STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G452	A. BUILDING -- B. WING	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	52812 HIGHLAND DR SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 04/29/2021 Facility Number: 000966 Provider Number: 15G452 AIM Number: 100244770 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 8. Quality Review completed on 05/06/21	E 0000		
E 0001 Bldg. --	403.748, 416.54, 418.113, 441.184, 482.15, 483.475, 483.73, 484.102, 485.625, 485.68, 485.727, 485.920, 486.360, 491.12 Establishment of the Emergency Program (EP) The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must 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			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the facility failed to meet the Condition of Participation to establish and maintain an emergency preparedness program in accordance with 42 CFR 483.475 that includes the following elements: a) An Emergency Plan b) Policies and Procedures c) A Communication Plan d) Training and Testing This deficient practice could affect all occupants. Findings include: During record review with the Program Director on 04/29/2021 from 11:20 a.m. to 12:10 p.m. no documentation could be provided regarding an	E 0001	Dungarvin Indiana is committed to operating in full compliance with the Condition of Participation to establish and maintain an emergency preparedness program in accordance with 42 CFR 483.475. Dungarvin Indiana has developed an emergency preparedness plan for this facility that includes the following elements: a) An Emergency Plan b) Policies and Procedures c) A Communication Plan d) Training and Testing On the date of this survey, the Program Director/QIDP went to the facility to meet the survey staff	05/29/2021

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	Emergency Preparedness Program compliant with 42 CFR 483.475 upon request. The facility was not able to provide an All-Hazards Risk Assessment, (See E0004), Plans and Policies (See E0013), Communications (See E0029), or Testing (See E0036). During interview at the time of record review, the Program Director stated she was unable to locate a paper copy or a computer-based copy of the Emergency Preparedness policy. This deficient finding was reviewed with the Program Director at the time of exit.		and was unable to locate the Emergency Plan binder which she had recently updated with F1s and the recently reviewed assessments, communication plans, and training and testing. It has been determined that this entire binder had been given to a staff member to return to the facility and that it was placed in the wrong cabinet. In order to demonstrate compliance with this condition, the following plan of action is underway: - The QIDP will ensure that the Emergency Plan book is audited and contains all required elements of the emergency preparedness plan. - The Area Director will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that all required elements are present in the book and that all assessments, communication plan, supplemental forms and policies are current and in the binder. - All facility staff will be trained on the correct location of the binder and on the contents of the Emergency Plan. This training will include testing to competency. - During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff on the location of the Emergency plan as	

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			well as various elements of the Site Specific Emergency Plan and the Emergency policies in order for staff to demonstrate continued competency. These visits are scheduled to take place 4 times per week for 2 weeks and then titrate to 3 times per week for 2 weeks and then 2 times per week for 2 weeks after that. Going forward, the QIDP is responsible to ensure that the emergency preparedness program is readily available at the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that all facility staff review the plan at staff meetings every other month to ensure ongoing comprehension and competency.	
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:			

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	(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. Based on record review and interview, the facility failed to develop an emergency preparedness plan that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(a). 42 CFR 483.475(a)(1) states this plan must be based on and include a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. This deficient practice could affect all occupants. Findings include:	E 0004	The facility has an emergency preparedness plan that has been reviewed and updated at least every two years in accordance with 42 CFR 483.475. On the date of this survey, the Program Director/QIDP went to the facility to meet the survey staff and was unable to locate the Emergency Plan binder which she had recently updated with the most recently reviewed and	05/29/2021

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	During record review with the Program Director on 04/29/2021 from 11:20 a.m. to 12:10 p.m., the facility was unable to provide a Emergency Preparedness Plan, Program, or Policies upon request. Based on interview at the time of record review, the Program Director stated she could not locate a paper copy or a computer based version of the emergency preparedness plan. This deficient finding was reviewed with the Program Director at the time of exit.		updated emergency preparedness plan. It has been determined that this entire binder had been given to a staff member to return to the facility and that it was placed in the wrong cabinet. In order to demonstrate compliance with this standard, the following plan of action is underway: - The QIDP will ensure that the Emergency Plan book is audited and contains all required elements of the emergency preparedness plan. - The Area Director will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the plan includes a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. - All facility staff will be trained on the correct location of the binder and on the contents of the Emergency Plan. This training will include testing to competency. - During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff on the location of the Emergency plan as well as various elements of the Site Specific Emergency Plan and the Emergency policies in order for staff to demonstrate continued competency. These	

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			visits are scheduled to take place 4 times per week for 2 weeks and then titrate to 3 times per week for 2 weeks and then 2 times per week for 2 weeks after that. Going forward, the QIDP is responsible to ensure that the emergency preparedness program is readily available at the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that all facility staff review the plan at staff meetings every other month to ensure ongoing comprehension and competency.	
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 (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			

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	paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *[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 develop emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: During record review with the Program Director on 04/29/2021 from 11:10 a.m. to 12:10 p.m., the facility could not provide policies regarding emergency preparedness upon request. Based on interview at the time of record review, the Program Director stated she was unable to locate a paper copy or computerized version of the	E 0013	The facility has developed emergency preparedness policies and procedures that have been reviewed and updated at least every two years in accordance with 42 CFR 483.475(b). On the date of this survey, the Program Director/QIDP went to the facility to meet the survey staff and was unable to locate the Emergency Plan binder which she had recently updated with the most recently reviewed and updated emergency preparedness policy. It has been determined that this entire binder had been given to a staff member to return	05/29/2021

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	emergency preparedness plan. This deficient finding was reviewed with the Program Director at the time of exit.		to the facility and that it was placed in the wrong cabinet. In order to demonstrate compliance with this standard, the following plan of action is underway: - The QIDP will ensure that the Emergency Plan book is audited and contains the most currently reviewed copies of Dungarvin's emergency preparedness policies and procedures. - The Area Director will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the plan includes the most recently reviewed copies of Dungarvin's emergency preparedness policies and procedures. - All facility staff will be trained on the correct location of the binder and on the location of the emergency preparedness policies and procedures. This training will include testing to competency. - During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff on the location of the Emergency plan as well as various elements of the Site Specific Emergency Plan and the Emergency policies in order for staff to demonstrate continued competency. These visits are scheduled to take place 4 times per week for 2 weeks and then titrate to 3 times per week for	

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			2 weeks and then 2 times per week for 2 weeks after that. Going forward, the QIDP is responsible to ensure that the emergency preparedness program, including related agency policy, is readily available at the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that all facility staff review the plan at staff meetings every other month to ensure ongoing comprehension and competency.	
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 (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). Based on record review and interview, the facility failed to develop an emergency preparedness communication plan that complies with Federal, State, and local laws 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: During record review with the Program Director on 04/29/2021 from 11:20 a.m. to 12:10 p.m., the facility was unable to provide an emergency preparedness plan upon request. Based on	E 0029	The facility has an emergency preparedness communication plan that has been reviewed and updated at least every two years in accordance with 42 CFR 483.475(c). On the date of this survey, the Program Director/QIDP went to the facility to meet the survey staff and was unable to locate the Emergency Plan binder which she had recently updated with the most recently reviewed and updated emergency preparedness	05/29/2021

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	interview at the time of record review, the Program Director stated she could not locate a paper or a computerized version of the emergency preparedness plan. This deficient finding was reviewed with the Program Director at the time of exit.		communication plan. It has been determined that this entire binder had been given to a staff member to return to the facility and that it was placed in the wrong cabinet. In order to demonstrate compliance with this standard, the following plan of action is underway: - The QIDP will ensure that the Emergency Plan book is audited and contains all required elements of the emergency preparedness communication plan. - The Area Director will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the plan includes the most recently updated emergency preparedness communication plan. - All facility staff will be trained on the correct location of the binder and on the contents of the emergency preparedness communication plan. This training will include testing to competency. - During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff on the location of the Emergency plan as well as various elements of the Site Specific Emergency Plan and the Emergency preparedness communication plan in order for staff to demonstrate continued competency. These visits are scheduled to take place 4 times	

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			per week for 2 weeks and then titrate to 3 times per week for 2 weeks and then 2 times per week for 2 weeks after that. Going forward, the QIDP is responsible to ensure that the emergency preparedness communication plan is readily available at the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that all facility staff review the plan at staff meetings every other month to ensure ongoing comprehension and competency.	
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 *[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, 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			

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	must be reviewed and updated at least every 2 years. *[For LTC at §483.73(d):] (d) Training 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,			

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	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. Based on record review and interview, the facility failed to develop an emergency preparedness training and testing program that was reviewed and updated at least every two years in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: During record review with the Program Director on 04/29/2021 from 11:20 a.m. to 12:10 p.m., the facility was unable to provide a emergency preparedness training and testing program upon request. Based on interview at the time of record review, the Program Director stated she was unable to locate a paper or computerized version of the emergency preparedness plan. This deficient finding was reviewed with the Program Director at the time of exit.	E 0036	The facility has an emergency preparedness training and testing program that has been reviewed and updated at least every two years in accordance with 42 CFR 483.475(d). On the date of this survey, the Program Director/QIDP went to the facility to meet the survey staff and was unable to locate the Emergency Plan binder which she had recently updated with the most recently reviewed and updated emergency preparedness training and testing program. It has been determined that this entire binder had been given to a staff member to return to the facility and that it was placed in the wrong cabinet. In order to demonstrate compliance with this standard, the following plan of action is underway: - The QIDP will ensure that the Emergency Plan book is audited and contains all required elements of the emergency preparedness training and testing program. - The Area Director will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the plan includes the most recently reviewed and updated emergency preparedness	05/29/2021

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			training and testing program. - All facility staff will be trained on the correct location of the binder and on the contents of the Emergency Plan. This training will include testing to competency. - During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff on the location of the Emergency plan as well as various elements of the Site Specific Emergency Plan and the emergency preparedness training and testing program in order for staff to demonstrate continued competency. These visits are scheduled to take place 4 times per week for 2 weeks and then titrate to 3 times per week for 2 weeks and then 2 times per week for 2 weeks after that. Going forward, the QIDP is responsible to ensure that the emergency preparedness training and testing program is readily available at the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that all facility staff review the plan at staff meetings every other month to ensure ongoing comprehension and competency.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health	K 0000		

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	in accordance with 42 CFR 483.470(j). Survey Date: 04/29/2021 Facility Number: 000966 Provider Number: 15G452 AIM Number: 100244770 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 was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in common living areas with none in client sleeping rooms. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, could not be determined due to the inavailability of F-1 Forms. As such, the facility was rated Impractical. Quality Review completed on 05/06/21			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided			

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	K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to provide documentation to the authority having jurisdiction to be able to determine an evacuation assistance score in accordance with 33.2.1.2.2. LSC 33.2.1.2.2 states that facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants. Findings include: Based on observation with the Program Director on 04/29/2021 between 11:20 a.m. and 12:10 p.m., the facility was unable to provide the F1worksheets used to rate the resident and determine the resident's overall need for assistance when requested. Based on interview at the time of observation, the Program Director agreed she was unable to provide the forms. This deficient finding was reviewed with the Program Director at the time of exit.	K S100	On the date of this survey, the Program Director/QIDP went to the facility to meet the survey staff and was unable to locate the Emergency Plan binder which she had recently updated with the most recently reviewed and updated F1 forms. It has been determined that this entire binder had been given to a staff member to return to the facility and that it was placed in the wrong cabinet. In order to demonstrate compliance with this standard, the following plan of action is underway: - The QIDP will ensure that the Emergency Plan book is audited and contains recently updated and reviewed F1 forms used to determine an evacuation assistance score. - The Area Director will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the recently updated F1 forms are in place for each individual residing at the facility. - All facility staff will be trained on the correct location of the binder and on the location of the F1 forms in the binder. This training will include testing to competency. Going forward, the QIDP is responsible to ensure that F1	05/29/2021

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			worksheets have been completed for all persons residing at the facility and that these are revised at a minimum on an annual basis. The QIDP will also be responsible to ensure new F1 forms are completed when new individuals are admitted to the facility or when any individual experiences a significant change in status which affects their overall score on the worksheet.	
K S211 Bldg. 01	NFPA 101 Means of Egress - General Means of Escape - General 2012 EXISTING Designated means of escape shall be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. 33.2.2 Based on observation and interview, the facility failed to maintain 1 of 1 designated secondary means of egress be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. This deficient practice could affect all occupants needing to use the secondary means of egress from the client area. Findings include: During a facility tour with the Program Director on 04/29/2021 at 12:12 p.m. the secondary means of egress from Sleeping Room #1 was a window. The window was obstructed by an entertainment center and staff were unable to open the window. Based on interview at the time of observation, the Program Director agreed that	K S211	The furniture is being rearranged in Sleeping Room #1 to ensure that the secondary means of egress will be continuously maintained clear of obstructions and impediments to full instant use in the case of fire or emergency. Maintenance has been asked to verify that the window is fully functional to ensure that there is no impediment to full instant use of the window as the secondary means of egress in the bedroom. All facility staff will be retrained on this deficiency and on the expectation that all windows and doors intended as secondary means of egress must be clear of	05/29/2021

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	the secondary means of egress was obstructed and was unable to be opened. This deficient finding was reviewed with the Program Director at the time of exit.		obstructions and impediments at all times. Going forward, the Lead DSP, Program Director/QIDP, Maintenance Staff and Area Director will all be responsible to monitor the bedrooms during routine site visits to ensure that no furniture has been moved back into a position where it blocks a secondary means of egress. This is documented monthly by the Lead DSP and verified by the Program Director/QIDP on the Monthly Site Risk Management Checklist.	
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 Fire Alarm system was maintained. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. This deficient practice could affect all building occupants.	K S345	In response to this deficiency, the Area Director consulted with the Maintenance Department on the maintenance provided for the Fire Alarm system over the past year. The Area Director was able to verify that FSS Technologies was at the facility on 01/04/2021 to install the "Front Smoke" above	05/29/2021

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	Findings include: During record review with the Program Director on 04/29/2021 at 11:55 p.m. the fire alarm annual test and inspection documentation from the vendor, dated 06/05/2020, stated: a) "Need to return with batteries for the panel" b) "Front smoke needs replaced" Based on interview at the time of record review, the Program Director could not provide any documentation that repairs had been completed. This deficient finding was reviewed with the Program Director at the time of exit.		the fire panel as recommended on the annual inspection in June of 2020. The paperwork from this inspection is being placed in the Emergency binder at the facility for review. The Area Director did not find written proof that the tech returned with new batteries for the Fire panel as was indicated on the summary report. The Area Director has requested that the contracted provider provide written proof of all follow up work completed as recommended on the annual fire alarm inspections. Going forward, the Area Director will be responsible to collaborate with the Maintenance Director and review all new written recommendations made on contracted inspections on at least a monthly basis to ensure that all follow up tasks are scheduled in a timely fashion and documented so that proof of follow up can be located in the Emergency Binder along with the required inspections.	
K S359 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING (Impractical) All Impractical Evacuation Capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. The system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified			

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	below. The adequacy of the water supply shall be documented. In Impractical Evacuation Capability Facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in one-and-two-Family Dwellings and Manufactured Homes, with a 30 minute water supply, shall be permitted. All habitable areas and closets shall be sprinklered. Automatic Sprinklers shall not be required in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials provided a 15-minute thermal barrier. In Impractical Evacuation Capability Facilities up to and including four stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted. All habitable areas and closets shall be sprinklered. Automatic sprinklers shall not be required in bathrooms not exceeding 55 square feet provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier. Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6. Attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected, by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6 by July 5, 2019. 2. Protected by automatic sprinkler system			

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	according to 9.7, by July 5, 2019. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. 33.2.3.5.3, 33.2.3.5.3.2, 33.2.3.5.3.5 through 33.2.3.5.3.7, 42 CFR 483.470(j)(1)(ii)			
	Based on record review and interview, the facility failed to install a 1 of 1 approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. LSC 33.2.3.5.3 requires facilities with an impractical evacuation capability to be sprinklered in accordance with NFPA 13D. LSC 33.2.1.2.2 states that facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants. Findings include: Based record review with the Program Director on 04/29/2021 between 11:20 a.m. and 12:10 p.m., the facility was unable to provide the F1worksheets used to rate the resident and determine the resident's overall need for assistance when requested. Due to the lack of furnished F1 forms, the facility was classified as "Impractical" and was not provided with an approved, supervised automatic sprinkler system. Based on interview at the time of observation, the Program Director acknowledged the aforementioned condition and confirmed no other paperwork was available for review.	K S359	On the date of this survey, the Program Director/QIDP went to the facility to meet the survey staff and was unable to locate the Emergency Plan binder which she had recently updated with the most recently reviewed and updated F1 forms. It has been determined that this entire binder had been given to a staff member to return to the facility and that it was placed in the wrong cabinet. In order to demonstrate compliance with this standard, the following plan of action is underway: - The QIDP will ensure that the Emergency Plan book is audited and contains recently updated and reviewed F1 forms used to determine an evacuation assistance score. - The Area Director will visit the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the recently updated F1 forms are in place for each individual residing at the facility. - All facility staff will be trained on the correct location of the binder and on the location of the F1	05/29/2021

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	This deficient finding was reviewed with the Program Director at the time of exit.		forms in the binder. This training will include testing to competency. Going forward, the QIDP is responsible to ensure that F1 worksheets have been completed for all persons residing at the facility and that these are revised at a minimum on an annual basis. The QIDP will also be responsible to ensure new F1 forms are completed when new individuals are admitted to the facility or when any individual experiences a significant change in status which affects their overall score on the worksheet. Dungarvin posits that once the completed F1 forms are reviewed, the score will not indicate a need for the facility to be sprinklered in accordance with NFPA 13D.	