STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING -- B. WING	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 02/02/2021 Facility Number: 012557 Provider Number: 15G791 AIM Number: 201017960A 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 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 02/04/21	E 0000		
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants. Findings include:	E 0004	The Program Director will review and make any necessary updated to the emergency preparedness no later than 3/1/21. The Area Director will reset the expectations for the Program Director to ensure the Emergency Preparedness Plan is updated no	03/01/2021

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	During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m. the facility provided emergency preparedness documentation, however it was incomplete. The facility failed to ensure the emergency preparedness plan was reviewed at least every two years. The most recent documented review was dated 05/24/18. This was confirmed by the House Coordinator at the time of record review, and she agreed that she was unable to provide any documentation of a subsequent review. This deficient finding was reviewed with the House Coordinator at the time of exit.		less than every two years in accordance to state regulations. The Area Director will review this plan at least annually to ensure updates and reviews are occurring.	
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) Subsistence Needs for Staff and Patients [(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). 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			

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	(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: (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, documentation of the following: (1) The provision of subsistence needs for staff and clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical	E 0015	The Program Director will ensure policy D-01b is placed in the Emergency Preparedness Binder. The Program Director will retrain all staff on ensure this policy is not removed from this Binder. I have attached the D-01b policy for your review as it address all deficient area noted in Tag	03/01/2021

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	supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m. the facility provided emergency preparedness documentation, however it was incomplete. The facility was unable to provide documentation of emergency preparedness policies and procedures regarding the provision of subsistence needs for staff and clients, including food, water, medical, and pharmaceutical supplies as well as alternate sources of energy to maintain temperatures, life safety systems, and sanitary systems. Based on interview at the time of record review, the House Coordinator agreed that she was unable to locate or provide the above requested information. This deficient finding was reviewed with the House Coordinator at the time of exit.		E0015. The Area Director will retrain the Program Director on completing a quarterly review of the emergency preparedness plan to ensure all components are include in the binder. The Area Director will review the Emergency plan quarterly to ensure all components in place and being implemented.	
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			

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	[(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).] 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;			

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	transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of 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 documented 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	E 0018	The Program Director will ensure policy D-01c is complete and placed in the Emergency Preparedness Binder. All staff will be trained on policy D-01c as it pertains to a specific locations	03/01/2021

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	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 in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants. Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m. the facility provided emergency preparedness documentation, however it was incomplete. The facility failed to ensure emergency preparedness policies and procedures include a documented 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. Based on interview at the time of record review, the House Coordinator agreed she could not locate a policy or procedure regarding staff and client tracking. This deficient finding was reviewed with the House Coordinator at the time of exit.		outline for on-duty staff and individuals in the event of an evacuation from the facility. The Area Director will retrain the Program Director on ensuring policy D-01c is included in the emergency preparedness binder. The Area Director will also review the Emergency Preparedness Binder quarterly to ensure all components are included and being implemented.	
E 0020 Bldg. --	403.748(b)(3), 416.54(b)(2), 418.113(b)(6)(ii), 441.184(b)(3), 482.15(b)(3), 483.475(b)(3), 483.73(b)(3), 485.625(b)(3), 485.68(b)(1), 485.727(b)(1), 485.920(b)(2), 491.12(b)(1), 494.62(b)(2) Policies for Evac. and Primary/Alt. Comm. [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in			

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	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). At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], 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 RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.			

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	* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include documented information for safe evacuation from the ICF/IID facility, which includes the following: 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 in accordance with 42 CFR 483.475(b)(3). This deficient practice could affect all occupants. Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m. the facility provided emergency preparedness documentation, however it was incomplete. The facility could not provide documentation which ensured the emergency preparedness policies and procedures included information for a safe evacuation that addressed the following: 1) Consideration of care and treatment needs of evacuees; 2) Staff responsibilities; 3) Transportation; 4) Identification of evacuation location(s); 5) Primary and alternate means of communication with external sources of assistance. Based on interview at the time of record review, the House Coordinator agreed that she could not provide documentation regarding the above	E 0020	The Program Director will ensure the action and communication plan is placed in the Emergency Preparedness Binder. The Action and Communication Plan will outline the consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location. This template will also address primary and alternate means of communication with external sources. The Area Director will reset the expectation for the Emergency Preparedness Plan to be reviewed quarterly to ensure all components are in place. The Area Director will review the Emergency Preparedness Plan quarterly to ensure all components are in place and being implemented.	03/01/2021

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	information. This deficient finding was reviewed with the House Coordinator at the time of exit.			
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 (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).] 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 policies and procedures include a means to	E 0022	The Program Director will ensure to include a protocol to shelter in place for individuals, staff and any	03/01/2021

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	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: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m. the facility provided emergency preparedness documentation, however it was incomplete. The facility could not provide documentation which ensured emergency preparedness policies and procedures included a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility. Based on interview at the time of record review, the House Coordinator agreed she could not provide the documentation listed above at the time of request. This deficient finding was reviewed with the House Coordinator at the time of exit.		volunteers who remain in the facility in the event of an emergency. The plan will include all food, medical and any emergency equipment needed to shelter within the facility. The Area Director will reset the expectation with the Program Director in regards to ensuring all components are include in the Emergency Preparedness Plan. The Area Director will review the Emergency Preparedness Plan quarterly to ensure all components are in place and being implemented.	
E 0026 Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary [(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			

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	LTC).] At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all occupants. Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m., the facility provided emergency preparedness documentation, however it was incomplete. No policy or procedure could be provided regarding the role of the facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act. Based on interview at the time of record review, the House Coordinator confirmed that she could not locate	E 0026	**Dungarvin's Policy and Procedure for Emergency Situations outlines the role of the facility under a waiver declared by the Secretary, in accordance with Section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. All staff will be trained on this policy by 3/1/21. It is expected that this policy will be in place in the emergency book at the home.** The Program Director will ensure this component of the Emergency Preparedness Plan is in place and implemented. Systemwide, all Area Directors and Area Managers will review this concern to ensure that it is	03/01/2021

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	or provide a a policy or procedure regarding the 1135 waiver upon request. This deficient finding was reviewed with the House Coordinator at the time of exit.		being addressed at all Dungarvin ICF/IIDs.	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is			

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	conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that			

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	is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not			

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	limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and			

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	maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.	E 0039	**The Program Director will complete exercises to test the emergency preparedness plan. The exercises will also include an unannounced drill/exercise. The Program Director will be sure to carefully plan the exercise to ensure the drill appears as real as possible. All details will be noted on the back of the p5-15 training form. All staff present during the drill will sign the p5-15 training form. The form will be filed in the emergency preparedness binder for future review.** **The Area Director will monitor this every quarter during the site visits. A review of all documentation will be done while conducting the site visit. In the event the exercise has not been complete upon review the Area director will ensure one is complete within two weeks. The Area Director will then revisit the site to confirm documentation is in place.**	03/01/2021

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	Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m. the facility provided emergency preparedness documentation, however it was incomplete. The facility provided documentation of the facility's response to the COVID-19 Public Health Emergency. Additionally, the facility completed a Table Top Exercise regarding downed transmission power lines on 08/23/2020. However, the facility was unable to provide an After Action Report or an analysis of the table top exercise. Based on interview at the time of record review, the House Coordinator agreed that she was unable to provide an analysis of the table top exercise. This deficient finding was reviewed with the House Coordinator at the time of exit.			
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.490(j). Survey Date: 02/02/2021 Facility Number: 012557 Provider Number: 15G791 AIM Number: 201017960A At this Life Safety Code survey, Dungarvin Indiana LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR subpart 483.490(j), Life Safety from Fire, and the 2012 edition of the National Fire	K 0000		

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	Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired detectors in all resident sleeping rooms. The facility has a capacity of 4 and had a census of 4 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.7. Quality Review completed on 02/04/21			
K S211 Bldg. 01	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 Based on observation and interview, the facility failed to maintain 1 of 1 designated means of egress be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all occupants needing to use the secondary means of egress from the client sleeping area. Findings include: During a facility tour with the House Coordinator on 02/02/2021 at 2:31 p.m. the	K S211	**The Program Director will retrain all staff on the importance of keeping all door ways and windows clear of hazard. The House Coordinator will complete weekly checks in the home making sure all door and windows are clear of debris and or objects.** **The Program Director will monitor this monthly during site visits.**	02/18/2021

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	secondary exit from Living Area 1 was obstructed by an easy chair on the inside, and when opened, was obstructed by a grill, which had been placed in front of the door. Based on interview at the time of the observation, the House Coordinator agreed that the easy chair and the grill obstructed the secondary means of egress. This deficient finding was reviewed with the House Coordinator at the time of exit.		**The Area Director will monitor this quarterly during site visits.**	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 33.3.3.4.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual	K S345	**The Maintenance Director will ensure that the home's primary fire alarm system is tested and maintained according to this standard. It is the responsibility of the Program Director and House Coordinator to ensure copies of all required tests and maintenance records are obtained and placed into the book at the home for review. The required test will be obtained and placed in the book by 3/15/21**	03/01/2021

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	fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m. the facility was unable to provide documentation for fire alarm testing and inspections subsequent to 06/13/2019. The most recent documented fire alarm annual test and inspection was dated 06/13/2019. There was no documented semi-annual fire alarm visual inspection for December, 2019. Due to the COVID-19 Public Health Emergency, the fire alarm test and inspections for 2020 were waived. Based on interview at the time of record review, the House Coordinator agreed she was unable to provide a semi-annual fire alarm inspection subsequent to 06/13/2019 and additionally stated that no fire alarm testing or inspection occurred in 2020. This deficient finding was reviewed with the House Coordinator at the time of exit.		**The Area Directors will review the reports on a quarterly bases to ensure all testing is maintained. In the event the testing reports are not located the Area Director will obtain them from maintenance and ensure they are placed in the binder.**	
K S351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Where an automatic sprinkler system is installed, for either total or partial building coverage, the system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with Section 9.6, as modified below. The adequacy of the water			

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	supply shall be documented. In Prompt Evacuation facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One and two Family Dwellings and Manufactured Homes, shall be permitted. Automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities where an automatic sprinkler system is in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, automatic sprinklers shall not be required in closets not exceeding 24 square feet and in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or material providing a 15-minute thermal barrier. In Prompt Evacuation Capability facilities in buildings four or fewer stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height, shall be permitted. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Where an automatic sprinkler is installed, attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected by July 5, 2019. Attics not used for			

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	15G791	A. BUILDING 01 B. WING	02/02/2021

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	living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.1, 33.2.3.5.3.3, 33.2.3.5.3.4, 33.2.3.5.3.6, 33.2.3.5.7			
	Based on record review and interview, the facility could not ensure that the attic spaces were protected by one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6. 2. Protected by automatic sprinkler system according to 9.7. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. This deficient practice could affect all building occupants. Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m., the facility was unable to provide documentation which ensured the attic spaces were protected. Based on interview at the time record review, the House Coordinator stated she did not know any information regarding the facility's attic. This deficient finding was reviewed with the House Coordinator at the time of exit.	K S351	The is a heating element that is housed in the attic to determine heat level. In the event of over heating it id directly connect to the fire department for emergency response. The Maintenance Department is responsible for ensuring the attic space is protected and has contracted Nobi to inspect this. Please see attached document as supporting evidence. All inspections will be documented and the document will be placed in the home for review. All sprinkler systems will be inspected quarterly as outline in regulation. Dungarvin had heat detecting sensors installed in the attic in 2019 to ensure safety for the home. Please see attached payment as proof. These sensor are inspected per regulation. The Program Director will ensure all inspection documentation is available for review at the home.	03/15/2021

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			The Program Director will ensure the inspection binder is reviewed monthly to ensure all documents are in place. The Area Director will review the site inspections quarterly to ensure they have been complete and the documentation is available for review.	
K S500 Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 32.2.5 and 33.2.5 Building Services that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			
	Based on record review, observation and interview; the facility failed to maintain a complete written record of monthly generator load testing for 7 of the most recent 12 months. LSC 4.5.7 states any building service equipment or safeguard provided to achieve the goals of this Code shall be designed, installed, and approved in accordance with applicable NFPA codes. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.1 states an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 110, Section 8.3.4 states a permanent record of EPSS inspections, tests, exercising, operation, and repairs shall be	K S500	A load test will be completed by 2/28/21, the House Coordinator will be re-trained on completing on weekly generator checks. The Maintenance Department will ensure monthly load test are complete and documentation of testing will ne left in the home for review. **The Program Director will ensure this is complete by monitoring the log for the weekly and month generator check during weekly routine site visits to the home.** **The Area Director will monitor this quarterly while in the home for site visits. At this time if at said documents are not present in the home an email will be**	02/28/2021

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	maintained and readily available. This deficient practice affects all clients, staff and visitors. Findings include: During record review with the House Coordinator on 02/02/2021 from 1:30 p.m. to 2:25 p.m., documentation of monthly generator load testing after 06/28/2020 was not available for review. Based on interview at the time of record review, the House Coordinator stated the facility has a natural gas fired emergency generator, and agreed that documentation of monthly generator load testing after June, 2020 was not available for review. Based on observation on the same date, one natural gas fired emergency generator was located outside the facility. This deficient finding was reviewed with the House Coordinator at the time of exit.		**sent within 24 hours to obtain all missing items. All missing item will then be placed in home within 48 hours.** System wide, all Area Directors will review this standard and assure that this concern is being addressed at all Dungarvin ICF/IID's.	
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 Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 3 of 4 electrical outlets were protected in Sleeping Room #1 according to 33.2.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 1 occupant.	K S511	All staff in the home will be retrained on the expectation of reporting all work orders timely. All staff will ensure all electrical outlets are protected. All electrical outlets will be covered no later than 2/19/21. The Program Director will follow up during	02/19/2021

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	Findings include: During a facility tour with the House Coordinator on 02/02/2021 at 2:30 p.m., three of the outlets in Sleeping Room #1 did not have faceplates installed over the receptacles. Based on interview at the time of observation, the House Coordinator agreed that the faceplates were missing. This deficient finding was reviewed with the House Coordinator at the time of exit.		weekly site visits to ensure regulations are being followed. The Area Director will monitor these issue on a quarterly bases during site visits	