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	03/25/2025

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey that exited on 02/10/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/25/2025 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 3. Quality Review conducted on 03/26/25	E 0000		
E 0009 Bldg. --	403.748(a)(4), 416.54(a)(4), 418.113(a)(Local, State, Tribal Collaboration Process 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	E 0009	**E009** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: The Emergency Plan includes a process for cooperation and collaboration with local, tribal,	04/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greta Goins	Area Director	04/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING -- B. WING	03/25/2025

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
	planning efforts in accordance with 42 CFR 483.475(a)(4). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Area Manager and House Lead on 03/25/2025 at 12:52 p.m., 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. Based on interview at 12:52 p.m. the Area Manager stated she was new to her position and was unaware of any additional documentation. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a process for cooperation or collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		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. Dungarvin policy D-01b page 13 and the site emergency action and communication plan (EP-01a) page 10 outlines who communication is with for local authorities. The Emergency Plans are in the Life Safety binder in the home and uploaded with this submission. 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 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	

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	03/25/2025

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
			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). This deficient practice could affect all residents and staff. Findings include: Based on record review and interview with the Area Manager and House Lead on 03/25/2025 at	E 0015	**E015** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were trained on 3/4/25 on the location of the emergency preparedness plan in the home. The site emergency action and communication plan (EP-01a) outlines how the facility will address food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures, emergency lighting, fire detection, and sewage and waste disposal. The Emergency Plans are in the Life Safety binder in the home and uploaded with this	04/11/2025

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	03/25/2025

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
	12:59 p.m., 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. Based on interview at 12:59 p.m. the Area Manager stated she was new to her position and was unaware of any additional documentation. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a plan for addressing 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. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		submission. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home, 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	
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	**E018** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics:	04/11/2025

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	03/25/2025

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
	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 residents and staff. Findings Include: Based on record review and interview with the Area Manager and House Lead on 03/25/2025 at 1:03 p.m., the facility was unable to provide a plan or process for tracking staff and clients in the event of an evacuation. Based on record review at 1:03 p.m. forms were available to be used for tracking but no explanation of the process, plan, or procedure for tracking on-duty staff or residents was available. Based on interview at 1:03 p.m. the House Lead stated she did not receive training about tracking and was not aware of any documentation regarding tracking of residents or staff. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a plan addressing tracking on-duty staff or clients. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		All DSPs, Lead DSP, and Program Director/QIDPs were trained by 3/4/25 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	
E 0023	403.748(b)(5), 416.54(b)(4), 418.113(b)(Policies/Procedures for Medical			

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	03/25/2025

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
Bldg. --	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 Area Manager and House Lead on 03/25/2025 at 1:08 p.m., 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 1:08 p.m. the House Lead stated she did not receive training about a system of medical documentation that preserves client information, protects confidentiality of client information, secures and maintains the availability of records and did not know of any policy or procedure. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a plan addressing medical documentation. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.	E 0023	**E023** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will 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 3/4/25 on the emergency plan and will be trained again on 4/10/25 on the plan. A copy of the 3/4/25 training is uploaded with this submission. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new facility staff are trained on emergency policies and where they are located in the home. Going forward, the QIDP and the	04/11/2025

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	03/25/2025

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
			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	
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 residents, staff and visitors. Findings include: Based on record review and interview with the Area Manager and House Lead on 03/25/2025 at 1:13 p.m., 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 and was not aware of any alternate methods of communication. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a plan addressing Primary and alternate means for communication. This finding was reviewed with the Area Manager and House Lead at the exit conference.	E 0032	**E032** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: All DSPs, Lead DSP, and Program Director/QIDPs were trained on 3/4/25 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. All facility staff will be trained again on 4/10/25 on the plan. 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	04/11/2025

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	03/25/2025

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
	This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		participation in collaborative and cooperative planning efforts. Dungarvin policy D-01b page 14 outlines primary and alternate communication for local authorities. The Emergency Plans are in the Life Safety binder in the home and uploaded with this submission. 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 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 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			

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	03/25/2025

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
	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 Area Manager and House Lead on 03/25/2025 at 1:15 p.m., 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 information about the general condition and location of clients under the facility's care. Based on interview at 1:15 p.m., the House Lead stated she did not receive training about a method for sharing information and medical documentation and was not aware of any policy or procedure in place. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a plan addressing sharing information and medical	E 0033	**E033** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: All facility staff will be retrained on the emergency preparedness plan on 3/4/25, 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. All facility staff will be retrained on 4/10/25 on the emergency preparedness plan, including 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, 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	04/11/2025

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	03/25/2025

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
	documentation. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		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 deficient practice could affect all occupants. Findings include: Based on record review and interview with the Area Manager and House Lead on 03/25/2025 at 1:21 p.m., no documentation could be located ensuring the emergency preparedness	E 0034	**E034** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: 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 were trained on the emergency preparedness	04/11/2025

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	03/25/2025

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
	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 1:21 p.m., the House Lead stated she did not receive training about 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 and she stated she was not aware of any policy or procedure in place. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a plan addressing 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. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		plan on 3/4/25, including 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 4/10/25. 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	

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	03/25/2025

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
			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 Area Manager and House Lead on 03/25/2025 at 1:24 p.m., 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 1:24 p.m., the House Lead stated she did not receive training about a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives and she stated she was not aware of any policy or procedure in place. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include a method for sharing information from the emergency plan that the facility has determined is	E 0035	**E035** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: The site specific emergency and action plan outlines on page 6 the method for sharing information with the individuals and their families or representatives. All facility staff were trained on the emergency preparedness plan on 3/4/25, 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. All facility staff will be retrained 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,	04/11/2025

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	03/25/2025

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
	appropriate with clients and their families or representatives. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		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	
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	E 0037	**E037** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics:	04/11/2025

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	03/25/2025

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
	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 Area Manager and House Lead on 03/25/2025 at 1:32 p.m., 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. Several documents were provided showing training conducted on various subjects but no documentation of training on the emergency preparedness program. Based on interview at 1:32 p.m., the House Lead stated she did not receive training about the emergency preparedness program or plan. The Area Manager contacted the Area Director at approximately 1:00 p.m. who sent an email to the facility with attached documentation, but the documentation did not include training conducted on the emergency preparedness program. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction		All DSPs, Lead DSP, and Program Director/QIDPs were trained on 2/4/25 on the emergency preparedness plan in the home. All DSPs, Lead DSP, and Program Director/QIDPs were trained on 3/4/25 on the emergency preparedness plan in the home, 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 again on 4/10/25 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 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.	

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	03/25/2025

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
	to prevent recurrence.		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 any annual emergency preparedness exercises to test the emergency plan, in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the	E 0039	**E039** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: All QIDPs were trained on 3/31/25 on training emergency preparedness policies and procedures to all new and existing	04/11/2025

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	03/25/2025

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
	Area Manager and House Lead on 03/25/2025 at 1:34 p.m., the Area Manager stated she had conducted a table-top exercise and showed documentation; however, the documentation did not include information about reviewing the emergency preparedness plan or policies and did not include an analysis or after-action review of the exercise. No documentation of a community based or facility-based exercise or an actual event was available. Based on interview at 1:34 p.m., the House Lead stated she was not aware of any exercises conducted. At 1:34 p.m. the Area Manager agreed with the House Lead. This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		staff and individuals, including the initial and biennial training and tabletop/community training exercises. 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. 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, emergency plans and training exercises are present, and that staff training is documented per state guidelines. Persons responsible: QIDP, area manager, area director	

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	03/25/2025

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey that exited on 02/10/2025 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/25/2025 Facility Number: 012557 Provider Number: 15G791 AIM Number: 201017960A At this PSR 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 3 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of 0.28. Quality Review conducted on 03/26/25	K 0000		
K S353	NFPA 101 Sprinkler System - Maintenance and Testing			

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	03/25/2025

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
Bldg. 01	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 Area Manager and House Lead on 03/25/2025 at 1:34 p.m., 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 at 1:34 p.m., 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 Area Manager and House Lead on 03/25/2025 at 1:34 p.m., Documentation for 4 of 4 quarters was	K S353	**K0353** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will 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 deficiencies in the system, but did not indicate what test had been completed and its results. The additional documentation has not 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. Going forward, the administrative coordinator will place the monthly maintenance inspections in the Life Safety binder monthly. How facility will identify other residents potentially affected & what measures taken All residents potentially are	04/23/2025

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	03/25/2025

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
	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 Area Manager and House Lead at the exit conference. These deficiencies were cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		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 are corrected. Persons responsible: maintenance manager	
K S500 Bldg. 01	NFPA 101 Building Services - Other 1. Based 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	K S500	**K0500** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: The maintenance manager created a weekly generator inspection sheet and trained staff on 3/14/25. Lead DSP will be retrained on weekly generator checks and filing the completed forms in the	04/23/2025

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	03/25/2025

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
	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 Area Manager and House Lead on 03/25/2025 at 1:53 p.m., 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. At 1:53 p.m. the maintenance technician at the facility stated all generator services are contracted out. 2. Based on 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		Life Safety binder. 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. 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	

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	03/25/2025

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
	Area Manager and House Lead on 03/25/2025 at 1:53 p.m., 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. At 1:53 p.m. the maintenance technician at the facility stated all generator services are contracted out. This finding was reviewed with the Area Manager and House Lead at the exit conference. These deficiencies were cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		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 manager	
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. Findings include: Based on observation and interview with the Area Manager at 12:40 p.m. on 03/25/2025, during tour of the facility with the Area Manager, a power strip located in the office area was powering a second power strip that was used to power a computer and other office equipment. Based on interview at the time of observation, the Area Manager acknowledged the power strip plugged into another power strip.	K S511	**K0511** Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID QT6622will be fully implemented, including the following specifics: The extension cord and power strip in the office have been removed. The Area Manager rearranged the office set-up to ensure that the appropriate power sources are utilized appropriately. All facility staff will be retrained on appropriate power sources and safety on 4/10/25. How facility will identify other residents potentially affected & what measures taken All residents potentially are	04/11/2025

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	03/25/2025

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
	This finding was reviewed with the Area Manager and House Lead at the exit conference. This deficiency was cited on 02/10/25. The facility failed to implement a systemic plan of correction to prevent recurrence.		affected, and corrective measures address the needs of all clients. <u>Measures or systemic changes facility put in place to ensure no recurrence</u> 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: QIDP, area manager, area director	