JENTERS FO	R MEDICARE & MEDIC	AID SERVICES			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 08/20/2024	
	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 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)	(X5) COMPLETION DATE	
E 0000	REGULATORT OF	CESC IDENTIFTING INFORMATION	IAU		DATE	
Bldg	Prepardness Survey	isit (PSR) for the Emergency that exited on 06/21/24 was adiana Department of Health in CFR 483.73	E 0000	n/a		
	Indiana LLC was for Emergency Prepare Medicare and Medi and Suppliers, 42 C.  The facility has 8 concertified for Medicathe census was 8.	244950 Preparedness PSR, Dungarvin bund not in compliance with edness Requirements for icaid Participating Providers				
E 0037 Bldg	Based on record rev failed to ensure staf preparedness polici ICF/IID facility mu Initial training in er and procedures to a individuals providing and volunteers, con roles; (ii) Provide e training at least eve	6.54(d)(1), 418.113(d)( ram  view and interview, the facility ff were trained in emergency es and procedures. The list do all of the following: (i) mergency preparedness policies all new and existing staff, mg services under arrangement, sistent with their expected mergency preparedness my two years; (iii) Maintain ll emergency preparedness	E 0037	E 037 Governing Body (Standard): The facility must do the following emergency preparedness policy and procedure training with all n and existing staff. Provide emergency preparedness training at least annually. Maintain documentation of a emergency preparedness	ew	

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

(X6) DATE

TITLE

Annmarie Fanning Area Director 09/13/2024

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

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  08/20/2024			
	PROVIDER OR SUPPLIER		422 M	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION Instrate staff knowledge of	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	emergency procedu preparedness policie significantly update	res; (v) If the emergency es and procedures are d, the facility must conduct		training. Demonstrate staff knowledge of emergency procedures.	
	accordance with 42	ould affect all occupants.		Corrective action for resident(s) found to have be affected:	een_
	Professional (DSP) and 1:55 p.m., there available for review	riew with the Direct Support on 08/20/24 between 1:27 p.m. was no documentation to indicate all facility staff monstrate knowledge of the		All parts of the POC for the survey ID VO4122, will be fur implemented, including the following specifics:  All facility staff did receive training on the most recent	lly
	for new staff and ev staff. Based on an it review, the Direct S they have frequent I policies/procedures all staff present, how	dness Program (EPP) initially rery two years for existing atterview at the time of record support Professional stated that mouse meetings that discusses based on the EPP which had wever she further stated that if		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.	of d
	most likely was at thome.  The finding was rever Professional during deficiency was cited	was available to be seen, it he main office and not in the riewed with the Direct Support the exit conference. This d on 06/21/24. The facility a systemic plan of correction ences.		The Program Director was reminded that all training documents in relation to the Life Safety Emergency Bind must be placed into the bind as a reference of those that have been trained. Program Director will place all trainin documents in the Emergence Plan binder, going forward.	er, der g
				The Quality Assurance Coordinator monthly will review and inspect the Life Safety Binder, during their monthly site visits to ensure drills, table-top exercises,	e all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G479		A. BUILDING COMPL		(X3) DATE SURVEY COMPLETED 08/20/2024			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
DUNGAR (X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION			ne oke on er, its lor		
ı							

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Event ID:

VO4122 Facility ID: 000993

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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 S	ETED	
		156479	B. WI	NG		08/20/	ZUZ4 
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY S	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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0039 Bldg	EP Testing Requir  Based on record rev	5.54(d)(2), 418.113(d)( rements riew and interview, the facility ercises to test the emergency	E 00	)39	9/13/2024 updated notes:		09/12/2024
		er year. The ICF/IID facility			On 9/11/2024, a natural emergency event occurred a		
	must do the following	-			the facility and surrounding	•	
		annual full-scale exercise that			community area, of a power		
	is community-based				transformer blowing causing	ıa	
	-	ity-based exercise is not			power outage. The electrical		
	accessible, conduct	an annual individual,			power was out from 9/11/202	4,	
	facility-based functi				5:30 pm until the following		
		cility experiences an actual			morning 9/12/2024, 7:30 am.		
		e emergency that requires			Staff followed procedures of		
		ergency plan, the ICF/IID			notifying other's and		
		om engaging its next required nunity-based or individual,			emergency generator backup was in use for the entire	0	
		cale functional exercise for 1			timeframe. The clients did n	ot	
	_	onset of the actual event.			require to be evacuated. On		
		itional exercise that may			power was restored on		
		mited to the following:			9/12/2024, the generator was		
	a. A second full-sca	_			shut down and regular use o		
	community-based o	r an individual, facility-based			electrical power was resume	d.	
	functional exercise.				On 9/12/2024, staff met with		
	b. A mock disaster of				their Program Director/QIDP,	,	
	-	se or workshop that is led by a			Area Manager and the Area	_	
		des a group discussion led by			Director to review the event		
		narrated, clinically-relevant , and a set of problem			the power outage, of the day		
		messages, or prepared			prior. A complete training ar review of the Community	10	
		to challenge an emergency			Based event that occurred or	n	
	plan.	as change an emergency			9/11/2024, with discussion of		
		F/IID facility's response to and			what happened during the	•	
	•	ation of all drills, tabletop			event, along with ways to		
	exercises, and emer	gency events, and revise the			improve for future events.		
	-	nergency plan, as needed in			Training included the review	of	
		CFR 483.475(d)(2). This			our Life Safety Binder,		
	deficient practice co	ould affect all occupants.			Emergency Preparedness		
					Policy along with the		
	Findings include:				Community Action Plan for t	he	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING		COMPL	LETED
		15G479	B. WI	NG		08/20/	/2024
				GENERA	ADDRESS SITU STATE TIP SOD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DUNGA DVIN INDIANA I I G			l	ARQUETTE TRAIL			
DUNGAF	RVIN INDIANA LLC			MICHIGAN 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		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					facility.		
	Based on record rev	view with the Direct Support			Documentation from the reco	ord	
	Professional (DSP)	on 08/20/24 between 1:27 p.m.			of Emergency Event, on		
	and 1:55 p.m., the f	following was not available for			9/11/2024, and the Communi	ty	
	review:				Based training from 9/12/202	-	
	a) No documentation	on of an annual full-scale			are attached for reference.		
	exercise that is com	munity-based, a facility-based			Both are also place in the Lif	e ·	
	functional exercise	when a community-based			Safety Binder at the facility a		
	exercise is not acce	ssible, or an actual natural or			well.		
	man-made emergen	icy.					
	b) No documentation of an additional annual						
	exercise of choice:	a second full-scale exercise that					
	is community-based	d, a facility-based functional			E 039		
	exercise, a mock di	saster drill, a tabletop exercise,			Governing Body (Standard):		
	or a workshop.	-			The facility must conduct		
	Based on interview	at the time of record review,			exercises to test the		
	the DSP acknowled	lged that the documentation			emergency plan		
	from the past year v	was missing, however she did			annually. Corrective action for	r	
	state that the facility	y has done certain exercises in			resident(s) found to have been		
	the past. Unfortuna	tely she was unnable to			affected:		
	provide that docum	entation during the revisit			All parts of the POC for the		
	survey.				survey ID VO4122, will be ful	ly	
					implemented, including the	-	
	This finding was re	viewed with the DSP during			following specifics: This		
	the exit conference.	This deficiency was cited on			exercise was completed in		
	06/21/24. The facility	ity failed to implement a			September of 2023; however	, it	
	systemic plan of co	rrection to prevent			was not available for review	in	
	reoccurrences.				the Emergency Plan binder.		
					The Program Director/QIDP		
					failed to have documentation	1	
					placed in the Emergency Pla	n	
					binder by 7/11/2024, as		
					previously stated.Copy of the	е	
					09/2023 table-top exercise is		
					uploaded with this Plan of		
				Correction. The Program			
					Director/QIDP, was reminded	i	
					that all drill and table-top		

exercise documentation, in relation to the Life Safety

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

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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	<u></u>	(X3) DATE SURVEY COMPLETED 08/20/2024	
	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				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-todocuments in the Emergency Plan binder, going forward.Program Director/Q completed another tabletop discussion on 09/05/2024 arcopy is uploaded here for reference, plus placed in the Life Safety Emergency Bind at the facility.The facility staincluding the Program Direct and Lead DSP will review the finding and be retrained on expectations regarding frequency and documentation of drills and table-top exercises, to test the emergency plan annually arto place the drill and table-to exercise documentation into the Emergency Plan binder the facility drills occur.The Quality Assurance Coordination monthly will review and inspect the Life Safety Bind during their monthly site visto ensure all drills, table-top exercises, community-base facility based, mock disasted drills, Policy and Procedure are the most up to date, fire and smoke detector sensitive inspection reports are present and any necessary training documentation is there for	or top cy still provided a second a sec

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

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	OF CORRECTION	IDENTIFICATION NUMBER  15G479	A. BUILDING B. WING	unstruction 	COMPLETED 08/20/2024		
	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)	(X5) COMPLETION DATE		
				review as required. The Area Manager and Area Director walso review and inspect the Life Safety Binder, during the monthly site visits to ensure drills, table-top exercises, community-based or facility based, mock disaster drills, Policy and Procedures are the most up to date, fire and smudetector sensitivity inspection reports are present, and any necessary training documentation is there for review as required. How facil will identify other residents potentially affected & what measures taken: All resident potentially are affected, and corrective measures address the needs of all clients. Personsible: Program Director/QIDP, Quality Assurance Coordinator, Are Manager and Area Director	eir e all he oke on lity s s s ons		
K 0000							
Bldg. 01	Code Recertification conducted on 06/21	00994 15G479	K 0000	n/a			

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Event ID:

VO4122

Facility ID: 000993

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       08/20/2024			
	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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	LLC was found not Requirements for Pace CFR Subpart 483.4 the 2012 Edition of Association (NFPA Chapter 33, Existing Occupancies.  This one story build determined to be not a monitored fire ala smoke detection in rooms and all living capacity of 8 and has this survey.  Calculation of the E (E-Score) using NF Approaches to Life facility Prompt with	Code PSR, Dungarvin Indiana 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 ding with a basement, was at sprinklered. The facility has rm system with hardwired corridors, in client sleeping g areas. The facility has a and a census of 8 at the time of Evacuation Difficulty Score PA 101A, Alternative Safety, Chapter 6, rated the n an E-Score of 0.67.			
K S345	NFPA 101 Fire Alarm System	n - Testing and			
Bldg. 01	facility failed to ens was maintained in a 9.6.1.3 requires a fit tested, and maintain 70, National Electri National Fire Alarm unless otherwise pe this Code, testing sl accordance with the more often if requir	review and interview, the sure 1 of 1 fire alarm systems accordance with 9.6.1.3. LSC are alarm system to be installed, and in accordance with NFPA cal Code and NFPA 72, 14.4.5 states rmitted by other sections of all be performed in a schedules in Table 14.4.5, or red by the authority having 172, 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 four smoke detectors do nhave sensitivity, due to the tof smoke detector they are. Documentation of the sensitivity report from 6/4/20 is attached for reference and placed in the Life Safety	vo ot ype

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, ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			, i	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 08/20/2024			
		15G479	B. W	/ING		08/20/2024
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-
		•	422 MARQUETTE TRAIL			
DUNGAF	RVIN INDIANA LLC			MICHIC	GAN CITY, IN 46360	
(X4) ID		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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		thin 1 year after installation.			Binder at the facility.	
		2 states sensitivity shall be				
	1	nate year thereafter unless				
	_	by compliance with 14.4.5.3.3.				
	This deficient practi	ice could affect all occupants.			<u>K0345</u>	
					Governing Body (Standard):	
	Findings include:				fire alarm system is tested a	
					maintained in accordance w	ith
		view from with the Direct			an approved program	
		al (DSP) between 1:27 p.m. and			complying with the	
	_	24, no documentation was			requirements of NFPA 70,	
		to show if the smoke detector			National Electric Code, and	
		ad been tested with in the last			NFPA 72, National Fire Alarn	n
		st documented smoke detector			Signaling Code. Records of	
		vas 06/25/15. Based on			system acceptance,	
		e of record review, the DSP			maintenance and testing are	
	_	nissing inspection and was			readily available. Corrective	
	unsure if the inspec	tion has been done within the			action for resident(s) found to	to_
	past two years.				have been affected:	
					All parts of the POC for the	
	_	cussed with the DSP at exit			survey ID VO4122, will be ful	lly
		ficiency was cited on 06/21/24.			implemented, including the	
		o implement a systemic plan of			following specifics: The fire	
	correction to preven	nt reoccurrences.			alarm inspection, which	
					includes sensitivity testing a	ind
		review and interview, the			visual inspection, was	.
		intain 1 of 1 fire alarm systems			completed on 06/04/2024, an	d
		NFPA 72, as required by LSC			is uploaded with this	.
		FPA 72, Section 14.3.1 states			submission. Copy of the vis	
		te permitted by 14.3.2, visual			and smoke detector sensitiv	- I
	-	performed in accordance with			testing inspection was place	
		ble 14.3.1, or more often if			in the Life Safety book by the	
		nority having jurisdiction.			Program Director on 7/10/20	24,
		that the following must be			however it was unable to be	
	visually inspected s	-			located at time of survey	
	a. Control unit troub	_			revisit. The Quality Assurance	
	b. Remote annuncia				Coordinator has since place	d
		(e.g. duct detectors, manual			again, the 06/04/2024 visual	
		at detectors, smoke detectors,			and smoke detector sensitiv	-
	etc.)				testing inspection, into the L	ife

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		15G479	B. W	ING		08/20/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ARQUETTE TRAIL		
DUNGAF	RVIN INDIANA LLC				GAN CITY, IN 46360		
	T				1		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	d. Notification appl				Safety Emergency binder, fo		
	e. Magnetic hold-op	ice could affect all building			reference of completion.In the		
	occupants.	ice could affect all building			future, the facility will ensure that the visual smoke detect		
	occupants.				sensitivity and fire alarm	OI	
	Findings include:				inspections are available		
	1 manigo merade.				within the home, in the Life		
	Based on record rev	view with the Direct Support			Safety Emergency binder, up	oon	
		on 08/20/24 between 1:27 p.m.			completion for reference.The		
		acility was able to produce an			Program Director was	-	
	-	re alarm inspection was dated			reminded that all fire and		
	January of 2024. He	owever, no six-month visual			smoke detector inspection		
	inspection after the annual functional testing was				documents, in relation to the	)	
	able to be produced	at the time of the survey.			Life Safety Emergency Binde	er,	
	Based on interview	at the time of record review,			must be placed into the bind	ler,	
	the DSP stated she	was unaware where the			as a reference of completion	١.	
		ld be as it should have been in			Program Director will place	all	
	the drill binder.				fire and smoke detector		
					inspection documents, in the		
		viewed with the DSP at exit			Emergency Plan binder, goi	_	
		ficiency was cited on 06/21/24.			forward.The Quality Assurar	ice	
		o implement a systemic plan of			Coordinator monthly will		
	correction to prever	nt reoccurrences.			review and inspect the Life		
					Safety Binder, during their	-11	
					monthly site visits to ensure drills, table-top exercises,	all	
					community-based or facility		
					based, mock disaster drills,		
					Policy and Procedures are the	ne	
					most up to date, fire and sm		
					detector sensitivity inspection		
					reports are present, and any		
					necessary training		
					documentation is there for		
					review as required.The Area		
					Manager and Area Director v		
					also review and inspect the		
					Life Safety Binder, during th	eir	
					monthly site visits to ensure	all	
					drills, table-top exercises,		

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NAME OF 1	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL				
DUNGA	RVIN INDIANA LLC		MICHI	GAN 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	
				community-based or facility based, mock disaster drills, Policy and Procedures are to most up to date, fire and sm detector sensitivity inspective 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 all clients. Persons responsi Program Director/QIDP, Qua Assurance Coordinator, Are Manager and Area Director	he oke on d & s of ble:		
K S363 Bldg. 01	NFPA 101 Corridor - Doors						
	failed to ensure 2 o provided with a dod latch securely in the practice could affect staff.  Findings include:  Based on observation Professional (DSP) and 2:00 p.m., the obedroom was self-co	on and interview, the facility f 5 client sleeping rooms were or which would self-close and e door frame. This deficient et approximately 5 clients and on with the Direct Support on 08/20/24 between 1:56 p.m. door to the Southeast client closing, however it did not	K S363	K0363 Governing Body (Standard): Doors shall be provided with latches or other mechanism suitable for keeping the doo 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 outomatic	n s r	09/13/2024	

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door would rub up against the door frame which

Furthermore, the door to the East bedroom was

would stop the door from fully closing.

Event ID:

VO4122

Facility ID: 000993

with 33.2.3.5.

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sprinkler system in accordance

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			ſ ′	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 08/20/2024			COMPLETED
		15G479	B. W			08/20/2024
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD	
DUNGAE	RVIN INDIANA LLC		422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360			
DUNGAR	·			MICHIC	3AN CITT, IN 40300	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	i	R LSC IDENTIFYING INFORMATION er when tested at it's fullest	+	TAG	Corrective action for	DATE
	•	of the door would rub			resident(s) found to have be	en
	•	nd would stop half-way and			affected:	<u>vii</u>
		ı pulled the door shut. Based			All parts of the POC for the	
	on interview at the	time of observation, the DSP			survey ID VO4122, will be ful	ly
		doors were not operating			implemented, including the	
		er stated that the client room			following specifics:	
	_	e to latch has been a			A 24-i-4	
	needed to properly	and agreed that the doors			A Maintenance request was entered for initial repair of th	• • • • • • • • • • • • • • • • • • •
	needed to properly	iuwii.			fire doors that were not	IG
	The finding was dis	scussed with the DSP at exit			latching. Maintenance repair	ed
	_	eficiency was cited on 06/21/24.			all doors, in the facility, which	• • • • • • • • • • • • • • • • • • •
	The facility failed to	o implement a systemic plan of			would not properly close and	d
	correction to prever	nt reoccurrences.			latch on, 07/08/2024. The	
					facility doors properly worke	
					in the facility as of the repair	'
					on 07/08/2024.	
					Upon 08/20/2024 survey rev	isit.
					it was noted that two of the	,
					facility bedroom doors would	d
					not properly latch or close.	4
					maintenance request was	
					entered for repair, to be	
					completed by 09/13/2024.	
					During maintenance's mont	hlv
					site inspections, they will ch	-
					that all doors properly close	
					and latch throughout the	
					facility. If they do not,	
					maintenance will initiate repa	air
					at that time.	
					The Brogram Director/OIDD	
					The Program Director/QIDP, Quality Assurance Coordina	
					Area Manager and Area	101,
					Director will also check that	all
					doors properly close and lat	

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VO4122

Facility ID: 000993

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

PRINTED: 09/20/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 08/20/2024
	PROVIDER OR SUPPLIEI		422 MA	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN 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	PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	
				throughout the facility, anytir they are at the site, minimum of a monthly check. If the doc 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 all clients.	of
				Measures or systemic change facility put in place to ensure no recurrence:	
				Persons responsible: Progra Director/QIDP, Maintenance, Quality Assurance Coordinator, Area Manager and Area Director	ım
K S511 Bldg. 01	NFPA 101 Utilities - Gas and	l Electric			
	failed to ensure 1 o properly and used i Section 10.2.4.2 sta cords meeting the r through 10.2.4.2.3	on and interview, the facility f 1 flexible cords were installed n a safe manor. NFPA 99, tes adapters and extension equirements of 10.2.4.2.1 shall be permitted. Section e cabling shall comply with	K S511	K0511 Governing Body (Standard): Equipment using gas or relat gas piping complies with NFF 54, National Fuel Gas Code, electrical wiring and equipment complies with NPF	PA

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Event ID:

VO4122 Facility ID: 000993

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED		
150		15G479	B. WING		08/20/2024			
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	L			RQUETTE TRAIL			
DUNGARVIN INDIANA LLC								
DUNGAR	TVIN INDIANA LLC			MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	OF CORRECTION (X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	10.2.3. Section 10.2	2.3.5.1 states cord strain relief			70, National Electric Code.			
	shall be provided at	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,							
	either pull, twist, or bend, is not transmitted to				Corrective action for			
	internal connections	s. This deficient practice could			resident(s) found to have been	<u>en</u>		
	affect approximatel	y 2 clients and staff.			<u>affected</u>			
	Findings include:			All parts of the POC for the survey ID VO4122, will be				
						ly		
				implemented, including the				
		on with the Direct Support			following specifics:			
	Professional (DSP) on 08/20/24 between 1:56 p.m.							
	and 2:00 p.m., the Northwest client bedroom				Previous noted power strips	;		
	contained a power strip that was used to power				that were in use, were			
	electrical appliances and electronics which was				removed on 7/08/24. Upon Li	fe		
	dangling off a clothing dresser by its power cord.				Safety survey revisit, on			
	Based on interview at the time of observation, the				08/20/2024, the northwest cli	ent		
	DSP acknowledged the power strip was dangling				bedroom contained a power			
	and further stated that she would try to fix the issue by the end of day.				strip that was used to power			
					electrical appliances and			
					electronics which was dangl	ing		
	1	ing was reviewed with the DSP during			off a clothing dresser, by its			
	the exit conference. This deficiency was cited on 06/21/24. The facility failed to implement a				power cord. DSP removed th			
					power strip on 08/20/2024 an			
	systemic plan of correction to prevent				assisted client to safely plug in			
	reoccurrences.				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 strip			
					in use, throughout the facility	y,		
					minimum with their monthly			
					site inspections. Anytime a			
					power strip is found in use, t	nat		
					staff will remove the power			
				strip immediately and find ar	1			
					alternate outlet solution.			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/20/2024
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 08/20/2024		
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
				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:  Persons responsible: Progra Director/QIDP, Quality Assurance Coordinator Area	of es		

Manager, Area Director, and

Maintenance

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