STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G479	A. BUILDING -- B. WING	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) for the Emergency Prepardness Survey that exited on 06/21/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73 Survey Date: 08/20/24 Facility Number: 000993 Provider Number: 15G479 AIM Number: 100244950 At this Emergency Preparedness PSR, Dungarvin Indiana LLC was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 08/23/24	E 0000	n/a	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness	E 0037	**E 037** **Governing Body (Standard):** **The facility must do the following emergency preparedness policy and procedure training with all new and existing staff. Provide emergency preparedness training at least annually. Maintain documentation of all emergency preparedness**	09/06/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annmarie Fanning	Area Director	09/13/2024

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	training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on record review with the Direct Support Professional (DSP) on 08/20/24 between 1:27 p.m. and 1:55 p.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of record review, the Direct Support Professional stated that they have frequent house meetings that discusses policies/procedures based on the EPP which had all staff present, however she further stated that if that documentation was available to be seen, it most likely was at the main office and not in the home. The finding was reviewed with the Direct Support Professional during the exit conference. This deficiency was cited on 06/21/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.		**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 ID VO4122, will be fully implemented, including the following specifics:** **All facility staff did receive training on the most recent policy and procedure, regarding the Emergency Preparedness Policy and Procedure. On 7/10/2024 and again on 7/17/2024. Copies of those trainings are uploaded with this Plan of Correction.** **The Program Director was reminded that all training documents in relation to the Life Safety Emergency Binder, must be placed into the binder as a reference of those that have been trained. Program Director will place all training documents in the Emergency Plan binder, going forward.** **The Quality Assurance Coordinator monthly will review and inspect the Life Safety Binder, during their monthly site visits to ensure all drills, table-top exercises,**	

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			community-based or facility based, mock disaster drills, Policy and Procedures are the most up to date, fire and smoke detector sensitivity inspection reports are present, and any necessary training documentation is there for review as required. **The Area Manager and Area Director will also review and inspect the Life Safety Binder, during their monthly site visits to ensure all drills, table-top exercises, community-based or facility based, mock disaster drills, Policy and Procedures are the most up to date, fire and smoke detector sensitivity inspection reports are present, and any necessary training documentation is there for review as required.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager and Area Director**	

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E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants. Findings include:	E 0039	**9/13/2024 updated notes:** **On 9/11/2024, a natural emergency event occurred at the facility and surrounding community area, of a power transformer blowing causing a power outage. The electrical power was out from 9/11/2024, 5:30 pm until the following morning 9/12/2024, 7:30 am. Staff followed procedures of notifying other's and emergency generator backup was in use for the entire timeframe. The clients did not require to be evacuated. Once power was restored on 9/12/2024, the generator was shut down and regular use of electrical power was resumed. On 9/12/2024, staff met with their Program Director/QIDP, Area Manager and the Area Director to review the event of the power outage, of the day prior. A complete training and review of the Community Based event that occurred on 9/11/2024, with discussion of what happened during the event, along with ways to improve for future events. Training included the review of our Life Safety Binder, Emergency Preparedness Policy along with the Community Action Plan for the**	09/12/2024

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	Based on record review with the Direct Support Professional (DSP) on 08/20/24 between 1:27 p.m. and 1:55 p.m., the following was not available for review: a) No documentation of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency. b) No documentation of an additional annual exercise of choice: a second full-scale exercise that 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 state that the facility has done certain exercises in the past. Unfortunately she was unnable to provide that documentation during the revisit survey. This finding was reviewed with the DSP during the exit conference. This deficiency was cited on 06/21/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.		**facility.** **Documentation from the record of Emergency Event, on 9/11/2024, and the Community Based training from 9/12/2024, are attached for reference. Both are also place in the Life Safety Binder at the facility as well.** **<u>E 039</u>** **<u>Governing Body (Standard)</u>: The facility must conduct exercises to test the emergency plan annually.<u>Corrective action for resident(s) found to have been affected:</u>** **All parts of the POC for the survey ID VO4122, will be fully implemented, including the following specifics: This exercise was completed in September of 2023; however, it was not available for review in the Emergency Plan binder. The Program Director/QIDP failed to have documentation placed in the Emergency Plan binder by 7/11/2024, as previously stated.Copy of the 09/2023 table-top exercise is uploaded with this Plan of Correction. The Program Director/QIDP, was reminded that all drill and table-top exercise documentation, in relation to the Life Safety**	

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			Emergency Binder, must be placed into the binder, as a reference of the drills and table-top exercises were completed. Program Director will place all drill and table-top documents in the Emergency Plan binder, going forward.Program Director/QIDP completed another tabletop discussion on 09/05/2024 and a copy is uploaded here for reference, plus placed in the Life Safety Emergency Binder at the facility.The facility staff, including the Program Director and Lead DSP will review this finding and be retrained on the expectations regarding frequency and documentation of drills and table-top exercises, to test the emergency plan annually and to place the drill and table-top exercise documentation into the Emergency Plan binder as the facility drills occur.The Quality Assurance Coordinator monthly will review and inspect the Life Safety Binder, during their monthly site visits to ensure all drills, table-top exercises, community-based or facility based, mock disaster drills, Policy and Procedures are the most up to date, fire and smoke detector sensitivity inspection reports are present, and any necessary training documentation is there for	

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			review as required.The Area Manager and Area Director will also review and inspect the Life Safety Binder, during their monthly site visits to ensure all drills, table-top exercises, community-based or facility based, mock disaster drills, Policy and Procedures are the most up to date, fire and smoke detector sensitivity inspection reports are present, and any necessary training documentation is there for review as required.<u>How facility will identify other residents potentially affected & what measures taken:</u>All residents potentially are affected, and corrective measures address the needs of all clients.Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager and Area Director	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 06/21/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 08/20/24 Facility Number: 000994 Provider Number: 15G479 AIM Number: 100244950	K 0000	n/a	

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	At this Life Safety Code PSR, Dungarvin Indiana LLC was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building with a basement, was determined to be not sprinklered. The facility has a monitored fire alarm system with hardwired smoke detection in corridors, in client sleeping rooms and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.67. Quality Review completed on 08/23/24			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity	K S345	**9/13/2024 updated notes:** **FSS Technologies forward their Sensitivity Report, that was completed on 6/4/2024. They reported in an email, two of our smoke detectors do not have sensitivity, due to the type of smoke detector they are. Documentation of the sensitivity report from 6/4/2024 is attached for reference and is placed in the Life Safety**	09/13/2024

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	shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review from with the Direct Support Professional (DSP) between 1:27 p.m. and 1:55 p.m. on 08/20/24, no documentation was available for review to show if the smoke detector sensitivity testing had been tested with in the last two years. The latest documented smoke detector sensitivity testing was 06/25/15. Based on interview at the time of record review, the DSP acknowledged the missing inspection and was unsure if the inspection has been done within the past two years. The finding was discussed with the DSP at exit conference. This deficiency was cited on 06/21/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.)		**Binder at the facility.** **K0345** **Governing Body (Standard): A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Signaling Code. Records of system acceptance, maintenance and testing are readily available.Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey ID VO4122, will be fully implemented, including the following specifics: The fire alarm inspection, which includes sensitivity testing and visual inspection, was completed on 06/04/2024, and is uploaded with this submission. Copy of the visual and smoke detector sensitivity testing inspection was placed, in the Life Safety book by the Program Director on 7/10/2024, however it was unable to be located at time of survey revisit. The Quality Assurance Coordinator has since placed again, the 06/04/2024 visual and smoke detector sensitivity testing inspection, into the Life**	

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	d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on record review with the Direct Support Professional (DSP) on 08/20/24 between 1:27 p.m. and 1:55 p.m., the facility was able to produce an annual functional fire alarm inspection was dated January of 2024. However, no six-month visual inspection after the annual functional testing was able to be produced at the time of the survey. Based on interview at the time of record review, the DSP stated she was unaware where the documentation could be as it should have been in the drill binder. The finding was reviewed with the DSP at exit conference. This deficiency was cited on 06/21/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.		**Safety Emergency binder, for reference of completion.In the future, the facility will ensure that the visual smoke detector sensitivity and fire alarm inspections are available within the home, in the Life Safety Emergency binder, upon completion for reference.The Program Director was reminded that all fire and smoke detector inspection documents, in relation to the Life Safety Emergency Binder, must be placed into the binder, as a reference of completion. Program Director will place all fire and smoke detector inspection documents, in the Emergency Plan binder, going forward.The Quality Assurance Coordinator monthly will review and inspect the Life Safety Binder, during their monthly site visits to ensure all drills, table-top exercises, community-based or facility based, mock disaster drills, Policy and Procedures are the most up to date, fire and smoke detector sensitivity inspection reports are present, and any necessary training documentation is there for review as required.The Area Manager and Area Director will also review and inspect the Life Safety Binder, during their monthly site visits to ensure all drills, table-top exercises,**	

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			community-based or facility based, mock disaster drills, Policy and Procedures are the most up to date, fire and smoke detector sensitivity inspection reports are present, and any necessary training documentation is there for review as required. How facility will identify other residents potentially affected & what measures taken:All residents potentially are affected, and corrective measures address the needs of all clients.Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager and Area Director	
K S363 Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 5 client sleeping rooms were provided with a door which would self-close and latch securely in the door frame. This deficient practice could affect approximately 5 clients and staff. Findings include: Based on observation with the Direct Support Professional (DSP) on 08/20/24 between 1:56 p.m. and 2:00 p.m., the door to the Southeast client bedroom was self-closing, however it did not completely close after testing three times. The door would rub up against the door frame which would stop the door from fully closing. Furthermore, the door to the East bedroom was	K S363	**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 by an approved automatic sprinkler system in accordance with 33.2.3.5.**	09/13/2024

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	self-closing, however when tested at it's fullest position, the bottom of the door would rub against the carpet and would stop half-way and not close unless you pulled the door shut. Based on interview at the time of observation, the DSP confirmed that the doors were not operating correctly and further stated that the client room doors not being able to latch has been a coninuous problem and agreed that the doors needed to properly latch. The finding was discussed with the DSP at exit conference. This deficiency was cited on 06/21/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.		**Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey ID VO4122, will be fully implemented, including the following specifics:** **A Maintenance request was entered for initial repair of the fire doors that were not latching. Maintenance repaired all doors, in the facility, which would not properly close and latch on, 07/08/2024. The facility doors properly worked in the facility as of the repair on 07/08/2024.** **Upon 08/20/2024 survey revisit, it was noted that two of the facility bedroom doors would not properly latch or close. A maintenance request was entered for repair, to be completed by 09/13/2024.** **During maintenance's monthly site inspections, they will check that all doors properly close and latch throughout the facility. If they do not, maintenance will initiate repair at that time.** **The Program Director/QIDP, Quality Assurance Coordinator, Area Manager and Area Director will also check that all doors properly close and latch**	

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			throughout the facility, anytime they are at the site, minimum of a monthly check. If the doors do not properly close and latch, they will initiate maintenance request at that time. **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Persons responsible: Program Director/QIDP, Maintenance, Quality Assurance Coordinator, Area Manager and Area Director**	
K S511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with	K S511	**K0511** **Governing Body (Standard): Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA**	08/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G479	A. BUILDING 01 B. WING	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360

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	10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect approximately 2 clients and staff. Findings include: Based on observation with the Direct Support Professional (DSP) on 08/20/24 between 1:56 p.m. and 2:00 p.m., the Northwest client bedroom contained a power strip that was used to power electrical appliances and electronics which was dangling off a clothing dresser by its power cord. Based on interview at the time of observation, the DSP acknowledged the power strip was dangling and further stated that she would try to fix the issue by the end of day. This finding was reviewed with the DSP during the exit conference. This deficiency was cited on 06/21/24. The facility failed to implement a systemic plan of correction to prevent reoccurrences.		**70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2** **Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey ID VO4122, will be fully implemented, including the following specifics:** **Previous noted power strips that were in use, were removed on 7/08/24. Upon Life Safety survey revisit, on 08/20/2024, the northwest client bedroom contained a power strip that was used to power electrical appliances and electronics which was dangling off a clothing dresser, by its power cord. DSP removed the power strip on 08/20/2024 and assisted client to safely plug in their electronic items, without the power strip.** **The Program Director/QIDP, Quality Assurance Coordinator, Area Manager and Area Director will routinely check that there are no power strips in use, throughout the facility, minimum with their monthly site inspections. Anytime a power strip is found in use, that staff will remove the power strip immediately and find an alternate outlet solution.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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			How facility will identify other residents potentially affected & what measures taken: **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Persons responsible: Program Director/QIDP, Quality Assurance Coordinator, Area Manager, Area Director, and Maintenance**	