07/17/2024

	T OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMPI 06/21	SURVEY LETED
	PROVIDER OR SUPPLIE		422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3 NATE	(X5) COMPLETION DATE
E 0000						
Bldg		paredness Survey was ndiana Department of Health in 2 CFR 483.475.	E 0000			
	Survey Date: 06/2	1/24				
	Facility Number: (Provider Number: AIM Number: 100	15G479				
	Dungarvin Indiana compliance with En Requirements for M	Preparedness survey, LLC was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR				
		pertified beds. All 8 beds are aid. At the time of the survey,				
	Quality Review con	mpleted on 06/24/24				
E 0004	403.748(a), 416.5 441.184(a), 482.1	54(a), 418.113(a), 15(a), 483.475(a), 483.73(a),				
Bldg	484.102(a), 485.6 485.727(a), 485.9 491.12(a), 494.62 Develop EP Plan Annually §403.748(a), §41	525(a), 485.68(a), 920(a), 486.360(a),				

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

§483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a),

§494.62(a).

TITLE (X6) DATE

Annmarie Fanning Area Director 07/10/2024

Any defiencystatement 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 disclo days 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.

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	CON	TE SURVEY MPLETED 21/2024
	DF PROVIDER OR SUPPLIE BARVIN INDIANA LLC		422 M	ADDRESS, CITY, STATE, ZIP CO ARQUETTE TRAIL GAN CITY, IN 46360	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Federal, State an preparedness required must develop estate comprehensive eleprogram that mees section. The eme program must incept the following elem (a) Emergency Ples develop and main preparedness plas and updated at lemust do all of the [For hospitals at §485.625(a):] Emor CAH] must confederal, State, an preparedness required comprehensive eleprogram that mees section, utilizing at [For LTC Facilities Emergency Plandevelop and main preparedness plas and updated at lemust develop and main preparedne	an. The [facility] must stain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital inply with all applicable and local emergency uirements. The [hospital or op and maintain a mergency preparedness is the requirements of this in all-hazards approach. Les at §483.73(a):] The LTC facility must stain an emergency in that must be reviewed, ast annually. Ities at §494.62(a):] The ESRD facility must stain an emergency in that must be [evaluated],	E 0004	E 004		07/10/2024
	based on record re	view and interview, the facility	E 0004	E 004		07/10/2024

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/21/2024	
	PROVIDER 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
140	failed to review and Preparedness Plan (in accordance with deficient practice of Findings include: Based on record review and years. The EPP had on the coverpage, he listed on the coversidocuments. Based or record review, the EPP did not have a if the EPP has been years.	update the Emergency EPP) at least every two years 42 CFR 483.475(b). This build affect all occupants. Triew of the facility's EPP with Professional (DSP) on 06/21/24 and 12:22 p.m., the facility I update the EPP every two a spot to list the review date owever no date had been theet or in any of the EPP on interview at the time of DSP acknowledged that the revision date and was unsure updated within the past two riewed with the DSP during the		Governing Body (Standard): The facility has an emergency preparedness plan that is to reviewed and updated at lead every two years in accordant with 42 CFR 483.475. Corrective action for resident(s) found to have been affected. All parts of the POC for the survey will be fully implemented, including the following specifics: The QIDP and Area Director Area Manager will ensure updated Emergency Plan is the facility site by 07/10/2020. The QIDP will ensure that the Emergency Plan book is audited and contains all required elements of the emergency preparedness plant the facility to ensure that Emergency Plan book is in the facility and will conduct a second level audit to ensure that the plan includes a documented facility-based accommunity-based risk assessment, utilizing an all-hazards approach, including missing clients. All facility staff will be train on the correct location of the	cy be st ce en f, in 4. ne an. the

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/21/2024
	ROVIDER OR SUPPLIE		422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				binder and on the contents of the Emergency Plan. This training will include testing to competency.	
				During upcoming site visits planned for Active Treatment observations, the QIDP will be responsible to quiz all staff of the location of the Emergency plan as well as various elements of the Site-Specific Emergency Plan and the Emergency Policies in order staff to demonstrate continual competency. These visits are scheduled to take place 4 timper month 2 months and the monthly after that. Going forward, the QIDP is responsible to ensure that the emergency preparedness program is readily available the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that a facility staff review the plant staff meetings every other month to ensure ongoing comprehension and competency.	of tope on cy
				How facility will identify oth residents potentially affected what measures taken:	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/21/2024		
	PROVIDER OR SUPPLIER		422 MA	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAU	All residents potentially are affected, and corrective measures address the needs all clients. Persons responsible: Progra	of ım
E 0006 Bldg	(1)-(2), 441.184(a) 483.475(a)(1)-(2), (1)-(2), 485.625(a) 485.727(a)(1)-(2), 486.360(a)(1)-(2), (1)-(2) Plan Based on All §403.748(a)(1)-(2) §418.113(a)(1)-(2), §480.84(a)(1)-(2), §483.73(a)(1)-(2), §484.102(a)(1)-(2), §485.625(a)(1)-(2) §491.12(a)(1)-(2), [(a) Emergency Pl develop and main preparedness plar	491.12(a)(1)-(2), 494.62(a) Hazards Risk Assessment), §416.54(a)(1)-(2),), §441.184(a)(1)-(2), §482.15(a)(1)-(2),), §485.68(a)(1)-(2),), §485.727(a)(1)-(2),), §486.360(a)(1)-(2), §494.62(a)(1)-(2) an. The [facility] must tain an emergency that must be reviewed,		Director/QIDP, Area Manager Area Director	
	must do the follow (1) Be based on a facility-based and assessment, utiliz approach.*	nd include a documented, community-based risk			

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	, ,	UILDING	NSTRUCTION	(X3) DATE COMPI 06/21	LETED
	ROVIDER OR SUPPLIEF			422 MA	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	emergency events assessment.	s identified by the risk					
	Plan. The Hospice maintain an emery that must be revie every 2 years. The following: (1) Be based on a facility-based and assessment, utiliz approach. (2) Include strategemergency events assessment, include the consequences disasters, and oth affect the hospice *[For LTC facilities Emergency Plan. develop and main preparedness plan and updated at lead of the following: (1) Be based on a facility-based and assessment, utiliz approach, includir (2) Include strategemergency events assessment. *[For ICF/IIDs at § Plan. The ICF/IID an emergency prebe reviewed, and	t §418.113(a):] Emergency e must develop and gency preparedness plan ewed, and updated at least e plan must do the and include a documented, community-based risk ing an all-hazards gies for addressing is identified by the risk adding the management of so of power failures, natural er emergencies that would 's ability to provide care. Se at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. The plan must and include a documented, community-based risk ing an all-hazards ing missing residents. gies for addressing is identified by the risk [3483.475(a):] Emergency must develop and maintain eparedness plan that must updated at least every 2 must do the following:					

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COMI	e survey leted 1/2024
06/2 SS, CITY, STATE, ZIP COD ETTE TRAIL	
SS, CITY, STATE, ZIP COD	1/2024
ETTE TRAIL	
	T 975)
PROVIDER'S PLAN OF CORRECTION	(X5)
ACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE	COMPLETION
DEFICIENCY)	DATE
1 <u>6</u> <u>erning Body (Standard)</u> : facility has an emergency	07/11/2024
paredness plan based on Hazards Risk Assessment E(s): 483.475(a)(1)-(2) and is e reviewed and updated at t every two years.	
rective action for dent(s) found to have been cted parts of the POC for the rey will be fully lemented, including the	
e QIDP will ensure that the ergency Plan book is ited and contains all uired elements of the ergency preparedness plan.	
Area Manager will visit facility to ensure that ergency Plan book is in the lity and will conduct a bond level audit to ensure the plan includes a umented facility-based and munity-based risk essment, utilizing an	
efall(et <u>rdcaren</u>) entitier efacilist une	erning Body (Standard): facility has an emergency aredness plan based on azards Risk Assessment (s): 483.475(a)(1)-(2) and is a reviewed and updated at a every two years. Fective action for lent(s) found to have been ated arts of the POC for the ey will be fully emented, including the wing specifics: QIDP will ensure that the regency Plan book is ated and contains all ired elements of the regency preparedness plan. Area Manager will visit acility to ensure that regency Plan book is in the ty and will conduct a and level audit to ensure the plan includes a amented facility-based and munity-based risk

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	OF CORRECTION	IDENTIFICATION NUMBER 15G479	A. BUILDING B. WING		COMPLETED 06/21/2024
	PROVIDER OR SUPPLIER RVIN INDIANA LLC		422 MA	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	that she did not initi risk-assessment was documentation could	ally know what a and was unsure where the		including missing clients. All facility staff will be train on the correct location of the binder and on the contents the Emergency Plan, by 7/11/2024. During upcoming site visits planned for Active Treatment observations, the QIDP will responsible to quiz all staff the location of the Emergency plan as well as various elements of the Site-Specific Emergency Plan and the Emergency These visits as scheduled to take place 4 tiper month 2 months and the monthly after that. Going forward, the QIDP is responsible to ensure that the emergency preparedness program is readily available the home and maintained in accordance with 42 CFR 483.475. The QIDP is also responsible to ensure that a facility staff review the plan staff meetings every other month to ensure ongoing comprehension and competency.	ed he of sent be on hecy cremes en the eat he at he at he at he at he at he at he he he at he

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/21/2024
	PROVIDER 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
				residents potentially affected what measures taken: All residents potentially are affected, and corrective	1 &
				measures address the needs all clients. Persons responsible: Progra	
				Director/QIDP, Area Manager Maintenance Manager, Area Director	
E 0013	484.102(b), 485.6. 485.727(b), 485.9. 491.12(b), 494.62 Development of E §403.748(b), §416 §441.184(b), §460 §483.73(b), §485. §485.68(b), §485. §485.920(b), §486 §494.62(b). (b) Policies and pr develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) or communication pla section. The polici be reviewed and u years.	5(b), 483.475(b), 483.73(b), 25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures 5.54(b), §418.113(b), 0.84(b), §482.15(b), 475(b), §484.102(b), 625(b), §485.727(b), 5.360(b), §491.12(b),			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULT A. BUILI B. WING	DING	NSTRUCTION	(X3) DATE : COMPL 06/21 /	ETED	
	F PROVIDER OR SUPPLIED		4	22 MAF	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The policibe reviewed and "*Additional Requi ESRD Facilities: *[For PACE at §4 procedures. The develop and imple preparedness pol on the emergency (a) of this section paragraph (a)(1) communication pl section. The polician address manager nonmedical emer limited to: Fire; ecfailure; care-related disasters likely to safety of the parti. The policies and previewed and upon the emergency (a) of this section paragraph (a)(1) on the emergency (a) of this section paragraph (a)(1) communication plong communicati	icies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must updated at least annually. The ments for PACE and procedures and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must ment of medical and gencies, including, but not quipment, power, or water ed emergencies; and natural threaten the health or cipants, staff, or the public. Procedures must be lated at least every 2 years. It is at §494.62(b):] Policies The dialysis facility must					

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		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING		COMPLETED	
		15G479	B. WING 06			06/21/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	be reviewed and u years. These eme not limited to, fire, failures, care-relat supply interruption likely to occur in the area. Based on record review and Preparedness Plan's at least every two years at least every two years. Findings include: Based on record review and procedures include: Based on record review and procedures every two page which had an areviewed, however other pages have a minterview at the time acknowledged that date and further stat was reviewed.	a LSC IDENTIFYING INFORMATION Appdated at least every 2 argencies include, but are equipment or power ted emergencies, water in, and natural disasters the facility's geographic Ariew and interview, the facility if update the Emergency is (EPP) policies and procedures ears in accordance with 42 this deficient practice could Ariew of the facility's EPP with Professional (DSP) on 06/21/24 and 12:22 p.m., the facility if update the EPP's policies and two years. The EPP had a cover area to list when the date was it was blank nor did any of the review date listed. Based on the of record review, the DSP the EPP had a missing review ted she was unaware when it	E 0	TAG	E 013 Governing Body (Standard): Development of EP Policies and Procedures CFR(s): 483.475(b) Facilities must develop and implement emergency preparedness policies and procedures, bas on the emergency plan and they must be reviewed and updated at least every 2 years. Corrective action for resident(s) found to have be affected All parts of the POC for the survey will be fully implemented, including the following specifics: Dungarvin's Emergency Pla Policy and Procedure, Policy D-01b, was most recently revised on 11/28/2023. A cur copy is submitted with this pof correction. Program Director to ensure the currer version is filed at the site by 07/10/2024. All facility staff to receive training on the most recent	o7/10/2024 sed rs. en rent blan nt	
					training on the most recent policy and procedure.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPL	
		15G479	B. W	ING		06/21/2024	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DUNCAR				422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360			
DUNGAR	RVIN INDIANA LLC		,	MICHIG	DAN OH 1, IN 40300		
(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 DEFICIENCY)	TE	COMPLETION
TAG	KEGULATOKY OR	LSC IDENTIFYING INFORMATION		TAG	Documentation of training to	`	DATE
					be placed in Emergency Plar		
					binder.	•	
					How facility will identify other	<u>er</u>	
					residents potentially affected	<u> </u>	
					what measures taken:		
					All residents potentially are affected, and corrective		
					measures address the needs	of	
					all clients.	, 01	
					Measures or systemic chang		
					facility put in place to ensure)	
					no recurrence:		
					Area Manager is developing	a	
					monitoring system in	a	
					conjunction with the Program	n	
					Director/QIDP to monitor the		
					Emergency Plan Binders		
					monthly to ensure that all		
					required components are	-11	
					current, present, and filed at times.	all	
					unico.		
E 0029	403.748(c), 416.54	• • • • • • • • • • • • • • • • • • • •					
Bldg	, ,	5(c), 483.475(c), 483.73(c),					
Bldg	484.102(c), 485.62 485.727(c), 485.92						
	491.12(c), 494.62						
		ommunication Plan					
		5.54(c), §418.113(c),					
		.84(c), §482.15(c),					
	§483.73(c), §483.4	475(c), §484.102(c),					
	- , , -	625(c), §485.727(c),					
		3.360(c), §491.12(c),					
	§494.62(c).						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G479		(X2) MULTIPLE C A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/21/2024		
	PROVIDER 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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
	an emergency preplan that complies local laws and must least every 2 yes facilities]. Based on record revialled to review and Preparedness Plan's least every two years 483.475(b). This description occupants. Findings include: Based on review of Direct Support Profibetween 10:52 a.m. failed to review and communication plants cover page had a sphowever it was left EPP could be located indicate when it was interview at the tim acknowledged that and was unsure who reviewed.	ust develop and maintain paredness communication with Federal, State and st be reviewed and updated ears [annually for LTC riew and interview, the facility update the Emergency (EPP) communication plan at its in accordance with 42 CFR ficient practice could affect all the facility's EPP with the fessional (DSP) on 06/21/24 and 12:22 p.m., the facility update the EPP's in every two years. The EPP of to to list a review date, blank. No other pages in the red during the survey to salast reviewed. Based on the of record review, the DSP the review dates were missing the the EPP had been last riewed with the DSP during the riewed with the DSP during the riewed with the DSP during the	E 0029	E 029 Governing Body (Standard The facility must develop a maintain an emergency preparedness communicated plan that complies with Federal, State, and local late and must be reviewed and updated at least every 2 yes. Corrective action for resident(s) found to have be affected. All parts of the POC for the survey will be fully implemented, including the following specifics: The Emergency Communication Plan for the facility was updated on 07//24. A current copy is submitted with this plan of correction. Program Direct to ensure the current versifiled at the site by 07/10/20. All facility staff to receive training on the most recent policy and procedure. Documentation of training be placed in Emergency Pl	ion ws ars. eeen e e o stor on is 24.

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE				
		15G479	B. W	ING		06/21/	/2024
	PROVIDER OR SUPPLIER			422 MA	ADDRESS, CITY, STATE, ZIP COD RQUETTE 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)	ιΤЕ	(X5) COMPLETION DATE
E 0036 Bldg	484.102(d), 485.6. 485.727(d), 485.9. 491.12(d), 494.62 EP Training and T §403.748(d), §416. §441.184(d), §460. §483.73(d), §483. §485.68(d), §485. §485.920(d), §486. §494.62(d). *[For RNCHIs at § Hospice at §418.1 PACE at §460.84,	5(d), 483.475(d), 483.73(d), 25(d), 485.68(d), 20(d), 486.360(d), (d)			How facility will identify other residents potentially affected what measures taken All residents potentially are affected, and corrective measures address the needs all clients. Measures or systemic change facility put in place to ensure no recurrence Program Director and Area Manager responsible to ensuthat Emergency Communication Plan for the facility, is reviewed and updated at least biennially.	d & s of ges	

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Event ID:

VO4121 Facility ID: 000993

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PRINTED: 07/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/21/2024	
	ROVIDER OR SUPPLIER		422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL BAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	485.727, CMHCs §486.360, and RHTraining and testin develop and main preparedness train that is based on the in paragraph (a) of assessment at passection, policies at (b) of this section, plan at paragraph training and testin reviewed and upd *[For LTC facilities and testing. The I and maintain an estraining and testing the emergency plans of this section, risk (a)(1) of this section at paragraph (b) of communication plasection. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plans this section, risk at (a)(1) of this section at paragraph (b) of communication plasection. The train the train programmer section at paragraph (b) of communication plasection. The train testing programmer section.	ragraph (a)(1) of this and procedures at paragraph and the communication (c) of this section. The g program must be ated at least every 2 years. Seat §483.73(d):] (d) Training LTC facility must develop mergency preparedness g program that is based on an set forth in paragraph (a) assessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least 483.475(d):] Training and D must develop and gency preparedness training om that is based on the et forth in paragraph (a) of ssessment at paragraph on, policies and procedures of this section, and the an at paragraph (c) of this ing and testing program and updated at least every			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SUI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL			COMPL	
		15G479	B. WING	<u> </u>		06/21/	2024
	PROVIDER OR SUPPLIEF			422 MA	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN 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	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	requirements for eat §483.470(i).	evacuation drills and training					
	Training, testing, a dialysis facility multiple emergency preparency and patient orients on the emergency (a) of this section, paragraph (a)(1) of procedures at parand the community of this section. The orientation prograupdated at every a Based on record revision failed to review and testing program at 1	view and interview, the facility I update the training and east every 2 years in CFR 483.475(d). This deficient	E 003	6	E 036 Governing Body (Standard): The facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan.		07/10/2024
	Based on record rev Professional (DSP) and 12:22 p.m., the EPP's Training and updated within the spot on the cover sh however it was left the EPP listed when an interview during acknowledged that when it was last rev was unaware when updated.	view with the Direct Support on 06/21/24 between 10:52 a.m. EPP had no date to show the Testing Plan was reviewed and last two years. The EPP had a neet to put the review date, blank. No other pages within it was last updated. Based on record review, the DSP the EPP had no date to confirm riewed and further stated she the EPP for the home was last viewed with the DSP during			Corrective action for resident(s) found to have been affected All parts of the POC for the survey will be fully implemented, including the following specifics: Training and testing program is included in Dungarvin's Emergency Plan Policy and Procedure, Policy D-01b, was most recently revised on 11/28/2023. A current copy is submitted with this plan of	m s	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING COMPLI B. WING 06/21/2			ETED		
	PROVIDER OR SUPPLIER		•	422 MA	ADDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL GAN CITY, IN 46360	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		MICHIG ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) correction. Program Directo to ensure the current version filed at the site by 07/10/2024 All facility staff to receive training on the most recent policy and procedure. Documentation of training to be placed in Emergency Plan binder. How facility will identify other residents potentially affected what measures taken All residents potentially are affected, and corrective measures address the needs all clients. Measures or systemic change facility put in place to ensure no recurrence Area Manager is developing monitoring system in conjunction with the Program Director/QIDP to monitor the	r n is is i.	(X5) COMPLETION DATE
E 0037 Bldg	441.184(d)(1), 482 483.73(d)(1), 484.	5.54(d)(1), 418.113(d)(1), 2.15(d)(1), 483.475(d)(1), 102(d)(1), 485.625(d)(1), 727(d)(1), 485.920(d)(1), 1.12(d)(1)			Emergency Plan Binders monthly to ensure that all required components are current, present, and filed at times.		

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	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	1 ′	JILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED 06/21/2024	
	PROVIDER OR SUPPLIER		<u> </u>	422 MA	ADDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL GAN CITY, IN 46360		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	COMPLETION DATE
TAG	REGULATORY OF EP Training Progr §403.748(d)(1), §441.184(d)(1), §483.73(d)(1), §445.68(d)(1), §445.68(d)(1). *[For RNCHIs at §491.12(d)(1). *[For RNCHIs at §484.102 §485.727, OPOs at §491.12:] (1) Training prograll of the following (i) Initial training ir policies and proceexisting staff, indivunder arrangement consistent with the (ii) Provide emergat least every 2 ye (iii) Maintain docupreparedness trait (iv) Demonstrate semergency proceev) If the emergency proceed (v) If	R LSC IDENTIFYING INFORMATION am 416.54(d)(1), §418.113(d)(1), 460.84(d)(1), §482.15(d)(1), 83.475(d)(1), §484.102(d)(1), 85.625(d)(1), §485.727(d) 1), §486.360(d)(1), 6403.748, ASCs at §416.54, 6.15, ICF/IIDs at §483.475, 62, "Organizations" under at §486.360, RHC/FQHCs am. The [facility] must do g: an emergency preparedness edures to all new and viduals providing services and, and volunteers, eir expected roles. ency preparedness training ears. mentation of all emergency aning. staff knowledge of dures. cy preparedness policies are significantly updated, the duct training on the and procedures. §418.113(d):] (1) Training. and all of the following:		TAG	CROSS-REFERENCED TO THE APPROPRIAT	TE	DATE
	policies and proce existing hospice e providing services	_					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2024	
	PROVIDER OR SUPPLIER			422 MAF	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	(iii) Provide emergat least every 2 ye (iv) Periodically reemergency preparemployees (includ with special emphase the procedures not and others. (v) Maintain documpreparedness trait (vi) If the emerger and procedures a hospice must consupdated policies approcedures. *[For PRTFs at §4 program. The PR following: (i) Initial training in policies and procedures and procedures trait (iii) After initial trait preparedness trait (iii) Demonstrate semergency procedure) (iv) Maintain documpreparedness trait (v) If the emergency procedures and proc	gency preparedness training gears. Eview and rehearse its redness plan with hospice ding nonemployee staff), hasis placed on carrying out ecessary to protect patients mentation of all emergency ning. Incy preparedness policies re significantly updated, the duct training on the and 141.184(d):] (1) Training TF must do all of the memergency preparedness edures to all new and viduals providing services int, and volunteers, eir expected roles. Ining, provide emergency ning every 2 years. Staff knowledge of dures. Immentation of all emergency ning. Incy preparedness policies re significantly updated, the uct training on the updated					
	existing staff, indi	viduals providing on-site					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G479	A. BU B. WI			06/21/	
		100479	D. W1			00/21/	2024
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC				GAN 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 DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!		DATE
		rangement, contractors, volunteers, consistent with					
	their expected role						
	•	ency preparedness training					
	at least every 2 ye	- · · · -					
	(iii) Demonstrate s						
	emergency procedures, including informing						
		at to do, where to go, and					
	whom to contact in case of an emergency. (iv) Maintain documentation of all training.						
		mentation of all training. ncy preparedness policies					
	` '	re significantly updated, the					
	1	uct training on the updated					
	policies and procedures.						
	Training Program. of the following: (i) Initial training ir policies and proce existing staff, indiv under arrangemer consistent with the (ii) Provide emerg at least annually. (iii) Maintain docu- preparedness train (iv) Demonstrate se emergency proced *[For CORFs at §4]	eir expected role. ency preparedness training mentation of all emergency ning. staff knowledge of dures. 485.68(d):](1) Training. The					
	preparedness poli new and existing s	of the following: raining in emergency cies and procedures to all staff, individuals providing rangement, and volunteers,					
	consistent with the (ii) Provide emerg	eir expected roles. ency preparedness training					
	at least every 2 ye (iii) Maintain docu	ears. mentation of the training.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<u></u>	COMPL	
		15G479	B. W	ING		06/21/	/2024
NAME OF T	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP COD		
		•		1	RQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC			MICHIG	AN 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 DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Staff knowledge of	+	TAG	DEI ICIENCI I		DATE
	` '	dures. All new personnel					
		and assigned specific					
	responsibilities regarding the CORF's emergency plan within 2 weeks of their first						
		ning program must include					
	instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the						
		uct training on the updated					
	policies and proce						
	i i						
	-	85.625(d):] (1) Training					
		H must do all of the					
	following:						
	.,	n emergency preparedness					
	reporting and extir	edures, including prompt					
		nere necessary, evacuation					
		nnel, and guests, fire					
		poperation with firefighting					
	and disaster autho	orities, to all new and					
	_	viduals providing services					
		nt, and volunteers,					
		eir expected roles.					
	at least every 2 ye	ency preparedness training					
		mentation of the training.					
		staff knowledge of					
	emergency proced	-					
	(v) If the emerge	ncy preparedness policies					
		re significantly updated, the					
		t training on the updated					
	policies and proce	edures.					
	*IFor CMHCs at &	485.920(d):] (1) Training.					
	-	orovide initial training in					
		redness policies and					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		15G479	B. WI	NG		06/21/	2024
	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	procedures to all rindividuals providinarrangement, and their expected role documentation of must demonstrate emergency proceded commentation of must demonstrate emergency proceded commentation of must demonstrate emergency proceded preparedness trainstrained to ensure staff preparedness policies ICF/IID facility must initial training in en and procedures to all individuals providinand volunteers, consideration of all training at least even documentation of all training; (iv) Demonemergency procedures policies significantly update training on the update accordance with 42 deficient practice confideration of the processional (DSP) and 12:22 p.m., therefore available for review were trained and determined a	new and existing staff, ng services under volunteers, consistent with es, and maintain the training. The CMHC staff knowledge of dures. Thereafter, the	E 00	TAG	E 037 Governing Body (Standard): The facility must do the following emergency preparedness policy and procedure training with all not and existing staff. Provide emergency preparedness training at least annually. Maintain documentation of a emergency preparedness training. Demonstrate staff knowledge of emergency procedures. Corrective action for resident(s) found to have been affected All parts of the POC for the survey will be fully implemented, including the following specifics: All facility staff to receive training on the most recent Emergency Preparedness policy and procedure. Documentation of training to be placed in Emergency Plar binder.	ew II	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 06/21/2024			
	PROVIDER OR SUPPLIER		422	ET ADDRESS, CITY, STATE, ZIP COD MARQUETTE TRAIL HIGAN CITY, IN 46360	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR for the emergency p where the document	iewed with the Direct Support	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	t to an ther ed &
E 0039 Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497 EP Testing Requir §416.54(d)(2), §47 §460.84(d)(2), §48 §483.475(d)(2), §48 §485.625(d)(2), §48 (2), §491.12(d)(2),	8.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)		Persons responsible: Prog Director/QIDP, Area Manag Area Director	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2024	
	PROVIDER OR SUPPLIEI			422 MA	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	CMHCs at §485.9	ons" under §485.727, 020, RHCs/FQHCs at RD Facilities at §494.62]:					
	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:						
	community-based (A) When a comr	full-scale exercise that is levery 2 years; or munity-based exercise is onduct a facility-based					
	functional exercise every 2 years; or (B) If the [facility] experiences an actual						
		ade emergency that requires					
		mergency plan, the [facility] gaging in its next required					
		or individual, facility-based					
		e following the onset of the					
	actual event.	laliticanal avenuica at legat					
	` '	Iditional exercise at least posite the year the full-scale					
		cise under paragraph (d)(2)					
		s conducted, that may					
		limited to the following:					
	` '	scale exercise that is					
		l or individual, facility-based					
	functional exercis	•					
	(B) A mock disast	er drill; or ercise or workshop that is					
		and includes a group					
	discussion using						
		emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an e	mergency plan.					
		acility's] response to and					
		ntation of all drills, tabletop					
	exercises, and en	nergency events, and revise					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479		JILDING	NSTRUCTION	(X3) DATE : COMPL 06/21 /	ETED
	PROVIDER OR SUPPLIER		-	422 MAF	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	*[For Hospices at (2) Testing for ho the patient's home conduct exercises plan at least annual the following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emerge of the emergency exempt from engascale community-facility-based functional exercise of this section is conclude, but is not (A) A second full-community-based functional exercise (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an entitle of the conduct of the conduct of the conduct of the community-based functional exercise (B) A mock disas (C) A tabletop exled by a facilitator discussion using a clinically-relevant set of problem star messages, or preto challenge an entitle conduct of the conduct of	espices that provide care in e. The hospice must so to test the emergency stally. The hospice must do a full-scale exercise that is levery 2 years; or nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or yency that requires activation plan, the hospital is aging in its next required full based exercise or individual ectional exercise following the gency event. Inditional exercise every 2 years the full-scale or e under paragraph (d)(2)(i) conducted, that may be limited to the following: I is a facility based exercise or workshop that is a rand includes a group a narrated, emergency scenario, and a stements, directed pared questions designed					
	care directly. The	spices that provide inpatient hospice must conduct he emergency plan twice					

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

Event ID:

VO4121 Facility ID: 000993

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PRINTED: 07/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING		COMPL	ETED
		15G479	B. W	ING		06/21/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			RQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC				SAN CITY, IN 46360		
							1
(X4) ID		STATEMENT OF DEFICIENCIE	PROV		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		spice must do the following:					
		n annual full-scale exercise					
	that is community						
	, ,	nunity-based exercise is not					
		ct an annual individual					
	facility-based fund						
	1 ' '	experiences a natural or					
		ency that requires activation plan, the hospice is					
		aging in its next required					
		nity based or facility-based					
		e following the onset of the					
	emergency event.	_					
	(ii) Conduct an additional annual exercise that may include, but is not limited to the						
	following:						
		scale exercise that is					
	1 ' '	or a facility based					
	functional exercise						
	(B) A mock disas						
	1 ' '	ercise or workshop led by a					
		udes a group discussion					
	using a narrated,	clinically-relevant					
	emergency scena	rio, and a set of problem					
	statements, direct	ed messages, or prepared					
	questions designe	ed to challenge an					
	emergency plan.						
	(iii) Analyze the h	ospice's response to and					
	maintain documer	ntation of all drills, tabletop					
	exercises, and em	nergency events and revise					
	the hospice's eme	ergency plan, as needed.					
	l -	l41.184(d), Hospitals at					
	§482.15(d), CAHs	- , , -					
	1 ' '	PRTF, Hospital, CAH] must					
		to test the emergency					
	1 '	ar. The [PRTF, Hospital,					
	CAH] must do the						
	(i) Participate in a	an annual full-scale exercise					

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PRINTED: 07/17/2024 FORM APPROVED OMB NO. 0938-039

	N OF CORRECTION	IDENTIFICATION NUMBER 15G479	r í	LDING		COMPL 06/21/	ETED
	F PROVIDER OR SUPPLIEF ARVIN INDIANA LLC			422 MAF	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	accessible, conduction facility-based functions (B) If the [PRTF, Fan actual natural of that requires active plan, the [facility] its next required from individual, facility following the onsequence of the conduction of the following the onsequence of the following the facility-based function (B) A moderate of the following clinically-based function of the following clinically-relevant set of problem states and following clinically-relevant set of problem states of problem	nunity-based exercise is not ct an annual individual, stional exercise; or Hospital, CAH] experiences or man-made emergency ation of the emergency ation of the emergency is exempt from engaging in cull-scale community based ty-based functional exercise at of the emergency event. In [additional] annual at may include, but is not wing: scale exercise that is or individual, a stional exercise; or ck disaster drill; or exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. The [facility's] response to umentation of all drills, and emergency events cility's] emergency plan, as 100.84(d):] FACE organization must at to test the emergency ally. The PACE do the following: an annual full-scale exercise					

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Event ID:

VO4121 Facility ID: 000993

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PRINTED: 07/17/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B.		r í	A. BUILDING COMPLETED B. WING 06/21/2024					
	F PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE		
	(B) If the PACE exor man-made emeractivation of the exist exempt from enfull-scale community-based functional exercise of this section is obut is not limited to the functional exercise of this section is obut is not limited to the functional exercise of this section is obut is not limited to the functional exercise of this section is obut is not limited to the functional exercise of this section is obut is not limited to the functional exercise of this section is obut is not limited to the functional exercise of this section is obut is not limited to the functional exercise of this section is obtained based functional exercises, using clinically-relevant set of problem star messages, or preto challenge an erection of the problem star messages, or preto challenge an erection of the problem star messages, and emercises, a	n additional exercise every he year the full-scale or e under paragraph (d)(2)(i) onducted that may include, o the following: scale exercise that is or individual, a facility exercise; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. PACE's response to and nation of all drills, tabletop mergency events and revise gency plan, as needed. Les at §483.73(d):] ty] must conduct exercises ency plan at least twice per announced staff drills using ocedures. The [LTC facility, the following: an annual full-scale exercise based; or aunity-based exercise is not ct an annual individual,						

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Event ID:

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	INT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479		JILDING	NSTRUCTION	(X3) DATE COMPL 06/21/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	actual natural or requires activation LTC facility is exerequired a full-scalindividual, facility-following the onset (ii) Conduct an act that may include, following: (A) A second full-community-based based functional (B) A mock disas (C) A tabletop ex led by a facilitator discussion, using clinically-relevant set of problem starmessages, or preto challenge an erection of the community for the community, and revise emergency plan, and the community for the community for the community (A) Testing. The left exercises to test the twice per year. The following: (i) Participate in a that is community (A) When a community (B) If the ICF/IID contural or man-material actual or man-material actual or man-material actual or man-material actual or man-material in a for the content of	ter drill; or ercise or workshop that is includes a group a narrated, emergency scenario, and a stements, directed pared questions designed mergency plan. LTC facility] facility's maintain documentation of exercises, and emergency e the [LTC facility] facility's as needed. \$483.475(d)]: CF/IID must conduct the emergency plan at least the ICF/IID must do the						

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Event ID:

VO4121

Facility ID: 000993

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	î ´	UILDING	NSTRUCTION	(X3) DATE COMPL 06/21/	ETED	
	PROVIDER OR SUPPLIEF		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 R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	full-scale community-based functions on the emerical full-scale community-based functions of the emerical full-scale community-based facility-based functions of the exempt from engaging full-scale community-based facility-based functions of the exempt from engaging full-scale community-based functions of the exempt from engaging full-scale community-based full-scale community-based functions of the exempt from engaging full-scale community-based full-scale full-sca	ditional annual exercise but is not limited to the scale exercise that is or an individual, stional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a tements, directed pared questions designed mergency plan. CF/IID's response to and hation of all drills, tabletop hergency events, and revise rgency plan, as needed. 34.102] e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is						

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	MENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	ì í	JILDING	NSTRUCTION	(X3) DATE COMPI 06/21	LETED	
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE	
	years, opposite the functional exercise of this section is continued, but is not (A) A second community-based facility-based function (B) A mock of (C) A tableton is led by a facilitar discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the Homaintain docume exercises, and enthe HHA's emergent to the HHA's emergent to challenge and enthe HHA's emergent the HHA's emergent to challenge and enthe HHA's emergencises to test to OPO must do the (i) Conduct a papor workshop at leexercise is led by group discussion, relevant emergency plan. actual natural or requires activation OPO is exempt for requires activation oPO is exempt for required testing enthe of the emergency of the emergency	iditional exercise every 2 le year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: full-scale exercise that is l or an individual, ctional exercise; or isaster drill; or p exercise or workshop that for and includes a group a narrated, emergency scenario, and a attements, directed pared questions designed mergency plan. HA's response to and intation of all drills, tabletop inergency events, and revise ency plan, as needed. 86.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cy scenario, and a set of ints, directed messages, or ins designed to challenge an lif the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset						

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Event ID:

VO4121 Facility ID: 000993

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING		COMPL	
		15G479	B. WI	NG		06/21/	2024
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN 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		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	maintain documer exercises, and em the [RNHCl's and needed. *[RNCHIs at §403 (d)(2) Testing. The exercises to test the RNHCl must do the (i) Conduct a paper at least annually. If group discussion I narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the RN maintain documer exercises, and em the RNHCl's emer Based on record reversited to conduct explan at least twice pomust do the following: (i) Participate in an is community-based a. When a community-based a. When a community accessible, conduct facility-based function. If the ICF/IID fact natural or man-mad activation of the em facility is exempt froull-scale in a community-scale in	atation of all tabletop nergency events, and revise OPO's] emergency plan, as 3.748]: a RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise A tabletop exercise is a led by a facilitator, using a r-relevant emergency et of problem statements, s, or prepared questions enge an emergency plan. NHCI's response to and ntation of all tabletop nergency events, and revise rgency plan, as needed. riew and interview, the facility nercises to test the emergency ver year. The ICF/IID facility ng: annual full-scale exercise that d; or ity-based exercise is not an annual individual,	E 00	TAG	CROSS-REFERENCED TO THE APPROPRIA	<u>en</u>	
	year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:				on 09/13/2023, however it wa		
					not available for review in the	-	
					Emergency Plan binder. The		
	a. A second full-sca				documentation will be placed		
	community-based o	r an individual, facility-based			in the Emergency Plan binde	r	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479 A. BUILDING B. WING O6/21/20 STREET ADDRESS, CITY, STATE, ZIP COD	
	U ∠ 4
STREET ADDRESS CITY STATE 710 COD	
NAME OF PROVIDER OR SUPPLIER	
422 MARQUETTE TRAIL DUNGARVIN INDIANA LLC MICHIGAN CITY, IN 46360	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION	(X5)
CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) functional exercise. by 7/11/2024.	DATE
b. A mock disaster drill; or	
c. A tabletop exercise or workshop that is led by a The facility staff, including the	
facilitator that includes a group discussion led by Program Director and Lead	
a facilitator, using a narrated, clinically-relevant DSP will review this finding	
emergency scenario, and a set of problem and be retrained on the	
statements, directed messages, or prepared expectations regarding	
questions designed to challenge an emergency plan. frequency and documentation of exercises to test the	
pian. (iii) Analyze the ICF/IID facility's response to and emergency plan annually and	
maintain documentation of all drills, tabletop to place the training	
exercises, and emergency events, and revise the documentation into the	
ICF/IID facility's emergency plan, as needed in Emergency Plan binder as the	
accordance with 42 CFR 483.475(d)(2). This facility training occurs.	
deficient practice could affect all occupants.	
Findings include: How facility will identify other	
Based on record review with the Direct Support residents potentially affected &	
Professional (DSP) on 06/21/24 between 10:52 a.m. what measures taken:	
and 12:22 p.m., the following was not available for	
review: All residents potentially are	
a) No documentation of an annual full-scale affected, and corrective	
exercise that is community-based, a facility-based measures address the needs of	
functional exercise when a community-based all clients.	
exercise is not accessible, or an actual natural or man-made emergency. Persons responsible: Program	
b) No documentation of an additional annual Director/QIDP, Area Manager,	
exercise of choice: a second full-scale exercise that Area Director Area Manager, Area Director	
is community-based, a facility-based functional	
exercise, a mock disaster drill, a tabletop exercise,	
or a workshop.	
Based on interview at the time of record review,	
the DSP acknowledged that the documentation	
from the past year was missing, however she did	
further state that they remember documenting an	
exercise that would have been for the two drills above, but did not have paperwork at the time of	
the survey.	
lane survey.	

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Event ID:

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PRINTED: 07/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G479			l í	UILDING	NSTRUCTION	COM	re survey ipleted 21/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION viewed with the DSP during		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE	
K 0000	the exit conference.							
Bldg. 01								
g. v .	-		K 0	0000				
	Facility Number: 0 Provider Number: 100:	00993 15G479						
	Indiana LLC was for Requirements for P CFR Subpart 483.4 the 2012 Edition of Association (NFPA	Code survey, Dungarvin bund not in compliance with articipation in Medicaid, 42 (70(j), Life Safety from Fire and the National Fire Protection (101, Life Safety Code (LSC), g Residential Board and Care						
	determined to be no a monitored fire ala smoke detection in rooms and all living	ling with a basement, was at sprinklered. The facility has rm system with hardwired corridors, in client sleeping graeas. The facility has a read a census of 8 at the time of						
	(E-Score) using NF Approaches to Life be determined at thi provided. LSC Cha such documentation	Evacuation Difficulty Score PA 101 A, Alternative Safety, Chapter 6, could not is time because no F-1's were upter 32.2.1.2.2 states where is not furnished, the ty shall be classified as						

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PRINTED: 07/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	01	COMPL	LETED
		15G479	B. WING	3		06/21/	/2024
		<u> </u>			DDDDGG OWN OF THE STREET		
NAME OF P	ROVIDER OR SUPPLIEF	3			DOLLETTE TRAIL		
DIMOAF					RQUETTE TRAIL		
DUNGAR	RVIN INDIANA LLC			IVIICHIG	AN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	,	TAG	DEFICIENCY)		DATE
	Impractical.						
	Quality Review cor	mpleted on 06/24/24					
K S100	NFPA 101						
	General Requiren						
Bldg. 01	General Requiren	nents - Other					
	2012 EXISTING						
		RKS section any LSC					
		3.2 General Requirements					
		essed by the provided					
	•	eficient. This information,					
		olicable Life Safety Code or					
	NFPA standard ci						
	on Form CMS-256	o7. eview and interview, the facility	V C10	,	K0400		07/10/2024
		of 8 F-1 work sheets to the	K S10	וע	K0100		07/10/2024
	-	risdiction to be able to			Governing Body (Standard): The facility management sha	.11	
		nation assistance score in			furnish to the authority havir		
		SC 33.2.1.2.2 which states that			jurisdiction where such	ษ	
		nt shall furnish to the authority			documentation is not furnish	ad.	
		upon request, an evacuation			the evacuation capability sha	-	
		ation using a procedure			be classified as impractical.	411	
		athority having jurisdiction;			This deficient practice could		
	•	entation is not furnished, the			affect all occupants. (failed		
		ty shall be classified as			provide 3 of 8 F-1's)		
	-	eficient practice could affect all					
	occupants.						
	•						
	Findings include:				Corrective action for		
					resident(s) found to have be	<u>en</u>	
	Based on record rev	view with the Direct Support			affected	_	
	Professional (DSP)	on 06/21/24 between 10:52 a.m.					
	and 12:22 p.m., the	re were seven F-1 forms			All parts of the POC for the		
	provided during the	e survey, however it was			survey will be fully		
	discovered that two	clients (JR and JW) out of the			implemented, including the		
		not in the home anymore.			following specifics:		
	_	the DSP, she stated that there					
		ns not provided for three newer					
	clients which were	EM, DG, and AM. Upon			On 7/5/24. F-1's was complet	ed	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 06/21/2024
	PROVIDER 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 R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) EBE RIATE COMPLETION DATE
IAU	further investigation DG have been in th approximately one arrived the weekend final interview at th DSP confirmed that missing and was un located other than in	n, the DSP stated that EM and	IAU	for the 3 missing individual In the future the QIDP, Are Manager and Area Director assure timely completion of F-1's for all individuals in thome. All staff in the home will be retrained on the standard of F1 forms be provided to the surveyor upon opening a Lasfety survey, as well as the designated location of the worksheets. The Program Director/QIDP will ensure the forms are present in the home by 7/10/24. How facility will identify of residents potentially affect what measures taken: All residents potentially affected, and corrective measures address the need all clients. Measures or systemic chafacility put in place to ensure the potential of the program of the pro	ar will of the that le line that l
				no recurrence: Going forward, it is the responsibility of the Programination of the Program Director / QIDP to ensure the worksheets are completed updated as necessary. The Program Director/QIDP is a	he F1 and

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

PRINTED: 07/17/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2024			
	ROVIDER OR SUPPLIER		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
				responsible to ensure that the worksheets are present in the home and filed and organize in a designated location, in order to ensure that they are available for review by any agency management or any authorized regulatory agent.	e d		
K S311	NFPA 101	Enclosuro					
Bldg. 01	not to expose a provertical openings protected if separa accordance with 8 passage of smoke primary means of Smoke partitions of strating on not less openings to the vecapable of resisting minutes. Stairs shall be per complying with secan 33.2.2.7. 33.2.3.1.1 through	- Enclosure Prompt) shall be protected so as imary means of escape. shall be considered ated by smoke partitions in .2.4 that resist the from one story to any escape on another story. shall have a fire resistance than 1/2 hour. Any doors or ertical opening shall be g fire for not less than 20 mitted to be open where ctions 33.2.2.4.6 or					
	failed to maintain p accordance of 33.2. vertical openings to partitions in accorda 8.4.3.5 requires doo	on and interview, the facility rotection of 1 of 1 stairway in 3.1.2. LSC 33.2.3.1.2 requires be protected by smoke ance with Section 8.4. LSC rs shall be self-closing or This deficient practice could	K S311	K0311 Governing Body (Standard): Stairs shall be permitted to be open where complying with sections 33.2.2.4.6 or 33.2.2. 33.2.3.1.1 through 33.2.3.1.4 requires vertical openings to be protected by smoke partitions in accordance with Section 8.4. LSC 8.4.3.5	7		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/21/2024	
	PROVIDER OR SUPPLIE		422 M	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Professional (DSP)	on with the Direct Support on 06/21/24 between 12:37 p.m.		requires doors shall be self-closing or automatic closing.	
	have a self-closing but the door failed times. Based on int	stairwell to the basement did device installed on the door, to latch after testing three terview at the time of SP confirmed that the door		Corrective action for resident(s) found to have bee affected	<u>en</u>
	would not latch and has not been able to	d further stated that the door o latch for some time. They ged that a maintenance order		All parts of the POC for the survey will be fully implemented, including the following specifics:	
	Findings were disc conference.	ussed with the DSP at exit		Maintenance request completed for repair of door latch and self-closing device. Maintenance completed repair of the reque on 7/08/2024.	est
				Lead DSP and Program Director/QIDP will report regularly of maintenance needs while completing site visit checklists.	
				Maintenance completes monthly site inspections. In future, the maintenance manager will ensure function operation of this door latch a well as all other within the home.	al
				How facility will identify other residents potentially affected what measures taken:	
				All residents potentially are	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2024	
	PROVIDER 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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
				measures address the needs all clients.	of	
				Persons responsible: Progra Director/QIDP, Area Manager Area Director, Maintenance		
K S345 Bldg. 01	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.7.5, 9.7.7, 9.7.8, 1. Based on record of facility failed to ensinitiating devices with eschedules for test. LSC Section 33.2.3 system shall be provided by Section 9.6, unless the 33.2.3.4.1.2 are met fire alarm system realing installed, tested, and with the applicable National Electric Conference of Alarm and Signaling Edition, Section 14. performed in according to the National Electric Conference of the National	Prompt) m is tested and maintained n an approved program requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available. and NFPA 25 review and interview; the sure all fire alarm system ere tested in accordance with sting frequency in NFPA 72. A.1 states a manual fire alarm wided in accordance with the provisions of 33.2.3.4.1.1 or a. LSC Section 9.6.1.3 states a required for life safety shall be d maintained in accordance requirements of NFPA 70, code and NFPA 72, National Fire g Code. NFPA 72, 2010 4.5 states testing shall be lance with the schedules in e 14.4.5 requires alarm	K S345	K0345 Governing Body (Standard): fire alarm system is tested ar maintained in accordance wir an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Signaling Code. Records of system acceptance, maintenance and testing are readily available. Corrective action for resident(s) found to have been	nd th	
		ces, batteries, and initiating		affected	<u> </u>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED
		15G479	B. W.	ING		06/21/2	2024
NAME OF I				STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER		422 MARQUETTE TRAIL				
DUNGAF	RVIN INDIANA LLC			MICHIC	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		at least annually. This			All parts of the POC for the		
	-	ould affect all clients, staff, and			survey will be fully		
	visitors.				implemented, including the		
	Findings include:				following specifics:		
	Findings include.				The fire alarm inspection, th	at	
	Based on record rev	view from 10:52 a.m. to 12:22			includes sensitivity testing a		
		ith the Direct Support			visual inspection, was		
	•	, the latest documented annual			completed on 06/04/2024 is		
	fire alarm inspection was dated 06/25/15. No other				uploaded with this submission	on.	
	documentation could be produced indicating the				In the future, the facility wil		
	fire alarm had been functionally tested within the				ensure that the fire alarm		
	past year. Based on interview at the time of record				inspections are available		
	review, the DSP acl	knowledged that the fire alarm			within the home.		
	reports were missin	g and further clarified that she					
		pany being out for checking fire			Copy of the fire alarm		
	-	ne fire alarm, but was unable to			inspection will be placed in t	he	
	remember when that				Life Safety book by the		
	documentation at the	e time of the survey.			Program Director by 7/10/202	24.	
	Findings were discu	ussed with the DSP at exit					
	conference.				How facility will identify other	<u>er</u>	
					residents potentially affected	<u> </u>	
		review and interview, the			what measures taken:		
		sure 1 of 1 fire alarm systems			All residents potentially are		
		accordance with 9.6.1.3. LSC			affected, and corrective	_	
	^	re alarm system to be installed,			measures address the needs	of	
		ned in accordance with NFPA			all clients.		
		cal Code and NFPA 72,			Management and acceptance of the control of the con		
		n Code. NFPA 72, 14.4.5 states rmitted by other sections of			Measures or systemic change		
	_	nall be performed in			facility put in place to ensure	<u>-</u>	
		e schedules in Table 14.4.5, or			no recurrence:		
		red by the authority having			Area Manager is developing	<u> </u>	
	_	72, 14.4.5.3.1 states sensitivity			monitoring system in	۳	
	1 "	thin 1 year after installation.			conjunction with the Program	ո	
		2 states sensitivity shall be			Director to monitor the Life		
		nate year thereafter unless			Safety books monthly to ens	ure	
	_	by compliance with 14.4.5.3.3.			that all required inspections	-	
	_	ice could affect all occupants.			are present and filed at all		

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE COMPL 06/21/	ETED
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DUNGAF	RVIN INDIANA LLC				RQUETTE TRAIL GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR		ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings include:				times.		
	Support Professionand 12:22 p.m. on (available for review sensitivity testing h two years. The later sensitivity testing winterview at the tim acknowledged the atthey further stated to coming out within the extinguishers and the	view from with the Direct al (DSP) between 10:52 a.m. 06/21/24, no documentation was very to show if the smoke detector ad been tested with in the last st documented smoke detector was 06/25/15. Based on the of record review, the DSP missing inspections, however that they remember a company the year to look at fire the fire alarm, however she was the ny documentation during the			Persons responsible: Progr Director/QIDP, Area Manage Area Director, Maintenance		
	Findings were discrete conference.	ussed with the DSP at exit					
	facility failed to main accordance with 101 Section 9.6. NI that unless otherwisinspections shall be the schedules in Tarequired by the auth Table 14.3.1 states visually inspected sa. Control unit troub. Remote annunciate. Initiating devices fire alarm boxes, he etc.) d. Notification apple. Magnetic hold-opensor.	ble signals ators (e.g. duct detectors, manual eat detectors, smoke detectors,					
	occupants.	ice could affect all building					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2024		
	PROVIDER OR SUPPLIER			422 MAI	DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN 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)	TE	(X5) COMPLETION DATE
	Professional (DSP) and 12:22 p.m., no indicate when the fi annual functional te confirm if a semi-arbeen conducted. Du forms indicate that are inspected on each listed is not a compito be inspected. Bas record review, the I when the last time tinspected and further alarm documentation was dated 2015.	riew with the Direct Support on 06/21/24 between 10:52 a.m. documentation was provided to re alarm inspection has had its esting, so it is unable to unual visual inspection has ever uring record review, fire drill certain parts of the fire alarm the fire drill, however the items dete list of the items that need sed on interview at the time of DSP stated they were unaware the fire alarm has been er confirmed that the only fire on provided during the survey					
K S359 Bldg. 01	NFPA 101 Sprinkler System Sprinkler System 2012 EXISTING (In All Impractical Evasual Supervised autom accordance with 3 The system shall In Section 9.7 and significant system in accordate below. The adequishall be document in Impractical Evasual Facilities, an automice system in accordate below.	Installation Impractical) acuation Capability facilities throughout by an approved, atic sprinkler system in 3.2.3.5.3. be in accordance with hall initiate the fire alarm ince with 9.6, as modified acy of the water supply ted. cuation Capability matic sprinkler system in IFPA 13D, Standard for the					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPL		COMPL	ETED	
		15G479	B. W	3. WING			06/21/2024	
		l .	<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	₹			RQUETTE TRAIL			
DUNGAE	RVIN INDIANA LLC				GAN CITY, IN 46360			
DUNGAR				MICTIC				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	one-and-two-Fam	ily Dwellings and						
		mes, with a 30 minute water						
		ermitted. All habitable						
		shall be sprinklered.						
		ers shall not be required in						
	bathrooms not ex	ceeding 55 square feet,						
	provided that such	n spaces are finished with						
	lath and plaster or	r materials provided a						
	15-minute therma							
		cuation Capability Facilities						
	up to and including four stories above grade							
	plane, systems in accordance with NFPA							
	13R, Standard for the Installation of Sprinkler							
		ential Occupancies up to						
	_	ır Stories in Height, shall be						
	permitted.							
		s and closets shall be						
	1 · ·	natic sprinklers shall not be						
		oms not exceeding 55						
		led that such spaces are						
		and plaster or materials						
		nute thermal barrier.						
		e alarm system shall not be						
	required for existing	_						
	accordance with 3							
		ng purposes, storage, or						
		ent are sprinkler protected,						
		ttics not used for living						
		e, or fuel-fired equipment						
	meet one of the fo	_						
		heat detection system to						
		arm system according to						
	9.6 by July 5, 201							
		automatic sprinkler system						
	according to 9.7, I	-						
		of noncombustible or						
	limited-combustib							
	_	of fire-retardant-treated						
	wood according to							
	33.2.3.5.3, 33.2.3	.5.3.2, 33.2.3.5.3.5 through						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		(X3) DATE COMPL 06/21/	ETED	
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	33.2.3.5.3.7, 42 C Based on record recording to install a 1 automatic sprinkler 33.2.3.5.3. LSC 33 impractical evacuation accordance with states that facility recorded authority having just evacuation capabilic procedure acceptabigurisdiction; where furnished, the evacuation include: Based record review Professional (DSP) and 12:22 p.m., the adequate F1worksh determine the clien when requested. Duforms, the facility wand was not provid supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the supervised automatinterview at the time acknowledged the acconfirmed no other review during the tree fails and the	FR 483.470(j)(1)(ii) view and interview, the facility of 1 approved, supervised system in accordance with 2.3.5.3 requires facilities with an tion capability to be sprinklered NFPA 13D. LSC 33.2.1.2.2 management shall furnish to the risdiction, upon request, an ty determination using a le to the authority having such documentation is not mation capability shall be stical. This deficient practice upants. w with the Direct Support on 06/21/24 between 10:52 a.m. facility was unable to provide teets used to rate all clients and ts's overall need for assistance the to the lack of furnished F1 was classified as "Impractical" ted with an approved, ic sprinkler system. Based on the of observation, the DSP afforementioned condition and paperwork was available for	K S.		Governing Body (Standard): Impractical Evacuation Capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system accordance with 33.2.3.5.3. ("impractical due to lack of F-1's) Corrective action for resident(s) found to have be affected All parts of the POC for the survey will be fully implemented, including the following specifics: This citation states that the home was assessed as "impractical" due to the failu to provide F1 worksheets. A staff in the home will be retrained on the standard th F1 forms be provided to the surveyor upon opening a Lif Safety survey, as well as the designated location of the worksheets. The Program Director/QIDP will ensure the the forms are present in the home by 7/10/24. How facility will identify other	ure II at fe at	07/10/2024

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	OF CORRECTION	IDENTIFICATION NUMBER 15G479	A. BUILDING B. WING	01	COMPLETED 06/21/2024
	ROVIDER OR SUPPLIER		422 MA	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				what measures taken: All residents potentially are affected, and corrective measures address the need all clients. Measures or systemic chan facility put in place to ensur no recurrence:	s of ges_
				Going forward, it is the responsibility of the Program Director / QIDP to ensure the worksheets are completed a updated as necessary. The Program Director/QIDP is alresponsible to ensure that the worksheets are present in the home and filed and organize in a designated location, in order to ensure that they are available for review by any agency management or any authorized regulatory agent	e F1 Ind so ne ne ed
K S363	NFPA 101 Corridor - Doors				
Bldg. 01	Corridor - Doors Doors shall meet a requirements: 1. Doors shall b other mechanisms door closed. 2. No doors shal the occupant from 3. Doors shall b automatic-closing	e provided with latches or suitable for keeping the Il be arranged to prevent			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		15G479	B. W	ING		06/21/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN 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	
TAG	throughout by an a sprinkler system in Door assemblies was swing in the direct inspected and test 33.2.3.6.4, 33.7.7 Based on observation failed to ensure 2 of provided with a door latch securely in the practice could affect staff. Findings include: Based on observation Professional (DSP) and 1:14 p.m., the debedroom was self-completely close affect door would rub up a would stop the door Furthermore, the does self-closing, however position, the bottom against the carpet an not close unless you on interview at the confirmed that the correctly and further southeast bedroom is slam the door or having active the doors us.	approved automatic in accordance with 33.2.3.5. with leaves required to ion of egress travel are ited annually per 7.2.1.15. In and interview, the facility is 5 client sleeping rooms were or which would self-close and ited door frame. This deficient it approximately 5 clients and in on the Southeast client closing, however it did not iter testing three times. The against the door frame which is from fully closing. From the East bedroom was ser when tested at it's fullest in of the door would rub ind would stop half-way and in pulled the door shut. Based time of observation, the DSP cloors were not operating in stated that the client for the has had incidents where he'd we behaviors which would	KS		K0363 Governing Body (Standard): Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. No doors shall be arranged to prevent the occupant from closing the door. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8 in building other than those protected throughout an approved automatic sprinkler system in accordar with 33.2.3.5. Corrective action for resident(s) found to have be affected All parts of the POC for the survey will be fully implemented, including the following specifics: A Maintenance request is entered for repair of the fire doors that were not latching. Area Manager to visit the facility to ensure that no furt damage has been done and that all doors are closing and latching.	07/11/2024 n s r	

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	OF CORRECTION	IDENTIFICATION NUMBER 15G479	A. BUILDING B. WING	01	COMPLETED 06/21/2024
	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
				Going forward, the Lead DS and PD are to monitor that a fire doors close and latch monthly and document this the Site Risk Management form.	II
				How facility will identify oth residents potentially affected what measures taken:	
				All residents potentially are affected, and corrective measures address the needs all clients.	
				Measures or systemic change facility put in place to ensure no recurrence: /b>	
				Persons responsible: Progr Director/QIDP, Area Manage Area Director, Maintenance	
K S511 Bldg. 01	complies with NFF Code, electrical w				
	32.2.5.1, 33.2.5.1, 1. Based on observa	, 9.1.1, 9.1.2 ation and interview, the facility	K S511	K0511	07/11/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2024		
	PROVIDER OR SUPPLIER		422 M	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360		
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION		
TAG		R LSC IDENTIFYING INFORMATION f 1 flexible cords were installed	TAG	Governing Body (Standard):	DATE	
		n a safe manor. NFPA 99,		Equipment using gas or relate		
		ates adapters and extension equirements of 10.2.4.2.1		gas piping complies with NF 54, National Fuel Gas Code,	PA	
	_	shall be permitted. Section		electrical wiring and		
	_	e cabling shall comply with		equipment complies with NP	FA	
		2.3.5.1 states cord strain relief		70, National Electric Code.		
	_	the attachment of the power		32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2		
	cord to the appliance so that mechanical stress,			Commenting action for		
	either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 2 clients and staff.			Corrective action for resident(s) found to have been	en l	
				affected	<u> </u>	
			All parts of the POC for the			
	Findings include:			survey will be fully		
	D1	- n id- dh - Din d C n d		implemented, including the		
		on with the Direct Support on 06/21/24 between 12:37 p.m.		following specifics:		
		Northwest client bedroom		The power strips that were i	n	
	_	strip that was used to power		use have been removed		
		s and electronics which was		7/08/2024.		
		ing dresser by its power cord.				
		at the time of observation, the		Maintenance repaired light		
	DSP acknowledged	the power strip was dangling.		switch cover near front door 7/08/2024.		
	This finding was re	viewed with the DSP during		770072024.		
	the exit conference.			Maintenance requests have		
				been made for repair of failing	ıg 💮	
		ation and interview, the facility		to ensure 1 of 3 wet locations	s	
		f 1 power strips were not used ixed wiring to provide power		were provided with ground	, l	
	equipment with a h			fault circuit interrupter (GFC) protection against electric	''	
		0.8 state unless specifically		shock, to be completed by		
	permitted in 400.7	flexible cords and cables shall		7/11/2024.		
		as a substitute for fixed wiring.				
	This deficient pract two staff.	ice could affect approximately		All facility staff to review this finding and review the	s	
	Findings include:			expectation that power strips are not to be used as a	5	
	<i>g</i>			substitute for fixed wiring.		
	Based on observation	on during a tour of the facility				

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/21/2024 15G479 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **422 MARQUETTE TRAIL** MICHIGAN CITY, IN 46360 DUNGARVIN INDIANA LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE with the Director Support Professional (DSP) on Going forward, the Lead DSP 06/21/24 between 12:37 p.m. and 1:14 p.m., a and Program Director are to refrigerator (high power draw equipment) was monitor that no power strips plugged into and supplied power by a power strip are in use as a substitute for in the employee office. Based on interview at the fixed wiring in the home on a time of observation, the DSP acknowledged the monthly basis and document power strip and further stated that she was this on the Site Risk unaware it had to be plugged into the wall. Management form. Staff will complete immediate The finding was discussed with the DSP at exit maintenance requests for conference. maintenance needs. 3. Based on observation and interview, the facility failed to ensure 1 of 1 exposed wiring locations How facility will identify other were protected. NFPA 70, 2011 Edition. Article residents potentially affected & 406.5 (F) Exposed Terminals, Receptacles shall be what measures taken: enclosed so that live wiring terminals are not All residents potentially are exposed to contact. This deficient practice could affected, and corrective affect all clients and staff. measures address the needs of all clients. Findings include: Measures or systemic changes Based on observation during a tour of the facility facility put in place to ensure with the Direct Support Professional (DSP) on no recurrence: 06/21/24 between 12:37 p.m. and 1:14 p.m., there was a light switch next to the front door which A monitoring system is in was covered partially with a strip of duct tape. place and the Program Director Upon further investigation, the light switch cover will monitor the Life Safety was broken and once the tape was removed, the compliance of the facility, light switch wires were exposed. Based on including a look behind check interview at the time of observation, the DSP of this documentation during acknowledged that the light switch cover was monthly visits. Area Manager to broken and indicated that a maintenance request further verify with a second was sent out and now they are waiting for it to be look behind during regular site fixed. visits. The finding was reviewed with the DSP during the Persons responsible: Program

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exit conference.

4. Based on observation and interview, the facility

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VO4121

Facility ID: 000993

Director/QIDP, Area Manager, Area Director, Maintenance

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
1:		15G479	B. WING			06/21/2024		
			I s	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			RQUETTE TRAIL			
DUNGARVIN INDIANA LLC				MICHIGAN CITY, IN 46360				
	1			-			Т	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE	
		f 3 wet locations were provided						
	-	ircuit interrupter (GFCI)						
	protection against electric shock. NFPA 70, NEC							
	2011 Edition at 210.8 Ground-Fault							
	Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for							
	_	-						
		provided as required in						
		C). The ground-fault						
	_	hall be installed in a readily						
	accessible location.							
	Informational Note: See 215.9 for ground-fault							
	circuit interrupter protection for personnel on							
	feeders. (D) Other Then Dividling Units All 125 yelt							
	(B) Other Than Dwelling Units. All 125-volt,							
	single-phase, 15- and 20-ampere receptacles							
	installed in the locations specified in 210.8(B)(1)							
	through (8) shall have ground-fault							
	circuit-interrupter protection for personnel.							
	(1) Bathrooms							
	(2) Kitchens							
	(3) Rooftops (4) Outdoors							
	(4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are							
	not readily accessible and are supplied by a							
	branch circuit dedicated to electric snow-melting,							
	deicing, or pipeline and vessel heating equipment							
		o be installed in accordance						
	with 426.28 or 427.							
	Exception No. 2 to (4): In industrial establishments							
	_	nditions of maintenance and						
	1	that only qualified personnel						
	•	sured equipment grounding						
		as specified in 590.6(B)(2)						
		for only those receptacle						
	_	ply equipment that would						
		ard if power is interrupted or						
	having a design that is not compatible with GFCI							
	protection.							
	(5) Sinks - where receptacles are installed within							
	1.8 m (6 ft.) of the outside edge of the sink.							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/21/2024				
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360					
	1			, I				
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEPCIENCT)	DATE			
	Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where							
		vould introduce a greater						
	_	mitted to be installed without						
	GFCI protection.	initied to be instance without						
	_	(5): For receptacles located in						
		ns of general care or critical						
	_	care facilities other than those						
	covered under							
	210.8(B)(1), GFCI	protection shall not be required.						
	(6) Indoor wet loca	tions						
	(7) Locker rooms w	vith associated showering						
	facilities							
	(8) Garages, service bays, and similar areas where							
	electrical diagnostic equipment, electrical hand							
	tools.							
	NFPA 70, 517-20 Wet Locations, requires all							
	receptacles and fixed equipment within the area of							
	the wet location to have ground-fault circuit							
		protection. Note: Moisture can						
		resistance of the body, and						
	electrical insulation is more subject to failure. This							
	deficient practice could affect all clients and staff.							
	Findings include:							
	Based on observation on 06/21/24 between 12:37							
	p.m. and 1:14 p.m. during a tour of the facility with							
	the Direct Support Professional (DSP), there were							
	two electrical receptacles within five feet of the							
	bathroom sink with	in the northwest bedroom.						
	When tested with a	GFCI tester, the tester						
	_	ground" which would not trip						
		nore, the bathroom in the main						
	1	northwest bedroom had two						
		es within five feet of the sink.						
		the surveyor also indicated an						
	"open ground" and would not trip the outlet as well. Based on interview at the time of							
	observation, the DS	SP acknowledged that the GFCI						

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

OMB NO. 0938-039

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
15G479		15G479	B. WING			06/21/2024	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	unaware why the ou	ip using the tester and was atlets would not trip. cussed with the DSP at exit					

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