STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING -- B. WING	02/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 02/10/25 Facility Number: 012557 Provider Number: 15G791 AIM Number: 201017960A At this Emergency Preparedness survey, Dungarvin Indiana, LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 02/12/25	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants.	E 0006	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: The emergency preparedness plan was completed on 1/27/25 and is uploaded with this submission. This plan is now filed in the Life Safety binder at the	03/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greta Goins	Area Director	03/06/2025

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	Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the facility failed to provide a risk assessment. Based on interview at the time of record review, the House Lead provided three copies of emergency plans each of which indicated that a risk assessment was available; however, none of the plans included a risk assessment. This finding was reviewed with the House Lead at the exit conference.		home. All facility staff were trained on the emergency preparedness plan on 2/4/25. The Emergency Plan is based on the facility risk assessment (EP-05) and it is uploaded with this submission. It is also filed in the Life Safety binder at the home. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. All QIDPs are trained on Dungarvin emergency plans upon hire and where they are located in the home, along with risk assessment (EP-05). Going forward, the QIDP and the Quality Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies, emergency plans and training exercises are present. Persons responsible: QIDP, Area manager, Area Director	
E 0009 Bldg. --	403.748(a)(4), 416.54(a)(4), 418.113(a)(Local, State, Tribal Collaboration Process			

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	Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the House Lead stated she only knew of the documentation that was provided and no other documentation was available to show a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency was available. This finding was reviewed with the House Lead at the exit conference.	E 0009	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: The Emergency Plan includes a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency, including documentation of the ICF/IID efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The emergency plan was revised to include ongoing communication with BDS and there have not been additional opportunities for collaboration with local, tribal, regional, State, and Federal emergency preparedness officials. Going forward, all communication and collaboration will be documented in the Emergency preparedness plan. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no	03/07/2025

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			recurrence All new facility staff are trained on emergency policies and where they are located in the home. All QIDPs are trained on Dungarvin emergency plans upon hire and where they are located in the home, in addition to documenting communication with local, tribal, regional, State, and Federal emergency preparedness officials. Going forward, the QIDP and the Quality Assurance coordinator will monitor the Life Safety books monthly to ensure that all required policies, emergency plans and training exercises are present. Persons responsible: QIDP, Area manager, area director	
E 0015 Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.1 Subsistence Needs for Staff and Patients Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1).	E 0015	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were trained on 2/4/25 on the location of the emergency preparedness plan in the home. The Emergency preparedness plan was revised to address the provision of subsistence needs for staff and individuals should there be a need to evacuate or shelter in place. All	03/07/2025

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	This deficient practice could affect all clients and staff. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the provided plan did not address (i) food, water, medical and pharmaceutical supplies or (ii) alternate sources of energy to maintain - (A) temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) sewage and waste disposal. At the time of the survey the House Lead was not aware of any documentation available. This finding was reviewed with the House Lead at the exit conference.		facility staff will be trained on the updated plan by 3/7/25. The emergency preparedness plan is uploaded with this submission. It will be filed in the Life Safety binder at the home. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home, and where to locate provisions of subsistence. Going forward, the QIDP and the Quality Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: QIDP, area manager, area director, QA manager	
E 0018 Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(Procedures for Tracking of Staff and Patients Based on record review and interview, the facility failed to ensure the emergency preparedness policies and procedures included a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the	E 0018	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and	03/07/2025

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	ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all clients and staff. Findings Include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the facility was unable to provide documentation for tracking staff and clients in the event of an evacuation. The House Lead was not aware of any documentation regarding tracking of clients or staff and stated that everything they know of was provided. This finding was reviewed with the House Lead at the exit conference.		Program Director/QIDPs will be trained by 3/7/25 on the location of the emergency preparedness plan and all applicable forms in the home. The emergency preparedness plan, Dungarvin policy D-01b for emergency situations and addendum (D-01c) includes tracking forms for staff (EP-04a) and supported individuals (EP-04b). The tracking forms are uploaded with this submission. These policies will be filed in the Life Safety binder at the home. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Quality Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: qidp, area manager, area director, qa manager	

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E 0023 Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(Policies/Procedures for Medical Documentation Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, no policies and procedures which include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records was available to review. Based on interview at the time of record review, the House Lead confirmed no such documentation was available for review. This finding was reviewed with the House Lead at the exit conference.	E 0023	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: The emergency preparedness and community action plan address Dungarvin's system for medical documentation that preserves client information, protects confidentiality of their information, and secures and maintains the availability of records on page 15 of the plan. It is uploaded with this submission and filed in the Life Safety binder at the home. All facility staff were trained on 2/4/25 on the emergency plan and will be trained by 3/7/25 on the revisions to the plan. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Quality Assurance Coordinator will	03/08/2025

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			monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: QIDP, area manager, area director	
E 0032 Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the Emergency Preparedness Communication Plan includes (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the House Lead stated she was not aware of a policy or plan addressing primary and alternate means of communication within the Emergency Preparedness Communication Plan. This finding was reviewed with the House Lead at the exit conference.	E 0032	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs will be trained by 3/7/25 on the updated emergency preparedness plan in the home, including primary and alternate means of communication to local, tribal, regional, State, and Federal emergency management agencies. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff (DSPs, Lead DSPs) are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Quality	03/07/2025

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			Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: QIDP, area manager, area director	
E 0033 Bldg. --	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418 Methods for Sharing Information Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, no documentation was available for a communication plan which includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing	E 0033	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were trained on 2/4/25 on the location of the emergency preparedness plan in the home. All facility staff will be retrained on the emergency preparedness plan by 3/7/25, including where it is located in the home and Dungarvin's method for sharing information and medical documentation for continuity of care in an emergency situation. Program Director/QIDP or designated supervisory staff will verify that the emergency plan is in place and will check staff competency on emergency procedures during weekly site visits. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time,	03/07/2025

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	information about the general condition and location of clients under the facility's care. Based on interview at the time of record review, the House Lead confirmed no documentation was available for review. This finding was reviewed with the House Lead at the exit conference.		observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Administrative Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present. Persons responsible: QIDP, area manager, area director	
E 0034 Bldg. --	403.748(c)(7), 416.54(c)(7), 418.113(c)(Information on Occupancy/Needs Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This	E 0034	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were	03/07/2025

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	deficient practice could affect all occupants. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, no documentation could be located ensuring the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or the Incident Command Center, or designee. Based on interview at the time of record review, the House Lead acknowledged a policy could not be provided to show the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance. This finding was reviewed with the House Lead at the exit conference.		trained on 2/4/25 on the location of the emergency preparedness plan in the home. The emergency action and communication plan was revised to include specific information on Dungarvin's method for providing information about the facility's occupancy, needs, and the ability to provide assistance. All facility staff will be retrained on the emergency preparedness plan by 3/7/25, including Dungarvin's method for providing information about the facility's occupancy, needs, and the ability to provide assistance. Program Director/QIDP or designated supervisory staff will verify that the emergency plan is in place and will check staff competency on emergency procedures during weekly site visits. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients.	

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			Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Quality Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present and staff demonstrate competency. Persons responsible: QIDP, area manager, area director	
E 0035 Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, no documentation could be located ensuring the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives. Based on interview at the time of record review, the House	E 0035	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were trained on 2/4/25 on the location of the emergency preparedness plan in the home. All facility staff will be retrained on the emergency preparedness plan by 3/7/25, including where it is located in the home and Dungarvin's method for sharing information from the emergency plan with the individuals and their families or representatives.	03/07/2025

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DUNGARVIN INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

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	Lead acknowledged the lack of a policy and could not provide evidence or additional information contrary to this deficient finding. This finding was reviewed with the House Lead at the exit conference.		Program Director/QIDP or designated supervisory staff will verify that the emergency plan is in place and will check staff competency on emergency procedures during weekly site visits. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the Quality Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies and emergency plans are present and staff demonstrate competency. Persons responsible: QIDP, area manager, area director	

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E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, there was a training policy in the emergency preparedness manual under the training and testing section; however, no evidence was available to show staff had received initial training or subsequent biennial training of the emergency preparedness program which included taking and passing a test on the subject. The House Lead stated she was not able to provide documentation of any training. This finding was reviewed with the House Lead at the exit conference.	E 0037	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were trained on 2/4/25 on the emergency preparedness plan in the home. All facility staff will be retrained on the emergency preparedness plan by 3/7/25, including where it is located, all relevant policies and procedures, and the site-specific emergency action and communication plan. All Program Directors/QIDPs will be trained on 3/3/25 on training emergency preparedness policies and procedures to all new and existing staff, individuals, and volunteers, if applicable, in addition to initial and biennial training timelines. Program Director/QIDP or designated supervisory staff will verify that the emergency plan is in place and will check staff competency on emergency procedures during weekly site visits. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time	03/07/2025

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			per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home, upon hire and at least bi-annually. Going forward, the QIDP and the Quality Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies, emergency plans and training exercises are present, and that staff training is documented per state guidelines. Persons responsible: QIDP, area manager, area director	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to provide documentation of conducting at least two annual emergency preparedness exercises to test the emergency plan, in accordance with 42 CFR 483.475(d)(2).	E 0039	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the	03/07/2025

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	This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the House Lead stated she was not aware of any exercises that had been conducted in the last 12 months and was not able to provide any documentation of annual emergency preparedness exercises. This finding was reviewed with the House Lead at the exit conference.		following specifics: The emergency preparedness plan tabletop exercise was completed on 2/4/25 and is uploaded with this submission. This exercise is now filed in the Life Safety binder at the home. The full-scale emergency preparedness exercise is being planned and all QIDPs will participate for their respective programs. A community partner has been contacted to assist in facilitating and participating but has not responded with date details at the time of this submission. Once completed it will be filed in the Life Safety binder at the home. All Program Directors/QIDPs will be trained on 3/3/25 on training emergency preparedness policies and procedures to all new and existing staff and individuals, including the initial and biennial training and tabletop/community training exercises. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home.	

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K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.490(j). Survey Date: 02/10/25 Facility Number: 012557 Provider Number: 15G791 AIM Number: 201017960A At this Life Safety Code survey, Dungarvin Indiana LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR subpart 483.490(j), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one-story facility was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas, hard wired detectors in all resident sleeping rooms and heat detection in the attic. The facility has a capacity of 4 and had a census of 4 at the time of this survey.	K 0000	Going forward, the QIDP and the Quality Assurance Coordinator will monitor the Life Safety books monthly to ensure that all required policies, emergency plans and training exercises are present, and that staff training is documented per state guidelines. Persons responsible: QIDP, area manager, area director	

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	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.28. Quality Review completed on 02/12/25			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all staff and clients.	K S345	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: FSS does not conduct semi-annual, visual fire alarm inspections, and only completes annual test and inspections of the fire alarm systems. Our Maintenance Manager has requested going forward for semi-annual, visual fire alarm inspections to also be completed in addition to our annual test and inspection of the fire alarm system. FSS stated that semi-annual inspections will begin on 3/7/25 and are anticipated to be completed by 3/19/25 at all Dungarvin owned properties. How facility will identify other residents potentially affected & what measures taken	03/07/2025

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	Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, 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 House Lead was not able to locate any documentation to indicate that a semi-annual fire alarm system inspection had been completed. This finding was reviewed with the House Lead at the exit conference.		All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Area Director is developing a monitoring system in conjunction with the Maintenance Dept and Quality Assurance Dept to monitor the Life Safety books monthly to ensure that all required inspections are present and filed at all times. The Maintenance Manager is reviewing systems to ensure that all FSS and VFP Fire Systems inspections and reports are reviewed and followed up on timely to ensure that deficiencies notated are corrected timely. Persons responsible: maintenance, QA dept, area director	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1.) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 33.2.3.5.8. LSC 33.2.3.5.8.1-15 indicates inspection and testing frequencies as referenced in NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the	K S353	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: The maintenance manager contacted VFP Fire Systems about the antifreeze testing and subsequent results. The quarterly antifreeze wet inspections were completed and indicated no	03/07/2025

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	House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, current monthly wet sprinkler system gauge and control valve inspection documentation was not available for review. Documentation provided during the survey indicated the inspections had been last documented 12/26/21. Based on interview during records review, the House Lead stated she was not aware of sprinkler valve and gauge inspections. 2.) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.3.4. Section 5.3.4 states that the freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solution if necessary. This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, documentation for 4 of 4 quarters was provided indicating inspection of the sprinkler system. All four documents indicated they were quarterly inspections of a wet-antifreeze system; however, the documentation did not include if an antifreeze test had been completed or what the results of the test were. These findings were reviewed with the House Lead at the exit conference.		deficiencies in the system, but did not indicate what test had been completed and its results. The additional documentation has been received at the time of this submission. The Maintenance staff conduct monthly site inspections that include gauge and valve checks. The monthly inspection forms are uploaded with this submission. The system for storing this documentation is being revised to ensure the form completed each month will be made available to regulatory agencies as needed. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Area Director is developing a monitoring system in conjunction with the Maintenance Dept and Quality Assurance Dept to monitor the Life Safety books monthly to ensure that all required inspections are present and filed at all times. The Maintenance Manager is reviewing systems to ensure that all VFP Fire Systems inspections and reports are reviewed and followed up on timely to ensure that deficiencies notated	

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			are corrected. Persons responsible: maintenance, qa dept, area director	
K S500 Bldg. 01	NFPA 101 Building Services - Other 1.) Based on observation, record review and interview; the facility failed to maintain a written record of generator weekly inspections for 52 of 52 weeks and generator monthly exercises for 12 of 12 months. LSC 33.2.5.1 states utilities shall comply with Section 9.1. Section 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 2010 edition Section 8.4.1 states an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 110, Section 8.3.4 states a permanent record of EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the facility failed to provide documentation of 52 of 52 weekly generator inspections and 12 of 12 monthly generator exercises. The facility provided a document titled "MONTHLY GENERATOR INSPECTION"; however, the documentation was from 2019. No current documentation of monthly generator exercises was provided. Based on observation a	K S500	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: The maintenance manager is developing a weekly generator inspection sheet. It will be completed and implemented by 3/7/25. Monthly generator inspections are part of the maintenance monthly inspections are all uploaded with this submission. The system for storing this documentation is being revised to ensure the form completed each month will be made available to regulatory agencies as needed. The maintenance manager is responsible for generator maintenance and testing. He is working on obtaining the necessary tools and documentation for completing monthly testing of electrolyte specific gravity or battery conductance testing for lead-acid batteries of the generator. The testing has not been started at the time of this submission and is	03/07/2025

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	Guardian Quiet propane generator was located outside the facility on the right side of the building. Based on interview at the time of record review, the House Lead stated she could not locate any additional documentation. 2.) Based on observation, record review and interview; the facility failed to maintain a written record of maintenance of lead-acid batteries. LSC 33.2.5.1 states utilities shall comply with Section 9.1. Section 9.1.3.1 Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 2010 edition Section 8.3.7.1 states maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the facility failed to provide documentation of monthly testing of electrolyte specific gravity or battery conductance testing for the lead-acid batteries of the generator located at the facility. Based on interview at the time of record review, the House Lead stated no further documentation was available. These findings were reviewed with the House Lead during the exit conference.		anticipated to begin no later than 3/7/25. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Area Director is developing a monitoring system in conjunction with the Maintenance Dept and Quality Assurance Dept to monitor the Life Safety books monthly to ensure that all required inspections are present and filed at all times. The Maintenance Manager is reviewing systems to ensure that all VFP Fire Systems inspections and reports, monthly maintenance inspections, and generator testing are reviewed and followed up on timely to ensure that any deficiencies notated are corrected timely. Persons responsible: maintenance, qa dept, area director	

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K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure power cords were not used as a substitute for fixed wiring. LSC Section 33.2.5.1 states Utilities shall comply with Section 9.1. and Section 9.1.2 states: Electrical wiring and equipment shall be in accordance with NFPA 70. NFPA 70 Section 400.8 states unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect all occupants. Findings include: Based on observation and interview with the House Lead from 12:45 p.m. to 1:15 p.m. on 02/10/25, during tour of the facility with the House Lead, an extension cord located in the office area was powering a power strip that was used to power a computer and other office equipment. Based on interview at the time of observation, the House Lead acknowledged the extension cord and power strip. This finding was reviewed with the House Lead at the exit conference.	K S511	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: The extension cord and power strip in the office have been removed. All facility staff will be retrained on appropriate power sources and safety by 3/7/25. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on State and Federal regulations and appropriate power sources in the home. Going forward, the QIDP, Area Manager, Area Director, and the Quality Assurance Coordinator will monitor the facility monthly to ensure only appropriate power sources are utilized. Persons responsible: maintenance, qa dept, area director	03/07/2025
K S711	NFPA 101 Evacuation and Relocation Plan			

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Bldg. 01	Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the facility's written fire safety plan. Such instruction is reviewed by the staff not less than every 2 months. This deficient practice affects all clients in the facility. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, the facility failed to provide training records to show all employees have been instructed of their duties and responsibilities at least every two months. Based on interview during record review, the QDDP and the Residential Manager stated they were not aware of the requirements for fire and/or evacuation drills. This finding was reviewed with the House Lead at the exit conference.	K S711	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were retrained on the requirement that fire drills must be per Dungarvin policy every month: one drill per shift per month and at varying times/days. Program Director/QIDP or designated supervisory staff will verify that evacuation drills are scheduled and being completed as such. Designated staff will check staff competency on evacuation procedures during weekly site visits. Initially these competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes	03/07/2025

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			facility put in place to ensure no recurrence Program Director/QIDP will audit fire and emergency drills that are scheduled and completed to ensure that they are done at varying times, days of the week, etc. Area Director is developing a monitoring system in conjunction with the Quality Assurance Dept to monitor the Life Safety books monthly to ensure that all required drills are present and always filed. Persons responsible: lead dsp, qidp, area manager, area director	
K S712 Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to provide documentation of fire drills for 3 of 3 shifts in 3 of 4 quarters. This deficient practice affects all staff and clients. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, there was no documentation of fire drills conducted on the first, second or third shifts of the second, third of fourth quarters of 2024. Based on interview at the time of record review, the House Lead was not able to provide any additional documentation or fir drills. This finding was reviewed with the House Lead at the exit conference.	K S712	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6621will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were retrained on the requirement that fire drills must be per Dungarvin policy every month: one drill per shift per month and at varying times/days. Program Director/QIDP or designated supervisory staff will verify that evacuation drills are scheduled and being completed as such. Designated staff will check staff competency on evacuation procedures during weekly site visits. Initially these	03/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING 01 B. WING	02/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			competencies will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Program Director/QIDP will audit fire and emergency drills that are scheduled and completed to ensure that they are done at varying times, days of the week, etc. Area Director is developing a monitoring system in conjunction with the Quality Assurance Dept to monitor the Life Safety books monthly to ensure that all required drills are present and always filed. Persons responsible: lead dsp, qidp, area manager, area director	
K S741 Bldg. 01	NFPA 101 Smoking Regulations Based on record review, observation and interview, the facility failed to provide a smoking policy, regulations, or other documentation which	K S741	Corrective action for resident(s) found to have been affected All parts of the POC for the survey	03/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING 01 B. WING	02/10/2025

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

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	included any of the provisions as required by LSC Section 33.7.4. This deficient practice could affect all clients, staff and visitors. Findings include: Based on record review and interview with the House Lead from 11:15 a.m. to 12:45 p.m. on 02/10/25, no documented smoking policy could be provided. Based on interview at the time of record review, the House Lead stated the facility has designated smoking areas in the rear area of the building but was not able to produce any documentation stating a policy or facility regulations regarding smoking. Based on observation and interview with House Lead during a tour of the facility from 12:45 p.m. to 1:30 p.m. on 02/10/25, a smokers pole was located in the back of the facility. This finding was reviewed with the House Lead at the exit conference.		with event ID QT6621will be fully implemented, including the following specifics: All facility staff will be retrained on Dungarvin smoking policy and designated areas. Policy E-12 pertaining to smoking and non-smoking areas is uploaded with this submission and in the Life Safety book in the home. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All facility staff are trained upon hire on smoking and non-smoking areas of each facility. Program Director/QIDP or designated staff will audit the Life Safety book monthly to ensure all policies, drills, forms, and documentation are present for the Regulatory agency. Area Director is developing a monitoring system in conjunction with the new Quality Assurance Dept to monitor the Life Safety books monthly to ensure that all required documents are present. Persons responsible: lead dsp, qidp, area manager, area director	