

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

PRINTED: 10/28/2021
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G573 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/13/2021 |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 51778 TROWBRIDGE LN SOUTH BEND, IN 46637 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
| W 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the investigation of complaint #IN00362766.</p> <p>Complaint #IN00362766: Substantiated, no deficiencies related to the allegation(s) are cited.</p> <p>This visit was done in conjunction with a Post Certification Revisit (PCR) to the predetermined full recertification and state licensure survey completed on 8/12/21.</p> <p>Dates of Survey: October 4, 5, 6, 7, and 13, 2021.</p> <p>Facility Number: 001087 Provider Number: 15G573 Aims Number: 100234320</p> <p>Dungarvin Indiana LLC was found to be in compliance with 42 CFR Part 483, Subpart I and 460 IAC 9 in regard to the investigation of complaint #IN00362766.</p> <p>Quality Review of this report completed by #15068 on 10/27/21.</p> | W 000 | | |

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.