STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G479	A. BUILDING -- B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	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	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: 01/09/23 Facility Number: 000993 Provider Number: 15G479 AIM Number: 100244950 At this Emergency Preparedness survey, Dungarvin Indiana LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 01/11/23	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Gichohi	Area Director	01/26/2023

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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	15G479	A. BUILDING -- B. WING	01/09/2023

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	§485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must			

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	15G479	A. BUILDING -- B. WING	01/09/2023

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	do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan (EPP) that was based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Program Director on 01/09/23 at 1:47 p.m., no documentation was available to show that the group home EPP was based on and included a documented facility-based and community-based	E 0006	E 006 Plan Based on All Hazards risk Assessment (Standard) – Failed to show that the group home EPP was based on and included a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS21 will be fully	02/09/2023

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	risk assessment, utilizing an all-hazards approach, including missing clients and included strategies for addressing emergency events identified by the risk assessment. Based on interview at the time of records review, the Program Director agreed paper work of a risk assessment could not be found. Findings were discussed with the Program Director at exit conference.		implemented, including the following specifics: • All Program Directors were retrained on the facility based and community based risk assessment in place at Dungarvin to assess risks and develop strategies for emergency events in the Emergency Plan. • Program Director is completing the facility-based and community-based risk assessment for the home. It will be made available with the other Emergency Plan documents in the Life Safety Binder at the home. 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 Area Director is developing a monitoring system in conjunction with the new Administrative Coordinator to monitor the Emergency Plan Binders monthly to ensure that all required components are current, present and filed at all times.	
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1)			

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	Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients 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 the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:			

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	(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, 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 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Program Director on 01/09/23 at 12:48 p.m., the provided plan did not address all components for subsistence needs for staff and clients. The items not addressed were sewage and waste disposal. Based on interview at the time of records review, the Program Director agreed the subsistence	E 0015	E 015 Subsistence Needs for Staff and Patients (Standard) – EPP did not address all components for subsistence needs for staff and clients. The items not addressed were sewage and waste disposal. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS21 will be fully implemented, including the following specifics: • Dungarvin's policy related to sheltering in place is being updated to specifically address the concerns of sewage and waste disposal to be considered when there is a need to shelter in place. Related forms, including the communication plan and facility specific emergency policy form are being revised to incorporate these considerations. • All facility staff to receive training	02/09/2023

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	needs for staff and clients was not complete. The finding was reviewed with the Program Director during the exit conference.		on the most recent policy and procedure. Documentation of training to be placed in Emergency Plan binder. 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 Area Director is developing a monitoring system in conjunction with the new Administrative Coordinator to monitor the Emergency Plan Binders monthly to ensure that all required components are current, present and filed at all times.	
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based			

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	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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of			

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	assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location	E 0018	E 018 Development of Communication Plan (Standard) – Facility EPP did not address procedures for tracking of staff and clients. Corrective action for resident(s) found to have been affected All parts of the POC for the survey	02/09/2023

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	in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants Findings Include: Based on review of the facility's EPP with the Program Director on 01/09/23 at 12:43 p.m., the plan provided did not address procedures for tracking of staff and clients. Based on interview at the time of records review, the Program Director confirmed that no documentation could be found for tracking staff and clients. The finding was reviewed with the Program Director during the exit conference.		with event ID C5YS21 will be fully implemented, including the following specifics: • Dungarvin Policy D-01b regarding Emergency Procedures addresses the procedures for tracking of staff and clients. The related forms are referenced in the policy and Program Director is to verify copies of these forms are included with the facility EPP in the Life Safety binder. • All Program Directors have been retrained on the purpose of the tracking forms and how to implement the tracking system according to Dungarvin policy and procedure. 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 Area Director is developing a monitoring system in conjunction with the new Administrative Coordinator to monitor the Emergency Plan Binders monthly to ensure that all required components, including the forms used to track staff and clients during an emergency are current, present and filed at all times.	

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E 0022 Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(6)(i), 441.184(b)(4), 482.15(b)(4), 483.475(b)(4), 483.73(b)(4), 485.625(b)(4), 485.68(b)(2), 485.727(b)(2), 485.920(b)(3), 491.12(b)(2), 494.62(b)(3) Policies/Procedures for Sheltering in Place §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. Based on record review and interview, the facility failed to ensure emergency preparedness plan	E 0022	E 022 Policies/Procedures for Sheltering	02/09/2023

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	(EPP) include a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Program Director on 01/09/23 at 12:40 p.m., the plan provided did not address procedures to shelter in place for clients, staff, and volunteers. Based on interview at the time of records review, the Program Director stated they were unable to find a policy for sheltering-in-place. Findings were discussed with the Program Director at exit conference.		in Place (Standard) – Facility EPP did not address procedures to shelter in place for clients, staff, and volunteers. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS21 will be fully implemented, including the following specifics: • Dungarvin Policy D-01b regarding Emergency Procedures addresses the procedures for sheltering in place for clients, staff, and volunteers. The policy is being updated to address the specific need to consider sewage and waste proedures when sheltering in place. • All facility staff being retrained on the Emergency Plan and the plan in the case of a need to shelter in place. 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 Area Director is developing a monitoring system in conjunction with the new Administrative Coordinator to monitor the Emergency Plan Binders monthly	

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			to ensure that all required components are current, present and filed at all times. There is an appendix to the policy which indicates where in the policy to locate the required elements. This is being placed in the binder to assist the staff and survey personnel during the survey process.	
E 0031 Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(2), 441.184(c)(2), 482.15(c)(2), 483.475(c)(2), 483.73(c)(2), 484.102(c)(2), 485.625(c)(2), 485.68(c)(2), 485.727(c)(2), 485.920(c)(2), 486.360(c)(2), 491.12(c)(2), 494.62(c)(2) Emergency Officials Contact Information §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(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 [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following:			

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	15G479	A. BUILDING -- B. WING	01/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) The State Licensing and Certification Agency (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c) (2). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 01/09/23 between 11:22 a.m. and 1:26 p.m. with the Program Director the emergency preparedness plan did not address the following items: 1) Federal, State, tribal, or local emergency preparedness staff, 2) The State Licensing and Certification agency 3) The Office of the State Long-Term Care Ombudsman Based on interview concurrent with record review	E 0031	E 031 Emergency Officials Contact Information (Standard) – EPP Communication Plan did not include Contact information for Federal, State, tribal, regional, or local emergency preparedness staff, the state licensing and certification agency, the office of the state long term care ombudsman. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS21 will be fully implemented, including the following specifics: • All Program Directors were retrained on the Emergency Plan and Communication Plan documents and all of the required elements per this standard.	02/09/2023

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	with the Program Director, it was stated this policy did not contain information concerning the aforementioned items above listed as 1, 2, and 3 listed above. Findings were discussed with the Program Director at exit conference.		• Program Director has revised the EPP Communication Plan for the facility and it will be made available with the other Emergency Plan documents in the Life Safety Binder at the home. • All facility staff to be trained on the updated EPP and EPP Communication Plan. 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 Area Director is developing a monitoring system in conjunction with the new Administrative Coordinator to monitor the Emergency Plan Binders monthly to ensure that all required components are current, present and filed at all times.	
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: 01/09/23 Facility Number: 000993	K 0000		

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	Provider Number: 15G479 AIM Number: 100244950 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 building with a basement, was determined to be not sprinklered. The facility has a monitored fire alarm system with hardwired smoke detection in corridors, in client sleeping rooms and all 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 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.61. Quality Review completed on 01/11/23			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic			

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	sprinkler system in accordance with 33.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 33.7.7 Based on observation and interview, the facility failed to ensure 1 of 4 client sleeping rooms were provided with a door which would self-close and latch securely in the door frame. This deficient practice could affect 2 of 8 clients. Findings include: Based on observation during a tour of the facility with the Program Director on 01/09/23 between 1:27 p.m. and 1:51 p.m., the door to client room #1 did not fully close and latch when tested. Upon interview at time of observation, the Program Director agreed that the door did not fully close nor latch when tested. Findings were discussed with the Program Director at exit conference.	K S363	K 0363 Corridor - Doors (Standard) – The door to client room #1 did not fully close and latch when tested. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS21 will be fully implemented, including the following specifics: • A Maintenance Request was filed immediately to repair the door that was not properly latching, and this has been repaired by Maintenance. • Maintenance Staff, Program Director, Lead DSP, and Administrative Coordinator will all receive retraining on the expectation that every bedroom must have a fire door that self-closes and latches securely during a fire. • All facility staff receiving retraining on filing maintenance requests and how to verify that all doors closed and latched properly during regular monthly fire drills. • Maintenance Personnel maintain responsibility for testing all fire doors during monthly site checks. The log is to be filled out on the monthly site inspection at each house. The Maintenance Director	02/09/2023

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			will be scanning the monthly site inspection to a shared drive each month so that copies can be printed and placed in the Life Safety binder at the home. • PD/QIDP, Lead DSP, Administrative Coordinator and Maintenance Director will receive retraining on their roles in monitoring compliance with this standard. 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 an Administrative Coordinator to monitor the Life Safety compliance of the facility, including a look behind check of safety checklist documentation during monthly visits. Area Director to further verify with a second look behind during regular site visits.	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric			

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	Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect all staff. Findings include: Based on observation with the Program Director on 01/09/23 between 1:27 p.m. and 1:52 p.m., the Laundry Room had a power strip used to power equipment, was not secured, and was dangling from the power cords. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Program Director agreed the power strip was dangling, not secured, and secured the powerstrip to the floor upon observation. This finding was reviewed with the Program Director during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 4 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for	K S511	K 0511 Utilities – Gas and Electric (Standard) – The Laundry Room had a power strip used to power equipment, was not secured, and was dangling from the power cords. Facility failed to ensure 1 of 4 wet locations were provided with GFCI protection against electric shock. There was one electric receptacle within five feet of the front bathroom sink that was not provided with GFCI protection. The laundry contained a power strip that was powering a high-powered appliance. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS21 will be fully implemented, including the following specifics: • The power strip was removed from the laundry room and the washer was plugged directly into the electrical outlet. • A GFCI outlet is being installed at the electric receptacle within five feet of the front bathroom sink. • All facility staff will review this finding. • Lead DSP and Program Director to be trained on the expectations regarding the use of power strips, the power supply for high-powered appliances, and the use of GFCI outlets.	02/09/2023

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	personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in		• These items are to be checked monthly on the Site Risk Management Checklist completed by the Lead DSP and reviewed by the Program Director • Maintenance staff to review this finding and to ensure that they are also checking for compliance with this standard during monthly site inspections. 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 Lead DSP and Program Director are responsible to note any concerns regarding this standard and communicate to the Mainenance Department any needed repairs. Maintenance is to tour the house monthly to monitor for safety concerns and Area Director is to conduct quarterly look behind visits to ensure compliance as well.	

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	patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect all clients and staff. Findings include: Based on observation on 01/09/23 between 1:27 p.m. and 1:52 p.m., during a tour of the facility with the Program Director, there was one electric receptacle within five feet of the front bathroom sink that was not provided with GFCI protection. When tested with a GFCI tester at the receptacle, it did not break the electrical circuit and indicated an "open ground." Based on interview at the time of observation, the Program Director agreed the electric receptacle around the bathroom sink were not provided with GFCI protection. Findings were discussed with the Program Director at exit conference. 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords was not used as a substitute for fixed wiring according to 33.2.5.1. 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			

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	NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all staff Findings include: Based on observation with the Program Director on 01/09/23 between 1:27 p.m. and 1:51 p.m., The laundry room contained a powerstrip that was powering a washing machine. Based on interview at the time of observation, the Program Director agreed the power strip was powering a high-powered appliance. The finding was reviewed with the Program Director during the exit conference.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation			

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	drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 1 of 12 shifts. This deficient practice affects all staff and clients. Findings include: Based on records review with the Program Director on 01/09/23 between 11:27 a.m. and 1:26 p.m., the facility did not have documentation for a third shift fire drill conducted in the fourth quarter of 2022. Based on interview at the time of record review, the Program Director stated documentation of a third shift fire drill for the last quarter of 2022 could not be located. Findings were discussed with the Program Director at exit conference.	K S712	K 0712 Fire Drills (Standard) – Failed to conduct fire drills quarterly on each shift of personnel and under varied conditions for 1 of 12 shifts. The facility did not have documentation for a third shift fire drill conducted in the fourth quarter of 2022. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID C5YS21 will be fully implemented, including the following specifics: • All facility staff to review this finding and receive retraining on the expectation that a fire drill must be documented on each shift each quarter. • Drills will be run on each shift by 1/31/2023 to ensure compliance for the current quarter. • Lead DSP will receive training on this expectation and the role of the Lead DSP in monitoring compliance with this standard. • PD/QIDP will receive retraining on the role of the PD in monitoring	02/09/2023

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			compliance with this standard. 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 is responsible to ensure that drills are completed on each shift monthly to safeguard compliance with this standard. This is documented on the Monthly Site Risk Management Checklist. Administrative Coordinator to be tasked to complete look behind verification. Area Director is also responsible to review fire drills during quarterly visits to catch any discrepancies and areas of concern.	