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	10/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 10/27/23 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 10/30/23	E 0000		
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greta Goins	Area Director	11/10/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	15G791	A. BUILDING -- B. WING	10/27/2023

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	assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location	E 0018	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID EZ9B21will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs will be trained by 11/8/23 on the location	11/10/2023

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	in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants Findings Include: Based on review of the facility's EPP with the House Coordinator and Program Director on 10/27/23 between 10:49 a.m. and 12:43 p.m., the plan provided did not address procedures for tracking of staff and clients. Based on interview at the time of records review, the House Coordinator stated that all clients and staff would be tracked, but did not know whether a policy or tracking log are available to use. The finding was reviewed with the Program Director and House Coordinator during the exit conference.		of the emergency preparedness plan and all applicable forms in the home. The emergency preparedness plan, Dungarvin policy D-01b for emergency situations and addendum (D-01c) includes tracking forms for staff (EP-04a) and supported individuals (EP-04b). The tracking forms are uploaded with this submission. These policies will be filed in the Life Safety binder at the home by 11/8/23. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Administrative Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons Responsible: QIDP, Admin coordinator, Area Director	
E 0024 Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6),			

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	485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the			

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	process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness plan (EPP) included the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Program Director and House Coordinator on 10/27/23 between 10:49 a.m. and 12:43 p.m., the plan provided did not address the use of volunteers in an emergency. Based on interview at the time of records review, the Vice President of Residential Compliance stated the plan did not address the use or non-use of volunteers in an emergency but did state that the facility does not use volunteers. Findings were discussed with the Program Director and House Coordinator at exit conference.	E 0024	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID EZ9B21will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs will be trained by 11/8/23 on the location of the emergency preparedness plan in the home. The emergency preparedness plan, Dungarvin policy D-01b for emergency situations includes how volunteers should be used in emergency situations on page 13 of the policy. An addendum to the policy (EP-04c), tracks volunteers during emergency situations. This policy and form will be filed in the Life Safety binder at the home by 11/8/23 and are uploaded with this submission. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home.	11/10/2023

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			Going forward, the QIDP and the Administrative Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: QIDP, admin coordinator	
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 §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (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			

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	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 plan (EPP) include the role of the ICF/IID 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: Based on record review with the Program Director and House Coordinator on 10/27/23 between 10:49 a.m. and 12:43 p.m., the EPP was missing roles of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act was available for review. Based on interview at the time of record review, the House Coordinator stated that the facility does have a policy in place, but the policy could not be found at the time of the survey. This finding was reviewed with the House Coordinator and Program Director during the exit conference.	E 0026	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID EZ9B21will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs will be trained by 11/8/23 on the location of the emergency preparedness plan in the home. The emergency preparedness plan, Dungarvin policy D-01b for emergency situations and addendum (D-01c) is uploaded with this submission. These policies will be filed in the Life Safety binder at the home by 11/8/23. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Administrative Coordinator will	11/10/2023

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			monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: QIDP, admin coordinator	
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: 10/27/23 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 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, hard wired detectors in all resident sleeping rooms and heat detection in the attic. 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	K 0000		

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	facility Prompt with an E-score of 0.27. Quality Review completed on 10/30/23			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements 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 and interview, the facility failed to document 2 of 7 portable fire extinguishers located in the facility was subject to maintenance at intervals of not more than one year. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect all clients, staff and visitors.	K S100	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID EZ9B21will be fully implemented, including the following specifics: The maintenance manager confirmed that the deficient fire extinguishers were replaced, and fire extinguishers were inspected monthly. Maintenance inspections, including fire extinguisher checks for the months of January 2023-October 2023 will be uploaded with this submission. All DSPs, House Coordinators, and Program Director/QIDPs will be retrained by 11/8/23 on the requirement that portable fire extinguishers must be inspected monthly and initialed by the person inspecting. The maintenance manager contacted VFP Fire Systems and	11/10/2023

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	Findings include: Based on record review with the House Coordinator on 10/27/23 between 10:49 p.m. and 12:43 p.m., the annual fire extinguisher report dated 01/24/23 titled "Fire Extinguisher Inspection List" recorded two fire extinguishers had failed its annual inspection. One ABC extinguisher located in the van was not available during its inspection which was listed as a deficiency. A second ABC extinguisher located at the front door required 6-year service. Based on interview at the time of observation, the House Coordinator stated that a previous vehicle was located at the home when the inspection happened, however was unsure if the fire extinguisher that's presently in the van is what was inspected. The House Coordinator also stated that they were unsure if both fire extinguishers obtained its required maintenance or inspection. Findings were discussed with the Program Director and House Coordinator at exit conference.		they were at the facility on 11/8/23 to correct deficient items notated on annual and quarterly inspections. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Maintenance staff are trained on monthly inspections and documentation of correcting deficiencies noted in a timely manner. Going forward, the QIDP and the Administrative Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: QIDP, admin coordinator, maintenance manager	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including			

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	Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4).			

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	15G791	A. BUILDING 01 B. WING	10/27/2023

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

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	13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on records review, observation, and interview the facility failed to ensure 1 of 2 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all clients and staff in the facility. Findings include:	K S353	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID EZ9B21will be fully implemented, including the following specifics: The maintenance manager contacted VFP Fire Systems about the 5-year inspection and gauge testing. VFP was at the facility on 11/8/23 and completed the 5-year inspection and recalibration/replacement of gauges as needed. The final inspection report was not available at the time of this submission. The Maintenance staff	11/10/2023

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	During a tour of the facility with the House Coordinator on 10/27/23 between 12:44 p.m. and 1:15 p.m., at the sprinkler riser, sprinkler gauge two had a manufacture date of 2013 listed on the face of the sprinkler gauge. During record review with the Program Director and House Coordinator between 10:49 a.m. and 12:43 p.m., no documentation could be provided to show the gauges had been replaced or recalibrated. Furthermore, the annual sprinkler report dated 04/14/23 provided during the survey listed a deficiency that stated a sprinkler gauge was out of date. Based on interview at the time of the observation and record review, the House Coordinator acknowledged one sprinkler system gauge was more than five years old and stated no documentation was available to show the gauge has been replaced or recalibrated. Findings were discussed with the House Coordinator and Program Director at exit conference. 2. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by this standard. 4.1.4.2 stated corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. This deficient practice could affect all clients and staff. Findings include: Based on record review with the House Coordinator and Program Director on 10/27/23		conduct monthly site inspections that include gauge and valve checks. The January 2023-October 2023 inspection forms are uploaded with this submission. The system for storing this documentation is being revised to ensure the form completed each month will be made available to regulatory agencies as needed. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Area Director is developing a monitoring system in conjunction with the Maintenance Dept and Administrative Coordinator to monitor the Life Safety books monthly to ensure that all required inspections are present and filed at all times. The Maintenance Manager is reviewing systems to ensure that all VFP Fire Systems inspections and reports are reviewed and followed up on timely to ensure that deficiencies notated are corrected. Persons responsible: QIDP, admin coordinator, maintenance manager	

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	between 10:49 a.m. and 12:43 p.m., the Wet Fire Sprinkler System Inspection Report dated 10/27/23 indicated three deficiencies described as the following: a.) System is due for required 5-year internal inspection b.) Valve use to be locked, lock and chain are missing. Valve should be secured to prevent accidental shutting of valve rendering the system out of service c.) Alarm system that monitors the fire protection system is doing the same as merrillville, valpo south. The FACP received a riser monitor. The FSS central station only received trouble conditions and restores. Based on interview at the time of record review, the House Coordinator stated that they were unaware if any of the deficiencies listed on the inspection report were fixed. The finding was reviewed with the Program Director and House Coordinator during the exit conference.			
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the			

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	evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code. 3. Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. 42 CFR 483.470(i) Based on record review and interview, the facility failed to ensure fire drills were held at varied dates for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all clients and staff in the facility. Findings include: Based on record review of the "Fire Drill Report" with the House Coordinator on 10/27/23 between 10:49 a.m. and 12:43 p.m., the following was noted for all three shifts over the past 12 months a.) All first shift drills were conducted on the 5th day of every month b.) All second shift drills were conducted on the 15th of every month c.) All third shift drills were conducted on the 25th of every month Based on interview at the time of record review, the House Coordinator stated that they following a schedule for fire drills, but was unaware that the drills had to be varying of date and time. Findings were discussed with the House Coordinator and Program Director at exit conference.	K S712	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID EZ9B21will be fully implemented, including the following specifics: All DSPs, House Coordinators, and Program Director/QIDPs were retrained on the requirement that fire drills must be per Dungarvin policy every month: one drill per shift per month and at varying times/days. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Program Director/QIDP will audit fire and emergency drills that are scheduled and completed to	11/10/2023

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			ensure that they are done at varying times, days of the week, etc. Area Director is developing a monitoring system in conjunction with the new Administrative Coordinator to monitor the Life Safety books monthly to ensure that all required drills are present and always filed. Persons responsible: QIDP, house coordinator, admin coordinator	