STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING				
		15G479	B. WI	NG	06/05		2024
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DUNGARVIN INDIANA LLC			422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG W 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
VV 0000							
Bldg. 00							
	This visit was for a	pre-determined full	$W_0$	000			
	recertification and s	tate licensure survey.					
	•	30/24, 5/31/24, 6/3/24, 6/4/24					
	and 6/5/24.						
	Facility Number: 00	00993					
	Provider Number: 1						
	Aims Number: 1002	244950					
	These deficiencies also reflect state findings in accordance with 460 IAC 9.						
	accordance with 400	JIAC 9.					
	Quality Review of t	his report completed by #27547					
	on 6/18/24.						
W 0104	483.410(a)(1)	2)/					
Bldg. 00	GOVERNING BOI	DY dy must exercise general					
Diag. 00		d operating direction over					
	the facility.	a operating an obtain ever					
		on and interview for 3 of 3	$W_0$	104	<u>W 104</u>		07/31/2024
		#2 and #3), plus 4 additional			Governing Body (Standard) -		
	•	and #7), the governing body			The governing body failed to	)	
	_	eneral policy, budget, and over the facility to ensure the			exercise general policy,		
	home was in good re				budget, and operating direction over the facility to		
	nome was in good i	opun.			ensure the home was in good	d	
	Findings include:				repair.		
		conducted on 5/30/24 from			Corrective action for		
		15 pm and 5/31/24 from 6:15 am lients #1, #2, #3, #4, #5, #6 and			resident(s) found to have been	<u>en</u>	
	-	oughout the observation			affected:		
	period.	-					
					All parts of the POC for the		
	1) Client #3's bathro	oom had 2 of the 3 light bulbs			survey will be fully		

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

(X6) DATE

TITLE

Annmarie Fanning Area Director 07/03/2024

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: VO4111 Facility ID: 000993 If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
		IDENTIFICATION NUMBER		UILDING	00	COMPLETED 06/05/2024	
15G479			B. W	'ING		06/05/2024	
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
		•			ARQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC		MICHIGAN CITY, IN 46360				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	_	was no shower curtain. The			implemented, including the		
		vered in a thick fuzzy gray			following specifics:		
		view was conducted with					
		Sessional (DSP #2) on 5/30/24 at			All facility staff have receive		
	_	ated "none of the showers have			retraining, on the importance		
	curtains."				of reporting all maintenance		
	2) Client #21a hadra	om had 19 areas on the walls			concerns immediately via th		
		ut not repainted. On 5/30/24 at			Maintenance Request forms and thoroughly cleaning		
		ated client #2's walls "have			surface areas throughout the	oir	
		I started working here, going			shifts. All maintenance	511	
	on 2 years now."	r started working here, going			concerns reported are being		
	on 2 years now.				addressed by the Maintenan		
	3) Client #2's bathro	oom had an overhead light that			department and will be		
		he bottom of the shower was			monitored weekly for progre	ee .	
	_	substance and there were tiles			until resolved.		
		fan was covered in a thick					
		e. There was no shower			A maintenance request was		
	curtain.				submitted for all maintenance		
					needs:		
	4) Client #5's bedro	om had several areas of					
	chipped and peeling	g paint.					
					#2's bedroom had 19 areas	on	
		emergency exit at the back of			the walls that were patched	but	
		rd loose and sticking up. The			not repainted. Client #2's		
	ramp was partially	obstructed by tree limbs.			bathroom had an overhead		
					light that was not working.	Γhe	
		along the length of the			bottom of the shower was		
	_	n was discolored with rotted			covered in a black substanc		
		yood missing along the length			and there were tiles loose. T		
	of the porch.				exhaust fan was covered in	a	
					thick fuzzy gray substance.		
		f the main hallway did not have			Client #5's bedroom had		
		our of the 5 lights were not			several areas of chipped and		
	working.				peeling paint. The ramp at t		
	0) The lii	had 2 and tables that 1-1			emergency exit at the back of		
		had 2 end tables that had			the home had a board loose		
		rn out and peeling. The arms of			and sticking up. The ramp v	vas	
		e material worn off. The arms			partially obstructed by tree		
	and one seat of the	couch had the material worn			limbs. The wainscoting alor	ng	

VO4111

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE	E SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMP	COMPLETED	
15G479 B. WING 06/05	5/2024	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP COD		
422 MARQUETTE TRAIL		
DUNGARVIN INDIANA LLC MICHIGAN CITY, IN 46360		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDED'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE	
off. the length of the enclosed back		
porch was discolored with		
9) The light in the entryway was not working and rotted wood. There was wood		
had a piece of tape over the light switch that missing along the length of the		
stated "do not use". porch. Four of the 5 lights		
were not working. The light in		
10) The van's driver's side step had one bracket the entryway was not working		
that was not attached to the van. The driver's side  and had a piece of tape over		
back tire had a hubcap missing. On 5/31/24 at 8:00 the light switch that stated, "do		
am DSP #2 stated the side step "drags on the not use". The van's drivers		
street when I'm driving. They have welded it back  sidestep had one bracket that		
a few times, but said they can't do it anymore."  was not attached to the van.		
The driver's side back tire had		
An interview with the Area Director (AD) was a hubcap missing. On 5/31/24 at		
conducted on 6/5/24 at 10:00 am. The AD stated,  8:00 am DSP #2 stated the		
"The clients' home should always be clean and in sidestep "drags on the street"		
good repair." when I'm driving. They have		
welded it back a few times but		
An interview with the Area Manager (AM) was said they can't do it anymore."		
conducted on 6/5/24 at 9:45 am. The AM stated,  Maintenance Manager has		
"The home should be kept clean and in good begun repairs on the home.		
condition with repairs done as needed. Walls  Dungarvin is also contracting		
should be painted as soon as they are repaired. with Michiana Tile, for the		
The light bulbs should be replaced. The ramp bathroom repair and tile		
should be repaired and unobstructed. The van replacement in the bathroom.		
should be kept in good repair. " Estimated completion for all		
repairs is 07/31/2024.		
9-3-1(a) Lead DSP staff will purchase		
shower curtains and rods.		
Area Manager purchased new		
sofa and loveseat for		
replacement on 07/02/2024.		
All facility staff re-trained on		
the importance of reporting all		
maintenance concerns		
immediately via the		
Maintenance Request forms.		
All maintenance concerns		
reported are being addressed		
through deep cleaning as well		

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

PRINTED: 07/08/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/05/2024		
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE COMPLETION DATE		
				as the completion of ne repairs by the Maintena department. Lead DSP and QIDP are responsible to note any items or maintenance n during daily and weekly observations at the hon DSP is to document cor on monthly Site Risk Management Checklist. visits several times per and is to report these coto Maintenance as need Area Director is also to least quarterly to ensurconcerns are being repenseded.	nce  broken eeds ne. Lead ncerns  QIDP month oncerns led. visit at e that		
				How facility will identify residents potentially afformation what measures taken: All residents potentially affected, and corrective measures address the real clients.	rare		
				Measures or systemic of facility put in place to en no recurrence:  All facility staff have be trained on maintenance request procedures and monthly site risk manage checklist. All new Prog	een I the gement		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VO4111 Facility ID: 000993

If continuation sheet

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

PRINTED: 07/08/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/05/2024	
	ROVIDER OR SUPPLIER		422 M	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				Director/QIDPs have been trained to maintenance requests and the procedure submitting requests to the maintenance department.  Going forward, the QIDP is to maintain a regular presence the home through scheduled and unscheduled visits multitimes per month, to monitor the overall quality of the maintenance and cleanlines of the home. In addition, the Area Manager is to tour the home monthly for any conceand the Area Manager is to conduct look behind visits to verify that concerns are being reported appropriately and the staff demonstrate competent in monitoring the cleanlines and safety of the home.  Persons responsible: Progra Director/QIDP, Area Manager, Area	for  o in d diple for s erns o ng hat cy s
W 0454	483.470(I)(1)			Director	
Bldg. 00	INFECTION CON The facility must p environment to av transmission of inf Based on observation sampled clients (#1,	rovide a sanitary oid sources and	W 0454	W 454 Governing Body (Standard) The facility must provide a	07/03/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VO4111 Facility ID: 000993

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
15G479		B. WING 06/05/2024			06/05/2024		
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L					
DUNGAR	N/INI INIDIANIA I I O		422 MARQUETTE TRAIL				
DUNGAR	DUNGARVIN INDIANA LLC			MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	ensure staff prompt	ed clients #1, #2, #3, #4, #5, #6			sanitary environment to avoi	d	
	and #7 to perform h	and hygiene before			sources and transmission of		
	medications and me				infections.Corrective action		
					resident(s) found to have be		
	Findings include:				affected:All parts of the POC		
	C				the survey will be fully		
	Observations were	conducted on 5/30/24 from			implemented, including the		
		15 pm and on 5/31/24 from 6:15			following specifics:		
		n. Clients #1, #2, #3, #4, #5, #6			All facility staff have received	d	
	_	t throughout the observation			retraining on the importance		
	period.	5			proper hand washing and	•	
	1				sanitizing, of both staff and		
	On 5/30/24 at 3:55	pm Direct Support Professional			individuals, before medication	ons	
	· ·	client #3 to the medication			and mealtimes. The facility	,9	
		ered client #3's medications.			has an active program in pla	Ce	
		mpt client #3 to sanitize their			for the prevention, control ar		
	hands before taking	-			investigation of infection and		
	_	prompted client #1 to the			communicable diseases. Th		
	-	ad administered client #1's			facility provides training to	`	
		2 did not prompt client #1 to			newly hired staff and annual	lv	
	sanitize their hands				thereafter, to incorporate	''	
	medications.	corore uniting unem			infection control which		
		prompted client #5 to the			includes encouraging staff		
	-	ad administered client #5's			washing their own hands and	d	
		2 did not prompt client #5 to			prompting the clients to was		
	sanitize their hands				their hands prior to medicati		
	medications.	corore uniting unem			administration.		
					How facility will identify othe	er	
	An interview was c	onducted with DSP #2 at 4:07			residents potentially affected		
		"oh yeah, the clients should			what measures taken:	<u>,, , , , , , , , , , , , , , , , , , ,</u>	
	-	tize their hands before meds."			All residents potentially are		
	or prompted to sum	in the state of th			affected, and corrective		
	On 5/30/24 at 4·49	pm clients #1, #2, #3, #4, #5, #6			measures address the needs	s of	
	· ·	at the dining room table and			all clients. Measures or syste	-	
	_	Sessional (DSP) #1 and #2			changes facility put in place	· · · · · · · · · · · · · · · · · · ·	
		plates from the kitchen. DSP			ensure no recurrence:All	<u></u>	
	* *	not prompt the clients to			facility staff have been traine	ad	
	perform hand hygie						
	perioriii nanu nygie	ne before the filear.			on the importance of proper		
	On 5/21/24 at 6:40	om DSD #2 prompted alients #1			hand washing and sanitizing		
	On 5/51/24 at 6:40	am DSP #2 prompted clients #1,			of both staff and individuals,		

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	A. BUILDING <u>00</u> B. WING			COMPLETED 06/05/2024	
		15G479	B. WING					
		100110				00,00,		
NAME OF P	PROVIDER OR SUPPLIER	3			DDRESS, CITY, STATE, ZIP COD			
			4	422 MA	RQUETTE TRAIL			
DUNGAF	RVIN INDIANA LLC			MICHIG	AN CITY, IN 46360			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
IAG		#6 to the dining room table for		IAG	before medications and		DATE	
		_						
		nm DSP #2 served the clients'			mealtimes. The Program			
		At 7:15 am client #2 came to the			Director/QIDP will make			
	-	and DSP #2 served him			unannounced weekly visits t			
		did not prompt the clients to			monitor the med pass to ens			
	perform hand hygie	ene before the meal.			the staff and clients are usin	g		
					proper hygiene. The Area			
		the Area Director (AD) was			Manager and Area Director w	/ill		
		4 at 10:00 am. The AD stated,			also make random monthly			
	"the clients should l	be prompted by staff to			unannounced visits to obser	ved		
	sanitize their hands	before meds and meals."			medication pass or mealtime	s,		
					to observe proper hand			
	An interview with t	the Area Manager (AM) was			washing or			
	conducted on 6/5/24	4 at 9:45 am. The AM stated,			sanitization.Persons			
	"hand hygiene shou	ıld be completed before			responsible: Program			
	medications, meals	and after personal care." The			Director/QIDP, Area Manager	•		
	AM stated, "Staff sl	hould prompt the clients to			Area Director	•		
	perform hand hygie							
	1 , ,							
	The Core A Indiana	a Direct Support Professional						
		2020 was reviewed on 6/4/24 at						
	-	w indicated, "Performing Hand						
	-	hands regularly is the number						
		renting the spread of disease						
		rself and individuals from						
	1 03	d wash hands before and after						
		Glove use: The CDC (Centers						
		l) recommends wearing gloves						
		possibility of exposure to						
		re performing procedures						
	-	oossibility of exposure to						
	-	ore applying gloves, DSPs						
	-	Always wash hands after						
		Aiways wasn nands after						
	removing gloves."							
	9-3-7(a)							
M 0 4 6 2								
W 0488	483.480(d)(4)							
	DINING AREAS A	AND SERVICE	1					

FORM CMS-2567(02-99) Previous Versions Obsolete

The facility must assure that each client eats

Bldg. 00

Event ID:

VO4111

Facility ID: 000993

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ľ í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	00	COMPLE	
15G479		B. Wl	NG		06/05/2	2024	
NAME OF P	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
					RQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC			MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		istent with his or her					
	developmental lev		W. C	100	N/ 400		07/02/2024
		on and interview for 3 of 3	I w c	1488	W 488 Coverning Body (Standard)		07/03/2024
		ients #1, #2, and #3) plus 4 clients #4, #5, #6 and #7), the			Governing Body (Standard) The facility must assure the	I	
		sure the clients assisted with			The facility must assure that each client eats in a manner		
		nd served themselves at dinner.			consistent with his or her		
	mear preparation at	de servee memberves at annier.			developmental level.		
	Findings include:				aovolopinoniai ievei.		
	Observations were conducted on 5/30/24 from 3:50 pm through 6:15 pm and 5/31/24 from 6:15 am				Corrective action for		
					resident(s) found to have be	en	
					affected:		
	through 8:15 am. Clients #1, #2, #3, #4, #5, #6 and						
	#7 were present throughout the observation				All parts of the POC for the		
	period.				survey will be fully		
					implemented, including the		
		pm clients #1, #2, #3, #4, #5, #6			following specifics:		
	_	at the dining room table and					
		fessional (DSP) #1 and #2			All facility staff have receive	I	
		plates from the kitchen. At			retraining on this finding an		
	_	sked for a second helping and			on the expectations of famil	- 1	
		#1's plate into the kitchen,			style dining. Training covere	ed	
		food on it and returned it to			ways each individual could		
	_	om DSP #2 took client #3's plate			participate in the preparatio		
		er she finished the meal. At			serving, and cleanup of mea	I	
		ok client #4's plate to the nished her meal. At 5:09 pm			according to their individual	1	
		#5's plate to the kitchen after			strengths and needs.		
		al. At 5:31 pm DSP #1 was in the			How facility will identify oth	or	
		e dishes. At 5:42 pm DSP #2			residents potentially affecte		
	_	I'll clean the rest of the			what measures taken:	<u> </u>	
		iew was conducted with DSP			All residents potentially are		
		42 and when DSP #2 was asked			affected, and corrective		
		l with meal prep and clean up			measures address the need	s of	
	_	2 stated "they do sometimes, it			all clients.		
	just depends."	-					
					Measures or systemic chan	ges	
	On 5/31/24 at 6:40	am DSP #2 prompted clients #1,			facility put in place to ensur		
		#6 to the dining room table for			no recurrence:		
	breakfast. At 7:02 a	am DSP #2 put cups on the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

VO4111 Fa

Facility ID: 000993

If continuation sheet

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

PRINTED: 07/08/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN C	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479		JILDING ING	ONSTRUCTION  00  ADDRESS, CITY, STATE, ZIP COD	(X3) DATE : COMPL 06/05/	LETED
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR table for the clients: clients' breakfast to am client #2 came to DSP #2 served him 7:22 am DSP #2 wind At 7:45 am DSP #4  Throughout the observer not prompted and they were not prompted and they were not proper or clean up.  An interview with the conducted on 6/5/24 "It is not safe for a complete to serve them how to work that in An interview with the conducted on 6/5/24 with the conducted	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  At 7:06 am DSP #2 served the them from the kitchen. At 7:15 to the dining room table and breakfast from the kitchen. At ped the dining room table off. was cleaning the kitchen.  ervation period the clients to serve themselves the meals rompted to help with meal  the Area Director (AD) was 4 at 10:00 am. The AD stated, couple of the clients in this selves. We have to figure out the rights restrictions."  the Area Manager (AM) was 4 at 9:45 am. The AM stated, erved family style with each 5 to their ability."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  All new employees are train on active treatment and fami style dining expectations in a ICF-IDD setting. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who a to follow policy and training. Nurse will also report any violations to the PD/QIDP for follow up.  The QIDP, Nurse, Area Manager, Area Director, or other qualified supervisory s will be responsible to condu- active treatment observation at varying times of the day to ensure that facility staff demonstrate competency on promoting independence for all individuals while dining.  Persons responsible: Progra Director/QIDP, Area Manager Area Director	ed lly the fail ct is	(X5) COMPLETION DATE