STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2023	
	ROVIDER OR SUPPLIER			422 MA	ADDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN 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)	ATE	(X5) COMPLETION DATE
E 0000	conducted by the In accordance with 42 Survey Date: 01/09 Facility Number: 0 Provider Number: 1002 At this Emergency 1 Dungarvin Indiana 2 compliance with En Requirements for M Participating Provided 483.475 The facility has 8 compliance 8 compliance 10 compl	200993 15G479 244950 Preparedness survey, LLC was found not in mergency Preparedness ledicare and Medicaid lers and Suppliers, 42 CFR ertified beds. All 8 beds are id. At the time of the survey,	E 00	000			
E 0006 Bldg	(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2),						

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

TITLE (X6) DATE

Susan Gichohi Area Director 01/26/2023

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.

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	ì	JILDING	NSTRUCTION	(X3) DATE COMPL 01/09/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN 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 APPROPRIATE OF T	ATE	(X5) COMPLETION DATE	
), §486.360(a)(1)-(2), §494.62(a)(1)-(2)						
	develop and main preparedness plan and updated at lea must do the follow (1) Be based on a	nd include a documented, community-based risk						
		gies for addressing s identified by the risk						
	Plan. The Hospice maintain an emer that must be revie	: §418.113(a):] Emergency e must develop and gency preparedness plan ewed, and updated at least e plan must do the						
	(1) Be based on a facility-based and assessment, utiliz approach. (2) Include strategemergency events assessment, includes	and include a documented, community-based risk ing an all-hazards gies for addressing identified by the risk iding the management of sof power failures, natural						
	disasters, and oth affect the hospice	er emergencies that would 's ability to provide care.						
	develop and main preparedness pla	s at §483.73(a):] The LTC facility must tain an emergency n that must be reviewed, ast annually. The plan must						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING		COMPL	ETED
		15G479	B. WI	NG		01/09/	/2023
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE	DATE
	facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency probe reviewed, and years. The plan must be reviewed, and years. The plan must be reviewed, and assessment, utiliz approach, includir (2) Include strategemergency events assessment. Based on record reviewed, facility risk assessment, utilized to maintain a plan (EPP) that was documented, facility risk assessment, utilized including missing the for addressing emerisk assessment in a 483.475(a) (1) and deficient practice control of the formal deficient practice of the formal design of the formal deficient of the formal deficient of the formal deficient of the formal deficient of the facility of the formal deficient practice of the formal deficient practice of the formal deficient of the facility of the formal deficient of the formal deficient of the facility of the formal deficient practice of the facility of the facility of the formal deficient practice of the facility	-	E 00	006	E 006 Plan Based on All Hazards ris Assessment (Standard) – Fail to show that the group home I was based on and included a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, includin missing clients and included strategies for addressing emergency events identified b risk assessment. Corrective action for resident(found to have been affected All parts of the POC for the su with event ID C5YS21 will be	ed EPP d wy the s)	02/09/2023

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIER		422 M	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
DUNGAF (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR risk assessment, utilincluding missing c for addressing emerisk assessment. Barecords review, the work of a risk assess	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION izing an all-hazards approach, lients and included strategies gency events identified by the used on interview at the time of Program Director agreed paper sment could not be found. Issed with the Program ference.	MICHI ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) implemented, including the following specifics: • All Program Directors were retrained on the facility based community based risk assessment in place at Dungt to assess risks and develop strategies for emergency eve the Emergency Plan. • Program Director is complete the facility-based and community-based risk assessment for the home. It was be made available with the ot Emergency Plan documents it Life Safety Binder at the hom. How facility will identify other residents potentially affected what measures taken All residents potentially are affected, and corrective meas address the needs of all clients.	and arvin nts in ing vill her n the e. & sures ts.
E 0015 Bldg	, , , ,	3.113(b)(6)(iii), 441.184(b) 483.475(b)(1), 483.73(b)(1),		Measures or systemic change facility put in place to ensure recurrence Area Director is developing a monitoring system in conjunc with the new Administrative Coordinator to monitor the Emergency Plan Binders mor to ensure that all required components are current, pres and filed at all times.	no tion nthly

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2023		
	ROVIDER OR SUPPLIER VIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
	Subsistence Need §403.748(b)(1), §4 §441.184(b)(1), §4 §441.184(b)(1), §4 §483.73(b)(1), §48 [(b) Policies and preparedness polion the emergency (a) of this section, paragraph (a)(1) communication plasection. The policies and proposed in the following: (1) The provision of staff and patients shelter in place, in to the following: (1) The provision of staff and patients shelter in place, in to the following: (i) Food, water, mosupplies (ii) Alternate source the following: (A) Temperatures and safety and for storage of provision (B) Emergency light (C) Fire detection, systems. (D) Sewage and water in place of the following and process of the	ds for Staff and Patients 418.113(b)(6)(iii), 460.84(b)(1), §482.15(b)(1), 83.475(b)(1), §485.625(b)(1) procedures. [Facilities] implement emergency icies and procedures, based or plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated every 2 years facilities]. At a minimum, rocedures must address of subsistence needs for whether they evacuate or include, but are not limited edical and pharmaceutical ces of energy to maintain to protect patient health rethe safe and sanitary ons. whiting. extinguishing, and alarm waste disposal. spice at §418.113(b)(6)(iii):] edures. are additional requirements ted inpatient care facilities and procedures must						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		15G479	B. W	NG		01/09/	2023
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
DUNCAL				422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360			
DUNGAR	RVIN INDIANA LLC			MICHIC	SAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	(iii) The provision	of subsistence needs for					
	hospice employee	es and patients, whether					
	they evacuate or shelter in place, include, but						
	are not limited to	the following:					
	(A) Food, water, r	nedical, and pharmaceutical					
	supplies.						
	(B) Alternate sour	ces of energy to maintain					
	the following:						
	(1) Temperatures	to protect patient health					
	and safety and for	r the safe and sanitary					
	storage of provision	ons.					
	(2) Emergency lighting.						
	(3) Fire detection,	extinguishing, and alarm					
	systems.						
	(C) Sewage and v						
		view and interview, the facility	E 0015		E 015		02/09/2023
		ergency preparedness policies			Subsistence Needs for Staff a		
	_	ude at a minimum, (1) The			Patients (Standard) – EPP did	not	
	_	tence needs for staff and			address all components for		
		hey evacuate or shelter in			subsistence needs for staff an		
	_	are not limited to the following:			clients. The items not address		
	* *	dical, and pharmaceutical			were sewage and waste dispo		
		ate sources of energy to			Corrective action for resident(s	s)	
		peratures to protect resident			found to have been affected		
		nd for the safe and sanitary			All parts of the POC for the su	-	
		ns; (B) Emergency lighting; (C)			with event ID C5YS21 will be t	ully	
		nguishing, and alarm systems;			implemented, including the		
		d waste disposal in accordance			following specifics:		
		75(b)(1). This deficient practice			Dungarvin's policy related to		
	could affect all occ	upants.			sheltering in place is being		
					updated to specifically address		
	Findings include:				the concerns of sewage and w		
		and a street paper and a			disposal to be considered whe		
		the facility's EPP with the			there is a need to shelter in pla	ace.	
	_	n 01/09/23 at 12:48 p.m., the			Related forms, including the		
	_	ot address all components for			communication plan and facilit	-	
	subsistence needs for staff and clients. The items not addressed were sewage and waste disposal.				specific emergency policy form		
		-			are being revised to incorpora	te	
		at the time of records review,			these considerations.		
	the Program Direct	or agreed the subsistence	1		 All facility staff to receive trail 	nıng	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIF A. BUILDII B. WING		NSTRUCTION	(X3) DATE COMPI 01/09	LETED
	PROVIDER OR SUPPLIER		42	2 MA	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	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 meas address the needs of all clien	ures	
					Measures or systemic change facility put in place to ensure recurrence Area Director is developing a monitoring system in conjunct with the new Administrative Coordinator to monitor the Emergency Plan Binders mor to ensure that all required components are current, pres and filed at all times.	no tion nthly	
E 0018 Bldg	and (v), 441.184(t) 483.475(b)(2), 483 485.920(b)(1), 486 Procedures for Tri §403.748(b)(2), §4 (ii) and (v), §441.1 §482.15(b)(2), §48 §485.625(b)(2), §4 (1), §494.62(b)(1)	6.54(b)(1), 418.113(b)(6)(ii) 6)(2), 482.15(b)(2), 6.73(b)(2), 485.625(b)(2), 6.360(b)(1), 494.62(b)(1) 6.360(b)(1), §418.113(b)(6) 84(b)(2), §460.84(b)(2), 83.73(b)(2), §483.475(b)(2), 845.920(b)(1), §486.360(b)					
	must develop and	implement emergency cies and procedures, based					

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Event ID:

C5YS21

Facility ID: 000993

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	î ´	UILDING	NSTRUCTION	(X3) DATE COMPI 01/09	LETED	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 NATE	(X5) COMPLETION DATE	
	(a) of this section, paragraph (a)(1) of communication plants section. The policity reviewed and upon [annually for LTC the policies and puthe following:] [(2) or (1)] A system on-duty staff and [facility's] care during the must document the location of the reconstruction of the reconstruction. *[For PRTFs at §4 §483.73(b), ICF/II §460.84(b):] Policity system to track the location. *[For PRTFs at §4 §483.73(b), ICF/II or PACE] emergency. If on residents are reloused emergency, the [FOR PACE] must document location. *[For Inpatient Horocation of the location. *[For Inpatient Horocation of evacues and procedure of evacues transportation; ideal location(s) and procedure of the location o	PRTF's, LTC, ICF/IID or iment the specific name e receiving facility or other aspice at §418.113(b)(6):]						

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Event ID:

C5YS21 Facility ID: 000993

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	MEDICARE & MEDIC		_		ONIB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		15G479	B. WING		01/09/2023	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		ARQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC		MICHIO	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	assistance.					
	(v) A system to tra	ack the location of hospice				
	employees' on-du	ty and sheltered patients in				
	the hospice's care	during an emergency. If				
	the on-duty emplo	yees or sheltered patients				
		ng the emergency, the				
		ument the specific name				
		e receiving facility or other				
	location.	g, e. ee.				
	*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the					
	. , ,	udes consideration of care				
		eds of evacuees; staff				
	1	ansportation; identification				
		ation(s); and primary and				
		of communication with				
	external sources	ot assistance.				
	*[For OPOs at § 4	-86.360(b):] Policies and				
	procedures. (2) A	system of medical				
	documentation that	at preserves potential and				
	actual donor infor	mation, protects				
	confidentiality of p	ootential and actual donor				
		secures and maintains the				
	availability of reco					
	*IFor ESRD at & 4	194.62(b):] Policies and				
		afe evacuation from the				
	dialysis facility, wh					
	1 -	nd needs of the patients.				
		view and interview, the facility	E 0018	E 018	02/09/2023	
		ergency preparedness policies	12 0010	Development of Communication		
		ude a system to track the		Plan (Standard) – Facility EPF		
		staff and sheltered clients in		not address procedures for	uiu	
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			tracking of staff and clients.			
			adding of stall and distills.			
			Corrective action for resident(s	2)		
			found to have been affected) 		
	1	-			7/0//	
	location of the rece	iving facility or other location		All parts of the POC for the su	rvey	

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL			COMPL	
		15G479	B. WING	G		01/09/	2023
	PROVIDER OR SUPPLIER			422 MA	NDDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL SAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<u> </u>	ID	- ,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	· ·	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		42 CFR 483.475(b)(2). This			with event ID C5YS21 will be t	ullv	
		ould affect all occupants			implemented, including the		
	Findings Include:				following specifics: • Dungarvin Policy D-01b rega	rding	
					Emergency Procedures addre	sses	
	Based on review of the facility's EPP with the				the procedures for tracking of		
	_ ~	n 01/09/23 at 12:43 p.m., the			and clients. The related forms	are	
	1 ^ ^	ot address procedures for			referenced in the policy and		
	_	d clients. Based on interview at			Program Director is to verify	ıdad	
		review, the Program Director ocumentation could be found			copies of these forms are inclu with the facility EPP in the Life		
	for tracking staff an				Safety binder.		
	for tracking start and chefits.				All Program Directors have be	een	
	The finding was rev	viewed with the Program			retrained on the purpose of the		
	Director during the	——————————————————————————————————————			tracking forms and how to		
					implement the tracking system	1	
					according to Dungarvin policy	and	
					procedure.		
					How facility will identify other		
					residents potentially affected &	k	
					what measures taken		
					All residents potentially are		
					affected, and corrective measu		
					address the needs of all client	S.	
					Measures or systemic change	s	
					facility put in place to ensure r		
					recurrence		
					Area Director is developing a		
					monitoring system in conjuncti	on	
					with the new Administrative		
					Coordinator to monitor the		
					Emergency Plan Binders mon	thly	
					to ensure that all required		
					components, including the formused to track staff and clients	ns	
						ont	
					during an emergency are curre present and filed at all times.	511L,	
					present and med at all times.		

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Event ID:

C5YS21 Facility ID: 000993

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIER		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 LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0022 Bldg	403.748(b)(4), 416 441.184(b)(4), 482 483.73(b)(4), 485. 485.727(b)(2), 485. 494.62(b)(3) Policies/Procedure §403.748(b)(4), §4 (i), §441.184(b)(4) (4), §483.73(b)(4), (2), §485.625(b)(4 §485.920(b)(3), §4 (b) Policies and pr must develop and preparedness polion the emergency (a) of this section, paragraph (a)(1) o communication pla section. The polici be reviewed and u years [annually for minimum, the polici address the follow [(4) or (2),(3),(5),(6) place for patients, remain in the [facil *[For Inpatient Hos Policies and proce (6) The following a for hospice-operat only. The policies address the follow (i) A means to she	A91.12(b)(2), §494.62(b)(3). Focedures. The [facilities] implement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least every 2 or LTC facilities]. At a cies and procedures must ring: [6)] A means to shelter in staff, and volunteers who lity]. Spices at §418.113(b):] edures. are additional requirements and procedures must		TAG	DEFICIENCY)		DATE
	Based on record rev	riew and interview, the facility ergency preparedness plan	E 002	22	E 022 Policies/Procedures for Shelte	ering	02/09/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		A. BUILDING B. WING		COMPLETED 01/09/2023	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
DUNGAF	RVIN INDIANA LLC			GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
1.40	(EPP) include a meaclients, staff, and void ICF/IID facility in a 483.475(b)(4). This all occupants. Findings include: Based on review of Program Director or plan provided did not shelter in place for a Based on interview the Program Director find a policy for shelter in the Program Director or plan provided did not shelter in place for a Based on interview the Program Director find a policy for shelter in the program Director find a policy for shelter in place and	the facility's EPP with the to address procedures to elients, staff, and volunteers. at the time of records review, or stated they were unable to litering-in-place.		in Place (Standard) – Facility did not address procedures to shelter in place for clients, stand volunteers. Corrective action for resident found to have been affected All parts of the POC for the swith event ID C5YS21 will be implemented, including the following specifics: • Dungarvin Policy D-01b reg Emergency Procedures address the procedures for sheltering place for clients, staff, and volunteers. The policy is bein updated to address the specineed to consider sewage and waste proedures when shelter in place. • All facility staff being retrain the Emergency Plan and the in the case of a need to shelt place. How facility will identify other residents potentially affected what measures taken All residents potentially are affected, and corrective meast address the needs of all clien. Measures or systemic chang facility put in place to ensure recurrence. Area Director is developing a monitoring system in conjunct with the new Administrative Coordinator to monitor the Emergency Plan Binders more designations.	EPP o aff, (s) urvey fully arding esses in ag iffic d ering ed on plan er in & sures ats. es no ction

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G479		 JILDING	NSTRUCTION	COMI	E SURVEY PLETED 9/2023	
	PROVIDER OR SUPPLIER		422 MA	DDRESS, CITY, STATE, ZIP (RQUETTE TRAIL AN CITY, IN 46360	COD	
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
				to ensure that all requisition components are curre and filed at all times. It appendix to the policy indicates where in the locate the required ele is being placed in the assist the staff and supersonnel during the sprocess.	nt, present There is an which policy to ements. This binder to rvey	
E 0031 Bldg	441.184(c)(2), 482 483.73(c)(2), 484. 485.68(c)(2), 485. 486.360(c)(2), 491 Emergency Officia §403.748(c)(2), §4 §441.184(c)(2), §4 §483.73(c)(2), §48 §485.68(c)(2), §48	5.54(c)(2), 418.113(c)(2), 2.15(c)(2), 483.475(c)(2), 102(c)(2), 485.625(c)(2), 727(c)(2), 485.920(c)(2), 1.12(c)(2), 494.62(c)(2) als Contact Information 16.54(c)(2), §418.113(c)(2), 160.84(c)(2), §482.15(c)(2), 163.475(c)(2), §484.102(c)(2), 165.625(c)(2), §485.727(c)(2), 166.360(c)(2), §491.12(c)(2),				
	an emergency pre plan that complies local laws and mu at least every 2 ye	nust develop and maintain paredness communication with Federal, State and st be reviewed and updated ears [annually for LTC nmunication plan must bllowing:				
	` '					
	-	s at §483.73(c):] (2) on for the following:				

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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	1	JILDING		COMPL	
		15G479	B. W	ING		01/09/	2023
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	NOOVEDERIC N. AV OF CONDECTION		(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		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
IAU	(i) Federal, State, emergency prepared (ii) The State Lice Agency. (iii) The Office of the Ombudsman. (iv) Other sources *[For ICF/IIDs at Sinformation for the Information for In	tribal, regional, and local redness staff. Insing and Certification The State Long-Term Care To fassistance. The following: Tribal, regional, and local redness staff. To fassistance. The following: Tribal, regional, and local redness staff. To fassistance. The facility emergency preparedness The includes (2) Contact To following: The facility emergency preparedness The facility emergency preparedness The following: The facility emergency preparedness The facility emergency emergency preparedness The facility emergency em	E 00		E 031 Emergency Officials Contact Information (Standard) – EPP Communication Plan did not include Contact information for Federal, State, tribal, regional, local emergency preparedness staff, the state licensing and certification agency, the office the state long term care ombudsman. Corrective action for resident(s found to have been affected All parts of the POC for the su with event ID C5YS21 will be f implemented, including the following specifics: • All Program Directors were retrained on the Emergency P and Communication Plan	r , or s of s) rvey fully	02/09/2023
	Ombudsman Based on interview	concurrent with record review			documents and all of the requi elements per this standard.	red	
	Dased on line view	Concurrent with record review	1		r elements per this standard.		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/09/2023		
NAME OF PROVIDER OF			4	22 MA	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
	CH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
did not of aforeme listed ab Findings	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 EPP Communication Plan for a facility and it will be made available with the other Emergency Plan documents in Life Safety Binder at the home. All facility staff to be trained of the updated EPP and EPP Communication Plan. How facility will identify other residents potentially affected 8 what measures taken All residents potentially are affected, and corrective measure address the needs of all client. Measures or systemic change facility put in place to ensure in recurrence. Area Director is developing a monitoring system in conjunctivity the new Administrative Coordinator to monitor the Emergency Plan Binders monito ensure that all required components are current, present and filed at all times.	the the the the the the the the	
K 0000							
conducto	ed by the In	Recertification Survey was diana Department of Health in CFR 483.470(j).	K 0000)			
	Number: 0						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE (A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 01/09/2023	
	PROVIDER OR SUPPLIER		422 N	FADDRESS, CITY, STATE, ZIP C IARQUETTE TRAIL IGAN CITY, IN 46360	OD	
(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 COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Provider Number: AIM Number: 100					
	Indiana LLC was for Requirements for Pour CFR Subpart 483.4 the 2012 Edition of Association (NFPA Chapter 33, Existing Occupancies. This one story build determined to be not	Code survey, Dungarvin bund not in compliance with articipation in Medicaid, 42 (70(j), Life Safety from Fire and the National Fire Protection (101), Life Safety Code (LSC), g Residential Board and Care ling with a basement, was at sprinklered. The facility has rm system with hardwired				
	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.					
	(E-Score) using NF Approaches to Life facility Prompt with	Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the an E-Score of 0.61. an Electron of 0.1/11/23				
K S363	NFPA 101 Corridor - Doors					
Bldg. 01	Corridor - Doors Doors shall meet a requirements: 1. Doors shall b other mechanisms door closed.	all of the following be provided with latches or be suitable for keeping the all be arranged to prevent				
	the occupant from 3. Doors shall be automatic-closing in buildings other					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 01/09/2023 15G479 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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 K S363 K 0363 02/09/2023 failed to ensure 1 of 4 client sleeping rooms were Corridor - Doors (Standard) - The provided with a door which would self-close and door to client room #1 did not fully latch securely in the door frame. This deficient close and latch when tested. practice could affect 2 of 8 clients. Corrective action for resident(s) Findings include: found to have been affected All parts of the POC for the survey Based on observation during a tour of the facility with event ID C5YS21 will be fully with the Program Director on 01/09/23 between implemented, including the 1:27 p.m. and 1:51 p.m., the door to client room #1 following specifics: did not fully close and latch when tested. Upon A Maintenance Request was interview at time of observation, the Program filed immediately to repair the door Director agreed that the door did not fully close that was not properly latching, and nor latch when tested. this has been repaired by Maintenance. Findings were discussed with the Program Maintenance Staff, Program Director at exit conference. 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

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		15G479	B. W	ING		01/09/	/2023
		<u> </u>	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ARQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC				GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					will be scanning the monthly s		
					inspection to a shared drive ea	ach	
					month so that copies can be		
					printed and placed in the Life		
					Safety binder at the home. • PD/QIDP, Lead DSP,		
					Administrative Coordinator and	d	
					Maintenance Director will rece		
					retraining on their roles in	100	
					monitoring compliance with the	is	
					standard.		
					How facility will identify other		
					residents potentially affected &	ķ	
					what measures taken		
					All residents potentially are		
					affected, and corrective meas	ures	
					address the needs of all client	S.	
					Measures or systemic change		
					facility put in place to ensure r	10	
					recurrence		
					A monitoring system is in plac		
					and delegated to an Administr		
					Coordinator to monitor the Life		
					Safety compliance of the facili	•	
					including a look behind check		
					safety checklist documentation during monthly visits. Area	1	
					Director to further verify with a		
					second look behind during reg		
					site visits.	ulai	
					S. C. Fiolici.		
K S511	NFPA 101						
	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and						
		gas or related gas piping					
	•	PA 54, National Fuel Gas					
		riring and equipment					
[complies with NP	FA 70, National Electric					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G479	B. W	ING		01/09	/2023
NAME OF I	DROWIDED OF CUIDNIED			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
	PROVIDER OR SUPPLIER	C			ARQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC			MICHIC	GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	Code.	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY.		DATE
	32.2.5.1, 33.2.5.1,	011 012					
		ation and interview, the facility	I K S	511	K 0511		02/09/2023
		f 1 flexible cords were installed	KS	311	Utilities – Gas and Electric		02/09/2023
	properly and used in a safe manor. NFPA 99,				(Standard) – The Laundry Ro	om	
		tes adapters and extension			had a power strip used to pow		
		equirements of 10.2.4.2.1			equipment, was not secured,		
	_	shall be permitted. Section			was dangling from the power	u	
	_	cabling shall comply with			cords. Facility failed to ensure	1 of	
		2.3.5.1 states cord strain relief			4 wet locations were provided		
	shall be provided at the attachment of the power				GFCI protection against electr		
	cord to the appliance so that mechanical stress,				shock. There was one electric		
	either pull, twist, or bend, is not transmitted to				receptacle within five feet of the	ne	
	internal connections. This deficient practice could				front bathroom sink that was r		
	affect all staff.				provided with GFCI protection	. The	
					laundry contained a power str	ip	
	Findings include:		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		that was powering a high-pow	ered	
					appliance.		
	Based on observation	on with the Program Director					
	on 01/09/23 betwee	n 1:27 p.m. and 1:52 p.m., the			Corrective action for resident(s)	
	Laundry Room had	a power strip used to power			found to have been affected		
		secured, and was dangling			All parts of the POC for the su	ırvey	
	_	ds. This condition could put			with event ID C5YS21 will be	fully	
	_	cord causing damage to the			implemented, including the		
	1 ~	on interview at the time of			following specifics:		
		rogram Director agreed the			The power strip was remove		
		ngling, not secured, and			from the laundry room and the		
	_	trip to the floor upon			washer was plugged directly i	nto	
	observation.				the electrical outlet.		
	TT1 : C* 1:	t didd b			A GFCI outlet is being install		
	_	viewed with the Program			at the electric receptacle withi		
	Director during the	exit conference.			five feet of the front bathroom		
	2 D1	Airman distribution of C. 119			All facility staff will review this	S	
		ation and interview, the facility			finding.		
		f 4 wet locations were provided			Lead DSP and Program Dire		
	_	reuit interrupter (GFCI)			to be trained on the expectation		
	^	lectric shock. NFPA 70, NEC			regarding the use of power sti	-	
	2011 Edition at 210				the power supply for high-pow		
	_	Protection for Personnel,			appliances, and the use of GF	·U	
	states, ground-fault	circuit-interruption for	1		outlets.		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2023		
		PROVIDER OR SUPPLIER			422 MA	ADDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL BAN CITY, IN 46360		
		SUMMARY (EACH DEFICIENT REGULATORY OF Personnel shall be propersonnel shall be circuit-interrupter properson (B) Other Than Dwisingle-phase, 15- arinstalled in the locathrough (8) shall har circuit-interrupter properson (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to not readily accessible branch circuit dedictions, or pipeline shall be permitted the with 426.28 or 427. Exception No. 2 to only, where the consupervision ensure are involved, an asset	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Provided as required in C). The ground-fault hall be installed in a readily : See 215.9 for ground-fault rotection for personnel on relling Units. All 125-volt, and 20-ampere receptacles tions specified in 210.8(B)(1) ave ground-fault protection for personnel. (3) and (4): Receptacles that are alleled and are supplied by a cated to electric snow-melting, and vessel heating equipment to be installed in accordance 2.2, as applicable. (4): In industrial establishments additions of maintenance and that only qualified personnel sured equipment grounding		422 MA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) • These items are to be check monthly on the Site Risk Management Checklist complete by the Lead DSP and reviewed the Program Director • Maintenance staff to reviewed finding and to ensure that they also checking for compliance of this standard during monthly sinspections. How facility will identify other residents potentially affected 8 what measures taken All residents potentially are affected, and corrective meast address the needs of all client Measures or systemic change facility put in place to ensure in recurrence Lead DSP and Program Directions are responsible to note any concerns regarding this standard communicate to the Mainenance Department any	ed eted d by this / are with site ures s. s no tor ard	(X5) COMPLETION DATE
		shall be permitted f outlets used to supp create a greater haz having a design tha	as specified in 590.6(B)(2) for only those receptacle oly equipment that would ard if power is interrupted or t is not compatible with GFCI			needed repairs. Maintenance tour the house monthly to mor for safety concerns and Area Director is to conduct quarterly look behind visits to ensure	nitor	
		1.8 m (6 ft.) of the of Exception No. 1 to receptacles used to removal of power whazard shall be periodered.	eceptacles are installed within outside edge of the sink. (5): In industrial laboratories, supply equipment where would introduce a greater mitted to be installed without			compliance as well.		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G479	B. W	ING		01/09/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				RQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC				GAN CITY, IN 46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1 ^	s of general care or critical					
	care areas of health care facilities other than those						
	covered under						
		protection shall not be required.					
	(6) Indoor wet locat						
		ith associated showering					
	facilities	1 1 1 1 1					
		bays, and similar areas where					
	1	equipment, electrical hand					
	tools.	V-4 I4: 11					
	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						
		is more subject to failure.					
		ice could affect all clients and					
	staff.	ice could affect all clients and					
	Stuff.						
	Findings include:						
	Based on observation	on on 01/09/23 between 1:27					
		during a tour of the facility with					
	1	or, there was one electric					
	1	ve feet of the front bathroom					
		ovided with GFCI protection.					
	_	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 l	Program Director agreed the					
	_	round the bathroom sink were					
	not provided with G	-					
		ssed with the Program					
	Director at exit conf						
		ation and interview, the facility					
		1 flexible cords was not used					
		xed wiring according to					
		5.1 states utilities shall comply					
		SC 9.1.2 requires electrical					
	wiring and equipme	ent shall be in accordance with					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G479	B. W	ING		01/09/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				RQUETTE TRAIL		
DUNGAR	RVIN INDIANA LLC				GAN CITY, IN 46360		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Electrical Code. NFPA 70, 2011					
		.8 requires that, unless					
	specifically permitted, flexible cords and cables						
		a substitute for fixed wiring of					
		icient practice could affect all					
	staff Findings include:						
	-						
		on 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 applia	ance.					
	The finding was rev	iewed with the Program					
	Director during the	exit conference.					
K S712	NFPA 101						
	Fire Drills						
Bldg. 01	Fire Drills						
	1. The facility mus	t hold evacuation drills at					
	least quarterly for	each shift of personnel and					
	under varied cond	itions to:					
	a. Ensure that al	ll personnel on all shifts are					
	trained to perform	assigned tasks;					
		ll personnel on all shifts are					
	familiar with the us	-					
	emergency and dis	saster plans and					
	procedures.						
	2. The facility mus						
	-	uate clients during at least					
	one drill each year						
	-	provisions for the					
	evacuation of clier	nts with physical					
	disabilities;						
		nd evaluation on each drill;					
	d. Investigate all	problems with evacuation					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		15G479	B. W	ING		01/09	/2023
	PROVIDER OR SUPPLIER			422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
	drills, including ac action; and e. During fire dri evacuated to a sa under the Health of the Life Safety 3. Facilities must paragraphs (i) (1) any live-in and rel 42 CFR 483.470(i Based on record review quarterly for each si varied conditions for practice affects all si Findings include: Based on records repractice affects all si Findings include: Based on records repractice affects all si findings include: Based on records repractice affects all si findings include: Based on records repractice affects all si findings include: Based on records repractice affects all si findings include: Based on records repractice affects all si findings include:	lls, clients may be fe area in facilities certified Care Occupancies Chapter Code. meet the requirements of and (2) of this section for ief staff that they utilize.) view and interview, the facility acuation/fire drills at least hift of personnel and under or 1 of 12 shifts. This deficient staff and clients. Eview with the Program 3 between 11:27 a.m. and 1:26 d not have documentation for a conducted in the fourth quarter interview at the time of record in Director stated third shift fire drill for the last ld not be located.	KS	712	K 0712 Fire Drills (Standard) – Failed conduct fire drills quarterly on each shift of personnel and ur varied conditions for 1 of 12 st. The facility did not have documentation for a third shift drill conducted in the fourth quof 2022. Corrective action for resident(found to have been affected All parts of the POC for the su with event ID C5YS21 will be implemented, including the following specifics: • All facility staff to review this finding and receive retraining the expectation that a fire drill must be documented on each each quarter. • Drills will be run on each shift 1/31/2023 to ensure compliant for the current quarter. • Lead DSP will receive training this expectation and the role of Lead DSP in monitoring compliance with this standard of PD/QIDP will receive retraining on the role of the PD in monitoring	nder hifts. fire uarter s) rvey fully on shift ft by ce ng on of the ing	02/09/2023

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2023			
	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
					compliance with this standard. 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 clients. Measures or systemic changes facility put in place to ensure not recurrence. Program Director is responsible ensure that drills are complete each shift monthly to safeguar compliance with this standard. This is documented on the Monthly Site Risk Managemer Checklist. Administrative Coordinator to be tasked to complete look behind verificating Area Director is also responsible to review fire drills during quar	ures s. s lo de to d on d			
					visits to catch any discrepancion and areas of concern.	-			

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