2, #3, prompted to serve to  An interview with a 12/12/22 at 5:25 pm family style dining will snatch food."	gram Director (PD) asked the ash their hands. re in the kitchen dishing out lients #1, #2, #3, #4, #5, #7 and dished out a bowl of chicken another bowl of fruit cocktail and staff #2 served each client drink. Staff #1 and #2 then bowl of chicken and dumplings. #4, #5, #7 and #8 were not		Corrective action for resident(s found to have been affected All parts of the POC for the sur with event ID C5YS11 will be further implemented, including the following specifics:  All facility staff receiving re-training regarding the expectations of family style dinical at all meals as well as the importance of using all teaching opportunities during meal preparation, while eating at the table, and while cleaning up affix meal.  The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varyitimes of the day to ensure that facility staff demonstrate competency on promoting independence for all individuals while dining	vey ully ing g er a	

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

PRINTED: 02/02/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  12/20/2022		
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION FACH CORRECTION ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE	
				How facility will identify other residents potentially affected 8 what measures taken All residents potentially are affected, and corrective measures address the needs of all client  Measures or systemic change facility put in place to ensure recurrence All new employees are trained active treatment and family sty dining expectations in the ICF setting. QIDP is to maintain a regular, frequent presence in thome and provide direct coacl and redirection to any staff wh to follow policy and training. N will also report any violations to the PD/QIDP for follow up.	ures s. s_no l on yle -IDD the hing o fail urse		

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