

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G452	(X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING _____	(X3) DATE SURVEY COMPLETED 08/01/2023
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 52812 HIGHLAND DR SOUTH BEND, IN 46635		
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 08/01/23</p> <p>Facility Number: 000966 Provider Number: 15G452 AIM Number: 100244770</p> <p>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</p> <p>The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 7.</p> <p>Quality Review completed on 08/03/23</p>	E 0000		
E 0037 Bldg. --	<p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54,</p>			

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

TITLE

(X6) DATE

Susan Gichohi

Area Director

08/30/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency 			

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	<p>preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. 			

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	<p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. <p>*[For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following:</p> <ul style="list-style-type: none"> (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. 			

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.</p>			

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	<p>Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Program Director on 08/01/23 between 2:26 p.m. and 3:38 p.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of records review, the Program Director stated that emergency preparedness training is conducted, but did not have documentation confirming that staff have been trained.</p> <p>The findings were review with the Program Director and Direct Support Professional during the exit conference.</p>	E 0037	<p><u>E 037</u></p> <p><u>EP Training Program (Standard)</u> – Failed to ensure staff were trained in emergency preparedness policies and procedures.</p> <p><u>Corrective action for resident(s) found to have been affected</u></p> <p>All parts of the POC for the survey with event ID FY4821 will be fully implemented, including the following specifics:</p> <ul style="list-style-type: none"> · All facility staff are receiving re-training on the emergency preparedness policies and procedures and the documentation of this training is being placed in the Life Safety Binder. Per Dungarvin policy, facility staff are to receive this training upon hire and at regular meetings at least every 60 days. <p><u>How facility will identify other residents potentially affected & what measures taken</u></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes facility put in place to ensure no recurrence</u></p> <p>A monitoring system is in place and delegated to an Administrative Coordinator to monitor the Life Safety compliance of the facility, including a look behind check that regular, ongoing training records are being completed for all staff and filed in the Life Safety binder. Area Director to further verify with</p>	08/31/2023

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E 0039 Bldg. --	<p>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)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <ul style="list-style-type: none"> (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) 		a second look behind during regular site visits.	

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	<p>(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(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:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(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.</p> <p>(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</p>			

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	<p>include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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</p>			

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	<p>statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(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.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(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.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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</p>			

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	<p>to challenge an emergency plan.</p> <p>(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.</p> <p>*[For PACE at §460.84(d):]</p> <p>(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE 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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p>			

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	<p>(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency</p>			

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	<p>events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(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:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(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.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(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.</p> <p>*[For HHAs at §484.102]</p>			

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	<p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA 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.</p> <p>(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:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(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.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct</p>			

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	<p>exercises to test the emergency plan. The OPO must do the following:</p> <p>(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.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]:</p> <p>(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is 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.</p> <p>(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct a community-based exercises within the last 12 months to test the emergency plan. The ICF/IID facility must do the following:</p>		E 0039	<u>E 039</u> <u>EP Testing Requirements</u> <u>(Standard)</u> – The facility failed to conduct a community-based
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	<p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>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.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>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.</p> <p>(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.</p> <p>Findings include:</p> <p>Based on record review with the Program Director on 08/01/23 between 2:26 p.m. and 3:38 p.m., there was documentation of an actual event with a COVID-19 outbreak within the facility, but there was no documentation of community-based exercise or a facility-based functional exercise</p>		<p>exercise within the last 12 months to test the emergency plan.</p> <p><u>Corrective action for resident(s)</u> <u>found to have been affected</u></p> <p>All parts of the POC for the survey with event ID FY4821 will be fully implemented, including the following specifics:</p> <ul style="list-style-type: none"> · A community-based drill exercise will be completed, fully documented and will be available for review in the Life Safety binder by 08/31/2023. · The facility staff, including the Program Director and Lead DSP will review this finding and be retrained on the expectations regarding frequency and documentation of exercises to test the emergency plan annually. <p><u>How facility will identify other residents potentially affected & what measures taken</u></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes facility put in place to ensure no recurrence</u></p> <p>A monitoring system is in place and delegated to an Administrative Coordinator to monitor the Life Safety compliance of the facility, including a look behind check of this documentation during monthly visits. Area Director to further verify with a second look behind during regular site visits.</p>	

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K 0000 Bldg. 01	<p>when a community-based exercise is not accessible conducted within the last year. Based on interview at the time of records review, the Program Director stated that bomb drills and evacuation drills are usually completed throughout the year, but documentation could not be found for the drills.</p> <p>Findings were discussed with the Program Director at exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 08/01/23</p> <p>Facility Number: 000966 Provider Number: 15G452 AIM Number: 100244770</p> <p>At this Life Safety Code survey, Dungarvin Indiana LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR subpart 483.470(j), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one-story facility was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in common living areas with battery-smoke detectors in all client rooms. The facility has a capacity of eight and had a census of seven at the time of this survey.</p>	K 0000		

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K S100 Bldg. 01	<p>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 0.56.</p> <p>Quality Review completed on 08/03/23</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 portable fire extinguisher located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist</p>	K S100	<p><u>K 0100</u> <u>General Requirements – Other (Standard)</u> – Failed to ensure 3 of 3 portable fire extinguishers located in the facility was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection.</p> <p><u>Corrective action for resident(s) found to have been affected</u> All parts of the POC for the survey with event ID FY4821 will be fully implemented, including the following specifics:</p> <ul style="list-style-type: none"> QIDP and Maintenance staff are being retrained on the requirement that each fire extinguisher in the facility be inspected at least monthly with the inspections documented 	08/31/2023

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K S300 Bldg. 01	<p>maintained on file, or by an electronic method. Records shall be kept demonstrating that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 09/19/17 during the tour from 3:40 p.m. to 4:20 p.m. with the Qualified Intellectual Disability Professional (QIDP), the kitchen and bedroom hallway portable fire extinguishers had an affixed inspection and maintenance tag and lacked monthly inspections of April, May and July 2023. Furthermore, the garage fire extinguisher was lacking months of June and July of 2023. Monthly site checks were found that checked off fire extinguisher inspections, but the only documentation from the annual inspection to now was dated June of 2023. Based on interview at the time of record review, the Program Director acknowledged the missing checks and agreed no other documentation was able to be found.</p> <p>Findings were discussed with the Program Director at exit conference.</p> <p>NFPA 101 Protection - Other Protection - Other</p>		<p>including the date and initials of the person performing the inspection.</p> <ul style="list-style-type: none"> The facility's risk management binder will be updated with information on the location of each fire extinguisher at the facility so that none of the extinguishers are missed at any of the monthly site risk inspections that are completed. Maintenance Staff, Program Director, and Administrative Coordinator are all receiving training on this standard and finding and related expectations. <p><u>How facility will identify other residents potentially affected & what measures taken</u> All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes facility put in place to ensure no recurrence</u> A monitoring system is in place and delegated to an Administrative Coordinator to monitor the Life Safety compliance of the facility, including a look behind check of this documentation during monthly visits. Area Director to further verify with a second look behind during regular site visits.</p>	

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	<p>2012 EXISTING</p> <p>List in the REMARKS section any LSC Section 33.2.3 Protection 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.</p> <p>Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 4 of 4 battery operated smoke alarms in resident rooms were complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests.</p> <p>Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>During a tour of the facility with the Qualified Intellectual Disabilities Professional (QIDP) on 08/01/23 between 3:40 p.m. and 4:20 p.m., battery operated smoke alarms were observed in each sleeping room of the house. During record review with the Program Director between 2:26 p.m. to 3:38 p.m., no documentation could be provided for testing of the smoke alarms. Based on interview at the time of record review, the Program Director stated that monthly site inspections are done and that documentation checks off if attention is needed when the fire alarm is tested, it does not</p>	K S300	<p>K 0300</p> <p><u>Protection - Other (Standard)</u> – Failed to ensure documentation or the preventative maintenance of 4 of 4 battery operated smoke alarms in the resident rooms were complete.</p> <p><u>Corrective action for resident(s) found to have been affected</u> All parts of the POC for the survey with event ID FY4821 will be fully implemented, including the following specifics:</p> <ul style="list-style-type: none"> Maintenance will be instructed to either remove the battery operated smoke alarms or to ensure a system is in place to implement a preventative maintenance program for them. Going forward, Maintenance is to ensure that all life safety features in the home must be maintained if they are going to be in place. <p><u>How facility will identify other residents potentially affected & what measures taken</u> All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes</u></p>	08/31/2023

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K S345 Bldg. 01	<p>specifically mention and pass/fail battery smoke detector testing.</p> <p>The findings were reviewed with the Program Director during the exit conference.</p> <p>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</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be</p>	K S345	<p><u>facility put in place to ensure no recurrence</u> A monitoring system is in place and delegated to an Administrative Coordinator to monitor the Life Safety compliance of the facility, including a look behind check of this documentation during monthly visits. Area Director to further verify with a second look behind during regular site visits.</p>	08/31/2023

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	<p>checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review from with the Program Director between 2:46 p.m. and 3:40 p.m. on 08/01/23, the only sensitivity testing report provided during the survey was dated 06/19/2019 from the previous fire alarm company. Based on interview at the time of record review, the Program Director stated that he was only aware of the inspection reports within the binder provided and did not know when the last sensitivity testing was done for the fire alarm system.</p> <p>Findings were reviewed with the Program Director at exit conference.</p> <p>2. 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 Section 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:</p> <ul style="list-style-type: none"> a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices <p>This deficient practice could affect all building occupants.</p>		<p>found to have been affected</p> <p>All parts of the POC for the survey with event ID FY4821 will be fully implemented, including the following specifics:</p> <ul style="list-style-type: none"> · Full testing of the fire alarm system including sensitivity testing was completed on 6/9/2023. The documentation completed for this testing is attached to this submission. A copy is being placed in the Emergency Binder at the facility. · UPDATE 8/30/23: The contracted provider has been provided the exact wording of the regulatory standard regarding sensitivity testing for fire alarm systems. The provider will perform the acceptable testing or ensure that a system that can be tested in accordance with the applicable code is put back in place. Testing in accordance with this standard to be completed at this and any other Dungarvin facility monitored by the same contracted provider. · The concern regarding Dungarvin's previous system for ensuring 6 month visual inspections were conducted and adequately documented was addressed at another facility this year and our contract with FSS technologies now includes follow up 6 month inspections for all of our fire alarm systems. These will be due in December 2023. · Maintenance Technician to review this finding and sign training 	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G452	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2023
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP COD 52812 HIGHLAND DR SOUTH BEND, IN 46635		
(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
K S500 Bldg. 01	<p>Findings include:</p> <p>Based on record review with the Program Director on 08/01/23 between 2:26 p.m. and 3:38 p.m. an annual fire alarm inspection was conducted on 06/03/2022. A visual fire alarm inspection should have been conducted six months after the annual fire alarm report which would have been approximately December of 2022. A monthly site inspection checklist was provided that marked if the fire alarm system needed attention with a "yes/no" checkbox, but was not within the time frame of when the visual inspection should have been completed nor itemized all devices required to be inspected. Based on interview at the time of observation, the Program Director stated that he was aware that the facility maintenance staff does site inspections, but was unaware if the alarm company had done another inspection. Furthermore, the Program Director also acknowledged that no documentation of a semi-annual visual fire alarm inspection was found during the time of the survey.</p> <p>Findings were discussed with the Program Director at exit conference.</p> <p>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.</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords was not used as a substitute for fixed wiring according to</p>	K S500	<p>regarding expectations going forward.</p> <p><u>How facility will identify other residents potentially affected & what measures taken</u></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes facility put in place to ensure no recurrence</u></p> <p>A monitoring system is in place and delegated to an Administrative Coordinator to monitor the Life Safety compliance of the facility, including a look behind check of this documentation during monthly visits. Area Director to further verify with a second look behind during regular site visits.</p>	08/31/2023

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	<p>33.2.5.1. LSC 33.2.5.1 states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect approximately all staff and clients.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disability Professional (QIDP) on 08/01/23 between 3:40 p.m. and 4:20 p.m. , in bedroom #4, an extension cord was used to power a television. Furthermore, an extension cord was plugged into and supplied power by a power strip for a fish tank light and circulation pump. Based on interview at the time of observation, the QIDP agreed extension cords were in use and plugged into a power strip and acknowledged the issues found.</p> <p>The finding was reviewed with the Program Director during the exit conference.</p>		<p>ensure 2 of 2 flexible cords was not used as a substitute for fixed wiring.</p> <p><u>Corrective action for resident(s)</u> <u>found to have been affected</u></p> <p>All parts of the POC for the survey with event ID FY4821 will be fully implemented, including the following specifics:</p> <ul style="list-style-type: none"> • The extension cords in use have been removed. • All facility staff to review this finding and review the expectation that extension cords are not to be used as a substitute for fixed wiring. • Going forward, the Lead DSP and PD are to monitor that no extension cords are in use as a substitute for fixed wiring in the home on a monthly basis and document this on the Site Risk Management form. <p><u>How facility will identify other residents potentially affected & what measures taken</u></p> <p>All residents potentially are affected, and corrective measures address the needs of all clients.</p> <p><u>Measures or systemic changes facility put in place to ensure no recurrence</u></p> <p>A monitoring system is in place and delegated to an Administrative Coordinator to monitor the Life Safety compliance of the facility, including a look behind check of this documentation during monthly visits. Area Director to further</p>	

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