STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G573	A. BUILDING -- B. WING	08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	51778 TROWBRIDGE LN SOUTH BEND, IN 46637

(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: 08/25/21 Facility Number: 001087 Provider Number: 15G573 AIM Number: 100239960 At this Emergency Preparedness survey, Dungarvin Indiana, LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 08/30/21	E 0000	**K0345 (Standard)** **Fire Alarm Testing and Maintenance** FINDING Facilities must ensure the effective operation of fire alarm systems through semi-annual visual inspections and maintain records that verify inspection and address concerns. Dungarvin was unable to produce documents that evidenced completion of these tests. Additionally, Dungarvin was unable to produce documents that verify required smoke detection sensitivity testing within the prescribed timeframes. CORRECTION- IMMEDIATE Dungarvin must ensure that fire alarm systems are inspected, and that documentation is present to verify compliance and report any further actions based upon those inspections. To correct these deficiencies, Dungarvin will implement the following: ·A thorough review of Dungarvin documentation will be conducted to ascertain the presence of evidence of visual inspection of fire alarms and smoke detector sensitivity by the Area Director. ·If such documentation is present, it will be located in an accessible location and all staff	

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

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			will be retrained. If the second semi-annual inspection has not been completed, it will be scheduled at this time. Locating, training, and scheduling of the next test will be completed on or before September 24, 2021. ·If no documentation of current testing status is available, the inspection company will be contacted, and an inspection will be scheduled for the earliest available time slot. Additional inspection dates will be scheduled for the remainder of 2021 and for 2022. Inspection dates will be obtained and documented on or before September 24, 2021. ·Staff Retraining will be completed on or before September 24, 2021, including ·Inspection purpose and timelines ·The location of documentation of inspections and how to access ·Implementation of relevant Policies and Procedures PREVENTION The necessity of fire alarm and smoke detector inspections, as well as the need for access to relevant documentation impacts all residents in the facility. To ensure full compliance, inspections will be scheduled as far in advance as possible, and at a minimum, will be scheduled to maintain compliance for the upcoming 12	

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			months. All associated documentation will be collected in an electronic format that is accessible at all times at the facility and in administrative offices. Inspection dates will be added to a corporate shared calendar with a specific Dungarvin employee accountable for compliance with established timeframes and practices. MONITORING A tracking mechanism for the facility will be developed and implemented to record environmental and emergency testing compliance. The completion of tests as well as the date of the next test will be included as part of this mechanism. This tracking mechanism will be the responsibility of the Area Director to maintain.	
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 §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

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	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. 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	E 0004	**E004 (Standard)**	09/24/2021

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	failed to maintain an emergency preparedness plan that was reviewed and updated at least every 2 years in accordance with 42 CFR 483.475(a). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Director on 08/25/21 at 11:28 a.m., the facility Emergency Preparedness Plan entitled "Dungarvin Indiana LLC Policy and Procedures for Emergency Situations" and "Dungarvin Indiana LLC Facility Specific Emergency Preparedness Supplemental Information" the only update information found within either document was dated 06/19/2018. Based on an interview at the time of record review, the Program Director was asked if the documentation provided for review was the most up-to-date Emergency Preparedness documentation she had for the facility and she stated that it was. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		**Emergency Preparedness Plan** FINDING Facilities must establish and maintain an emergency preparedness program. Dungarvin did not meet this standard. Specifically, an up-to-date plan was not available for review. Additionally, there was no evidence available to verify that the plan was reviewed and updated every two years as required by regulations. CORRECTION- IMMEDIATE Dungarvin is dedicated to ensuring the health and safety of the clients entrusted to its care. An important element of this commitment is the development and implementation of an emergency preparedness plan, regularly updated and accessible to staff. Specific corrective actions include: ·Staff Retraining will be completed on or before September 24, 2021, including ·The purpose, location and use of the most recent Emergency Preparedness Plan ·The location of supplementary and facility-specific Emergency Plan Documents ·The necessary schedule of tests and drills to ensure effective implementation of the plan ·Communication and individual roles in ensuring a safe	

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			environment and effectiveness during emergency situations ·The Current Emergency Preparedness Plan, along with supplementary and facility-specific materials will be reviewed, updated, and distributed on or before September 24, 2021 PREVENTION The inability to access the most current Emergency Preparedness plan impacts all individuals residing in the facility. To ensure that the plan and all supplementary and facility-specific materials are current and up to date, Dungarvin will update compliance processes to include verification that the plan is reviewed and updated at a minimum of every two years. Review dates will be added to the corporate policy review calendar with a specific Dungarvin employee accountable for its accuracy and effectiveness. Any and all changes will be communicated to all Dungarvin personnel. MONITORING A cover sheet will be added to the Emergency Preparedness Plan and all associated facility-specific materials which will include the date of the most recent review, significant changes, and the signature of the accountable	

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			Dungarvin employee.	
E 0013 Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (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 at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities:			

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	*[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update emergency preparedness policies and procedures at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants.	E 0013	**E013 (Standard)** **Policies and Procedures** FINDING Facilities must develop and implement policies and	09/24/2021

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	Findings include: Based on record review with the Program Director on 08/25/21 at 11:28 a.m., the facility Emergency Preparedness Plan entitled "Dungarvin Indiana LLC Policy and Procedures for Emergency Situations" and "Dungarvin Indiana LLC Facility Specific Emergency Preparedness Supplemental Information" the only update information found within either document was dated 06/19/2018. Based on an interview at the time of record review, the Program Director was asked if the documentation provided for review was the most up-to-date Emergency Preparedness documentation she had for the facility and she stated that it was. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		procedures based on the Emergency Plan. Dungarvin did not meet this expectation as indicated by the absence of supplemental information demonstrating compliance with review and update requirements. CORRECTION- IMMEDIATE Dungarvin maintains up-to-date policies and procedures for implementing the Emergency Preparedness Plan. As these materials were not locatable at the time of the survey, the following corrective actions will be initiated ·Staff Retraining will be completed on or before September 24, 2021, including ·The purpose, location and use of the most recent Emergency Preparedness Plan ·The location of supplementary and facility-specific Emergency Plan Documents ·The necessary schedule of tests and drills to ensure effective implementation of the plan ·Communication and individual roles in ensuring a safe environment and effectiveness during emergency situations ·Implementation of relevant Policies and Procedures ·All policies and procedures related to the Emergency Preparedness Plan or referenced in the plan will be reviewed, updated, and distributed on or before September 24, 2021	

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			PREVENTION The inability to access the current Policies and Procedures regarding emergency preparedness impacts all individuals residing in the facility. To ensure these policies and procedures are current and up to date, Dungarvin will update compliance processes to include verification that the plan is reviewed and updated at a minimum of every two years. Review dates will be added to the corporate policy review calendar with a specific Dungarvin employee accountable for its accuracy and effectiveness. Any and all changes will be communicated to all Dungarvin personnel. MONITORING A cover sheet will be added to relevant Policies and Procedures which will include the date of the most recent review, significant changes, and the signature of the accountable Dungarvin employee.	
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c),			

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	§485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to maintain an emergency preparedness communication plan that complies with Federal, State, and local laws that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(c). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Director on 08/25/21 at 11:28 a.m., the facility Emergency Preparedness Plan entitled "Dungarvin Indiana LLC Policy and Procedures for Emergency Situations" and "Dungarvin Indiana LLC Facility Specific Emergency Preparedness Supplemental Information" the only update information found within either document was dated 06/19/2018. Based on an interview at the time of record review, the Program Director was asked if the documentation provided for review was the most up-to-date Emergency Preparedness documentation she had for the facility and she stated that it was. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0029	**E029 (Standard)** **Communication Plan** FINDING Facilities must develop and implement a communication plan as a component of the Emergency Plan. Dungarvin did not meet this expectation as indicated by the absence of supplemental information demonstrating compliance with review and update requirements. CORRECTION- IMMEDIATE Dungarvin is expected to maintain a current emergency communication plan as a component of its Emergency Preparedness Plan. As these materials were not locatable at the time of the survey, the following corrective actions will be initiated ·Staff Retraining will be completed on or before September 24, 2021, including ·The purpose, location and use of the most recent Emergency Preparedness Plan ·The location of supplementary and facility-specific	09/24/2021

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			Emergency Plan Documents ·Communication during emergency situations ·Communication and individual roles in ensuring a safe environment and effectiveness during emergency situations ·Implementation of relevant Policies and Procedures ·An emergency communication plan, as a component of Dungarvin's Emergency Preparedness Plan, will be reviewed, updated, and distributed on or before September 24, 2021 PREVENTION The inability to access a current communication plan, as a component of the Emergency Preparedness Plan, impacts all individuals residing in the facility. To ensure the communication plan is current and up to date, Dungarvin will update compliance processes to include verification that the plan is reviewed and updated at a minimum of every two years. Review dates will be added to the corporate policy review calendar with a specific Dungarvin employee accountable for its accuracy and effectiveness. Any and all changes will be communicated to all Dungarvin personnel. MONITORING The cover sheet for the Emergency Preparedness plan will	

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			include the communication plan, and will include the date of the most recent review, significant changes, and the signature of the accountable Dungarvin employee.	
E 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training			

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	and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			

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	15G573	A. BUILDING -- B. WING	08/25/2021

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	Based on record review and interview, the facility failed to review and update the training and testing program at least every 2 years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on record review with the Program Director on 08/25/21 at 11:28 a.m., the facility Emergency Preparedness Plan entitled "Dungarvin Indiana LLC Policy and Procedures for Emergency Situations" and "Dungarvin Indiana LLC Facility Specific Emergency Preparedness Supplemental Information" the only update information found within either document was dated 06/19/2018. Based on an interview at the time of record review, the Program Director was asked if the documentation provided for review was the most up-to-date Emergency Preparedness documentation she had for the facility and she stated that it was. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.	E 0036	**E036 (Standard)** **Training and Testing** FINDING Facilities must develop and maintain an emergency preparedness training and testing program. Dungarvin did not meet this expectation as there was no evidence or records of training and testing that met this standard. CORRECTION- IMMEDIATE Dungarvin is expected to maintain a training and testing program as part of the Emergency Preparedness Plan. As these materials were not locatable at the time of the survey, the following corrective actions will be initiated ·Staff Retraining will be completed on or before September 24, 2021, including ·The purpose, location and use of the most recent Emergency Preparedness Plan ·The location of supplementary and facility-specific Emergency Plan Documents ·Training and Testing requirements, based upon the current Emergency Preparedness Plan ·Communication and individual roles in ensuring a safe environment and effectiveness during emergency situations ·Implementation of relevant Policies and Procedures ·A training and testing plan, as a	09/24/2021

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			component of Dungarvin's Emergency Preparedness Plan, will be reviewed, updated, and distributed on or before September 24, 2021 PREVENTION The inability to access a current EP Training and Testing Plan, as a component of the Emergency Preparedness Plan, impacts all individuals residing in the facility. To ensure the communication plan is current and up to date, Dungarvin will update compliance processes to include verification that the plan is reviewed and updated at a minimum of every two years. Review dates will be added to the corporate policy review calendar with a specific Dungarvin employee accountable for its accuracy and effectiveness. Any and all changes will be communicated to all Dungarvin personnel. MONITORING The cover sheet for the Emergency Preparedness plan will apply the training and testing plan, and will include the date of the most recent review, significant changes, and the signature of the accountable Dungarvin employee.	
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),			

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	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 §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). *[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]: (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 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			

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	(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. (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			

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	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 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			

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	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 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.			

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	*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization 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 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. (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 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):]			

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	(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. (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			

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	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. (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 HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or			

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	(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (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. (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 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA'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			

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	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 maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (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. (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.			
	Based on record review and interview, the facility failed to conduct at least two exercises to test the emergency plan at least annually. 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	E 0039	**E039 (Standard)** **Emergency Plan Testing Requirements** FINDING Facilities must conduct exercises to test the emergency plan twice each year, one of which tests must be a community-based or facility-based exercise, and the	09/24/2021

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	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 community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Or conduct an exercise that may include, but is not limited to the following: a. A 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. Findings include: Based on record review with the Program Director on 08/25/21 at 11:28 a.m., the facility Emergency Preparedness Plan entitled "Dungarvin Indiana LLC Policy and Procedures for Emergency Situations" and "Dungarvin Indiana LLC Facility Specific Emergency Preparedness Supplemental Information" the only updated information found within either document was dated 06/19/2018. Based on an interview at the time of record review, the Program Director was asked if the facility had conducted at least two exercises consisting of a community-based or an individual, facility-based functional exercise, or a mock disaster drill, or a		other either an additional exercise or an allowable alternative testing methodology. Dungarvin did not meet this expectation as there was no evidence or records of training and testing that met this standard. CORRECTION- IMMEDIATE Dungarvin has the expectation of performing emergency plan testing twice each year, conforming to the required regulations. Further, these tests must be fully documented, the response analyzed, and any changes, improvements, or need for retraining identified. As evidence of these testing exercises were not present at the time of the survey, the following corrective actions will be taken: ·A thorough review of Dungarvin documentation will be conducted to ascertain the presence of evidence of emergency plan testing and follow-up records that have taken place within the last six months by the Area Director. ·If such documentation is present, it will be located in an accessible location and all staff will be retrained. A second test of the emergency plan will be scheduled to occur within six months of the latest documented test. Locating, training, and scheduling of the next test will be completed on or before September 24, 2021.	

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(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
	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, and she answered not yet. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		·If no documentation of current testing status is available, a test will take place and results documented no later than September 24, 2021. Additionally, a second test will be scheduled within six months of the September 2021 test. ·Staff Retraining will be completed on or before September 24, 2021, including ·The purpose, location and use of the most recent Emergency Preparedness Plan ·The location of supplementary and facility-specific Emergency Plan Documents ·Training and Testing requirements, based upon the current Emergency Preparedness Plan ·Communication and individual roles in ensuring a safe environment and effectiveness during emergency situations ·Implementation of relevant Policies and Procedures PREVENTION The inability to access documentation and analysis of semi-annual testing of the emergency preparedness plan impacts all individuals residing in the facility. To ensure full compliance with Standard E039, all associated planning and testing documentation will be collected in an electronic format that is	

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			accessible at all times at the facility and in administrative offices. Testing dates will be added to the corporate shared calendar with a specific Dungarvin employee accountable for compliance with established timeframes and practices. The date of the next test will be determined and posted as a part of the concluding analysis and review process of each test. These prevention steps will be complete on or before September 24, 2021. MONITORING A tracking mechanism for the facility will be developed and implemented to record environmental and emergency testing compliance. The completion of tests as well as the date of the next test will be included as part of this mechanism. This tracking mechanism will be the responsibility of the Area Director to maintain.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in Accordance with 42 CFR 483.470(j). Survey Date: 08/25/21	K 0000	**K0345 (Standard)** **Fire Alarm Testing and Maintenance** FINDING Facilities must ensure the effective	

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	Facility Number: 001087 Provider Number: 15G573 AIM Number: 100239960 At this Life Safety Code survey, Dungarvin Indiana LLC, was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one-story facility with a basement was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in the living areas. The facility has a capacity of 8 and had a census of 6 at the time of this survey. Calculation of the Evaluation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.28. Quality Review completed on 08/30/21		operation of fire alarm systems through semi-annual visual inspections and maintain records that verify inspection and address concerns. Dungarvin was unable to produce documents that evidenced completion of these tests. Additionally, Dungarvin was unable to produce documents that verify required smoke detection sensitivity testing within the prescribed timeframes. CORRECTION- IMMEDIATE Dungarvin must ensure that fire alarm systems are inspected, and that documentation is present to verify compliance and report any further actions based upon those inspections. To correct these deficiencies, Dungarvin will implement the following: ·A thorough review of Dungarvin documentation will be conducted to ascertain the presence of evidence of visual inspection of fire alarms and smoke detector sensitivity by the Area Director. ·If such documentation is present, it will be located in an accessible location and all staff will be retrained. If the second semi-annual inspection has not been completed, it will be scheduled at this time. Locating, training, and scheduling of the next test will be completed on or before September 24, 2021. ·If no documentation of current testing status is available,	

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			the inspection company will be contacted, and an inspection will be scheduled for the earliest available time slot. Additional inspection dates will be scheduled for the remainder of 2021 and for 2022. Inspection dates will be obtained and documented on or before September 24, 2021. ·Staff Retraining will be completed on or before September 24, 2021, including ·Inspection purpose and timelines ·The location of documentation of inspections and how to access ·Implementation of relevant Policies and Procedures PREVENTION The necessity of fire alarm and smoke detector inspections, as well as the need for access to relevant documentation impacts all residents in the facility. To ensure full compliance, inspections will be scheduled as far in advance as possible, and at a minimum, will be scheduled to maintain compliance for the upcoming 12 months. All associated documentation will be collected in an electronic format that is accessible at all times at the facility and in administrative offices. Inspection dates will be added to a corporate shared calendar with a specific Dungarvin employee accountable for	

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			compliance with established timeframes and practices. MONITORING A tracking mechanism for the facility will be developed and implemented to record environmental and emergency testing compliance. The completion of tests as well as the date of the next test will be included as part of this mechanism. This tracking mechanism will be the responsibility of the Area Director to maintain.	
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 1) 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	K S345	**KS345 (Standard)** **Fire Alarm Testing and Maintenance** FINDING Facilities must ensure the effective operation of fire alarm systems through semi-annual visual inspections and maintain records	09/24/2021

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	visually inspected semi-annually: 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 This deficient practice could affect all clients and staff. Findings include: Based on record review on 08/25/21 at 11:46 a.m. with the Program Director present, no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months. Based on interview at the time of record review, the Program Director acknowledged there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review and added that she would have it scheduled with the facility vendor right away. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding. 2) Based on record review and interview, the facility failed to ensure all facility smoke detectors were within their listed and marked sensitivity range. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6. Section 9.6.1.3 states a fire alarm system shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of		that verify inspection and address concerns. Dungarvin was unable to produce documents that evidenced completion of these tests. Additionally, Dungarvin was unable to produce documents that verify required smoke detection sensitivity testing within the prescribed timeframes. CORRECTION- IMMEDIATE Dungarvin must ensure that fire alarm systems are inspected, and that documentation is present to verify compliance and report any further actions based upon those inspections. To correct these deficiencies, Dungarvin will implement the following: ·A thorough review of Dungarvin documentation will be conducted to ascertain the presence of evidence of visual inspection of fire alarms and smoke detector sensitivity by the Area Director. ·If such documentation is present, it will be located in an accessible location and all staff will be retrained. If the second semi-annual inspection has not been completed, it will be scheduled at this time. Locating, training, and scheduling of the next test will be completed on or before September 24, 2021. ·If no documentation of current testing status is available, the inspection company will be contacted, and an inspection will be scheduled for the earliest	

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	installation, and 14.4.5.3.2 states every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all clients and staff. Findings include: Based on record review with the Program Director at 12:08 a.m. on 08/25/21, documentation of a smoke detector sensitivity test within the most		available time slot. Additional inspection dates will be scheduled for the remainder of 2021 and for 2022. Inspection dates will be obtained and documented on or before September 24, 2021. ·Staff Retraining will be completed on or before September 24, 2021, including ·Inspection purpose and timelines ·The location of documentation of inspections and how to access ·Implementation of relevant Policies and Procedures PREVENTION The necessity of fire alarm and smoke detector inspections, as well as the need for access to relevant documentation impacts all residents in the facility. To ensure full compliance, inspections will be scheduled as far in advance as possible, and at a minimum, will be scheduled to maintain compliance for the upcoming 12 months. All associated documentation will be collected in an electronic format that is accessible at all times at the facility and in administrative offices. Inspection dates will be added to a corporate shared calendar with a specific Dungarvin employee accountable for compliance with established timeframes and practices.	

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	recent two-year period was not available for review. Based on interview at the time of record review, the Program Director acknowledged documentation of smoke detector sensitivity testing within the most recent two-year period was not available for review stating that she would have the vendor schedule it as soon as possible. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		MONITORING A tracking mechanism for the facility will be developed and implemented to record environmental and emergency testing compliance. The completion of tests as well as the date of the next test will be included as part of this mechanism. This tracking mechanism will be the responsibility the Area Director to maintain.	
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 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,			

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	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). 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			

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	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 record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all clients and staff. Findings include: Based on record review on 08/25/21 at 11:36 a.m. with the Program Director present, an inspection from the State Fire Marshalls office dated 05/05/21 stated that "the facility was overdue for the internal pipe investigation on the sprinkler system." Furthermore, the document entitled "Wet Fire Sprinkler System Inspection Report" dated 07/19/21 from the facilities Sprinkler system vendor also noted in the deficiencies section, "Internal Pipe Investigation was due on 03/03/21. The Sprinkler system riser was then inspected, and it was noted that the basement sprinkler piping was metallic and would indeed need to be	K S353	**KS353 (Standard)** **Sprinkler System** FINDING Facilities must comply with the mandated inspection schedule and act upon any noted deficiencies. Dungarvin did not meet this standard as evidenced by being able to provide no documentation of an inspection of piping and branch line conditions for obstructions within the required five-year period. Additionally, there was no evidence that two sprinkler system gauges were tested and recalibrated or replaced within the required five-year period. CORRECTION- IMMEDIATE Dungarvin must ensure that sprinkler systems are inspected and maintained , and that documentation is present to verify compliance and report any further actions based upon those inspections. To correct these deficiencies, Dungarvin will implement the following: ·A thorough review of Dungarvin documentation will be conducted to ascertain the presence of	09/24/2021

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	internally inspected on a 5-year basis. Based on interview at the time of the observation, the Program Director was asked if documentation of a 5-year internal pipe investigation could be provided for record review, the Program Director stated that the inspection had not yet been completed. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding. 2) Based on observation and interview, the facility failed to ensure 2 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: Based on observations made on 08/25/21 at 12:04 p.m. with the Program Director present, it was noted that the sprinkler system had two visible gauges. When inspected, one gauge was manufactured in 2014, and the other was manufactured 2015 based on the dates within the gauge. These were both over 5 years old and needed to be re-calibrated or replaced. Based on interview at the time of the observations, the Program Director acknowledged that documentation of sprinkler system gauge recalibration was not available for review and that both sprinkler system gauges was more than five		evidence of sprinkler inspection and maintenance by the Area Director. ·If such documentation is present, it will be located in an accessible location and all staff will be retrained on or before September 24, 2021. ·If no documentation is available, the inspection company will be contacted, and a fully compliant inspection and maintenance schedule will developed for the remainder of 2021 and 2022. Inspection dates will be obtained and documented on or before September 24, 2021. ·Staff Retraining will be completed on or before September 24, 2021, including ·Inspection purpose and timelines ·The location of documentation of inspections and how to access ·Implementation of relevant Policies and Procedures ·An internal pipe inspection in compliance with NFPA standards will be completed on or before September 24, 2021. ·Replacement or recalibration of both system gauges in compliance with NFPA standards will be completed by September 24, 2021 PREVENTION Compliance with sprinkler inspection and maintenance	

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	years old. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		schedules can impact the safety of all facility residents. To ensure that inspection and maintenance of the sprinkler system is fully in compliance, a full NFPA compliant inspection and maintenance schedule will be developed in partnership with the contracted sprinkler entity. Timelines and specific dates will be scheduled, whenever possible, for the remainder of 2021 and 2022. All associated documentation will be collected in an electronic format that is accessible at all times at the facility and in administrative offices. Inspection dates will be added to a corporate shared calendar with a specific Dungarvin employee accountable for compliance with established timeframes and practices. MONITORING A tracking mechanism for the facility will be developed and implemented to record environmental and emergency testing compliance. The completion of tests as well as the date of the next test will be included as part of this mechanism. This tracking mechanism will be the responsibility of the Area Director to maintain.	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric			

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	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 1 of 1 multiplug was not used as a substitute for fixed wiring according to 33.2.5.1. 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 one client. Findings include: Based on observations made on 08/25/21 at 12:04 p.m. with the Program Director present, it was noted that the client in Bedroom #1 had a power strip in use. A video game console, a desk lamp, a phone charger, and a flat screen television were all plugged into the power strip. Based on an interview at the time of the observation, the Program Director stated that she did not know the client was using the power strip and would speak to him about options other than the use of the power strip within his room. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.	K S511	**K0511 (Standard)** **Gas and Electric** FINDING Facilities must maintain compliance with all applicable sections of NPFA, including the National Electric Code. Dungarvin did not meet this standard as evidenced by the observation of a multiplug used to power multiple electrical devices in Bedroom #1 CORRECTION- IMMEDIATE Dungarvin must ensure that the use of electricity is compliant with the national electric code as it applies to the facility. To correct this deficiency, Dungarvin will complete the following corrective actions: ·The multiplug that did not meet the standard was removed from Bedroom #1 on 9/9/2021 and returned to the family of the individual served. ·A surge suppressing power strip that complies with standards will be purchased for the individual who was utilizing the multiplug unit and installed on or before September 24, 2021. ·The client was trained informally on the use of potentially	09/24/2021

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	15G573	A. BUILDING 01 B. WING	08/25/2021

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			overloaded electrical outlets and alternatives on 9/9/2021 and this training will be formally documented with him on or before September 24, 2021.. ·Staff Retraining will be completed on or before September 24, 2021, including ·Compliance with national electric code and electricity safety ·The location of standards and regulations that can be accessed to review applicable regulations PREVENTION While this deficiency was noted in a single location, safety measures will apply to the facility as a whole. Prevention steps will include regular inspection of electrical use in the facility as part of the Dungarvin monthly walk-through inspection, and the notification of the Dungarvin Maintenance department of any identified issues or the need for increased wired outlets as client usage patterns demand. The inclusion of this item on the Dungarvin inspection form was confirmed on September 10, 2021. These preventative measures will be implemented on or before September 24, 2021. MONITORING Documentation of Dungarvin environmental walk-throughs will be maintained in an electronic	

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			format accessible from the facility and from administrative offices. The addition of these items on the Dungarvin Inspection Form will be permanent.	
K S712 Bldg. 01	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation 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 provide documentation of a fire drill conducted on the first, second and third shift for 3 of 4 quarters. This deficient practice affects all	K S712	**K0712 (Standard)** **Fire Drills** FINDING	09/24/2021

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	clients and staff. Findings include: Based on record review with the Program Director at 11:23 a.m. on 08/25/21, documentation of a fire drill conducted on the first, second and third shift for the first quarter, (January, February, and March) of 2021, the second quarter (April, May, and June) of 2021 and the fourth quarter (October, November, and December) of 2020 were not available for review. Based on interview at the time of record review, the Program Director stated that the fire drills were kept on the facility computer and that she was having trouble getting access to them. During the exit conference with the Program Director at 1:05 p.m., no additional information or evidence could be provided contrary to this deficient finding.		Facilities must conduct evacuation drills every quarter for each shift that include all included components. Dungarvin did not meet this standard, as documentation of these drills were not available for review. CORRECTION- IMMEDIATE Dungarvin must ensure that all required evacuation drills are conducted, and that documentation is present to verify compliance and determine if staff training is needed or evacuation protocols require revision. To correct these deficiencies, Dungarvin will implement the following: ·A thorough review of Dungarvin documentation will be conducted to ascertain the presence of evidence of the conduction of drills for each shift per quarter by the Area Director. ·If such documentation is present, it will be located in an accessible location and all staff will be retrained on or before September 24, 2021. ·If any or all of the referenced documents are not available, accountability for the missing documents will be established and appropriate staff retrained as stated below. This corrective action will occur on or before September 24, 2021. ·Staff Retraining will be completed on or before September	

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			24, 2021, including ·Evacuation Drills ·Evaluation of performance during evacuation drills ·Implementation of relevant Policies and Procedures ·All shifts that have not already done so will conduct the required drills for the third quarter of 2021 by September 24, 2021. PREVENTION Compliance with mandatory evacuation drills can impact the safety of all facility residents. To ensure staff competency and full compliance with regulations, evacuation drill dates will be determined and scheduled for the remainder of 2021 and for 2022. All associated documentation will be collected in an electronic format that is accessible at all times at the facility and in administrative offices. Drill dates will be added to a corporate shared calendar with a specific Dungarvin employee accountable for compliance with established timeframes and practices. Dates will be scheduled and documented by September 24, 2021. MONITORING A tracking mechanism for the facility will be developed and implemented to record environmental and emergency testing compliance. The	

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			completion of evacuation drills, results, and upcoming dates will be included in this record. This tracking mechanism will be the responsibility of the Area Director to maintain.	