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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G760	A. BUILDING -- B. WING	06/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	5138 GREENVIEW CT BATTLE GROUND, IN 47920

(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. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 06/12/18 Facility Number: 012034 Provider Number: 15G760 AIM Number: 200970250 At this Emergency Preparedness survey, 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 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 06/15/18 - DA The requirement at 42 CFR, Subpart 483.475 is NOT MET as evidenced by:	E 0000		
E 0022 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants.	E 0022	Corrective Action: Dungarvin Administrators comprised a committee to update emergency preparedness programs to meet state regulations. The Dungarvin Team met on several occasions to roll out a new template for all Dungarvin locations. Each	07/10/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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	Findings include: Based on record review with the Area Director on 06/12/18 from 12:00 p.m. through 12:30 p.m., a policy and procedure that included a means to shelter in place for clients, staff, and volunteers who remain in the ICF/IID facility was not available for review. Based on interview during the exit conference on 06/12/18 at 12:35 p.m., the Area Director confirmed no additional information or evidence could be provided contrary to this deficient finding.		Dungarvin home will complete the emergency preparedness plan in order to ensure compliance with Life Safety. (Please see the attached template). Template will be filled out in accordance with each homes location and site specific community risk assessment. The Emergency Preparedness Plan includes: Emergency Preparedness (Community Risk Assessment), Policies and Procedures, Communication, Training and Testing. The emergency in place shelter will include list of contacts, food emergency, medication, paper documentation, and also how to address the outside community who may also be seeking shelter. Dungarvin utilizes a natural gas generator, which would also the home and the individuals power to keep the home as safe and accessible as possible in an emergency situation. Systematic Correction: The Area Manager/ Area Directors will retrain all the QDDPS on the expectation that all Emergency Preparedness Plans are updated using the new template, as well as reviewed, tested, and trained on by all staff, at minimum, yearly. The Area Manager/Area Directors will ensure that Annual training is complete and available at each ICF/IDD.	

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E 0024 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review with the Area Director on 06/12/18 from 12:00 p.m. through 12:30 p.m, a policy and procedure that included the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency was not available for review. Based on interview during the exit conference on 06/12/18 at 12:35 p.m., the Area Director confirmed no additional information or evidence could be provided contrary to this deficient finding.	E 0024	Corrective Action: Dungarvin Administrators comprised a committee to update emergency preparedness programs to meet state regulations. The Dungarvin Team met on several occasions to roll out a new template for all Dungarvin locations. Each Dungarvin home will complete the emergency preparedness plan in order to ensure compliance with Life Safety. (Please see the attached template). Template will be filled out in accordance with each homes location and site specific community risk assessment. The Emergency Preparedness Plan includes: Emergency Preparedness (Community Risk Assessment), Policies and Procedures, Communication, Training and Testing. Staffing Strategies include always having employees schedules a month in advance. Administrators and staff may travel in any environmental situation to work, due to the 24 hour healthcare needs of our individuals. Administrators and Dungarvin nurse are available via telephone 24 hours a day for questions/concerns. Additional doctors/location lists will be posted in the homes for emergency situation. Systematic Correction: The Area	07/10/2018

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			Manager/ Area Directors will retrain all the QDDPS on the expectation that all Emergency Preparedness Plans are updated using the new template, as well as reviewed, tested, and trained on by all staff, at minimum, yearly. The Area Manager/Area Directors will ensure that Annual training is complete and available at each ICF/IDD.	
E 0035 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Area Director on 06/12/18 from 12:00 p.m. through 12:30 p.m, a policy and procedure that included a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives was not available for review. Based on interview during the exit conference on 06/12/18 at 12:35 p.m., the Area Director confirmed no additional information or evidence could be provided contrary to this deficient finding.	E 0035	Corrective Action: Dungarvin Administrators comprised a committee to update emergency preparedness programs to meet state regulations. The Dungarvin Team met on several occasions to roll out a new template for all Dungarvin locations. Each Dungarvin home will complete the emergency preparedness plan in order to ensure compliance with Life Safety. (Please see the attached template). Template will be filled out in accordance with each homes location and site specific community risk assessment. The Emergency Preparedness Plan includes: Emergency Preparedness (Community Risk Assessment), Policies and Procedures, Communication, Training and Testing. In the template, specific to each location, there is an outline of	07/10/2018

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			sharing information with the individuals, their families, and emergency contacts. Systematic Correction: The Area Manager/ Area Directors will retrain all the QDDPS on the expectation that all Emergency Preparedness Plans are updated using the new template, as well as reviewed, tested, and trained on by all staff, at minimum, yearly. The Area Manager/Area Directors will ensure that Annual training is complete and available at each ICF/IDD.	
E 0036 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on record review with the Area Director on 06/12/18 from 12:00 p.m. through 12:30 p.m, the emergency preparedness training and testing portion of emergency preparedness has not been created nor practiced. Based on interview during the exit conference on 06/12/18 at 12:35 p.m., the Area Director confirmed no additional information or evidence could be provided contrary to this deficient finding.	E 0036	Corrective Action: Dungarvin Administrators comprised a committee to update emergency preparedness programs to meet state regulations. The Dungarvin Team met on several occasions to roll out a new template for all Dungarvin locations. Each Dungarvin home will complete the emergency preparedness plan in order to ensure compliance with Life Safety. (Please see the attached template). Template will be filled out in accordance with each homes location and site specific community risk assessment. The Emergency Preparedness Plan includes: Emergency Preparedness (Community Risk Assessment), Policies and	07/10/2018

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			Procedures, Communication, Training and Testing. Systematic Correction: The Area Manager/ Area Directors will retrain all the QDDPS on the expectation that all Emergency Preparedness Plans are updated using the new template, as well as reviewed, tested, and trained on by all staff, at minimum, yearly. The Area Manager/Area Directors will ensure that Annual training is complete and available at each ICF/IDD.	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale 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 individual, facility-based. (B) a tabletop exercise 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	E 0039	Corrective Action: Dungarvin Administrators comprised a committee to update emergency preparedness programs to meet state regulations. The Dungarvin Team met on several occasions to roll out a new template for all Dungarvin locations. Each Dungarvin home will complete the emergency preparedness plan in order to ensure compliance with Life Safety. (Please see the attached template). Template will be filled out in accordance with each homes location and site specific community risk assessment. The Emergency Preparedness Plan includes: Emergency Preparedness (Community Risk Assessment), Policies and Procedures, Communication,	07/10/2018

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	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: Based on record review with the Area Director on 06/12/18 from 12:00 p.m. through 12:30 p.m. the facility failed to participate in 2 full scale exercises or 1 full exercise and 1 table top exercise. Based on interview during the exit conference on 06/12/18 at 12:35 p.m., the Area Director confirmed no additional information or evidence could be provided contrary to this deficient finding.		Training and Testing. Staff will complete a community based drill as well as table-top exercises. This testing also includes the unannounced staff drills using the emergency procedures listed. Systematic Correction: The Area Manager/ Area Directors will retrain all the QDDPS on the expectation that all Emergency Preparedness Plans are updated using the new template, as well as reviewed, tested, and trained on by all staff, at minimum, yearly. The Area Manager/Area Directors will ensure that Annual training is complete and available at each ICF/IDD.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 06/12/18 Facility Number: 012034 Provider Number: 15G760 AIM Number: 200970250 At this Life Safety Code survey, 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	K 0000		

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	Occupancies. This one story facility with basement was sprinklered. The facility has a fire alarm system with smoke detection in the corridors, common living areas and hard wired detectors in all client sleeping rooms. The facility has a capacity of four and had a census of four at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-score of .4. Quality Review completed on 06/15/18 - DA			
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25:			

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	1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. __________________________			

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	B. Show who provided the service. ________________ C. Note the source of the water supply for the automatic sprinkler system. ________________ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Findings include: Based on record review with the Area Director on 06/12/18 from 11:10 a.m. through 11:47 a.m. the form titled "Sprinkler System Monthly Sight Inspection" had a month, date and comments section. The comments section only stated "system normal" and had no indication as to what the form was to be documenting in regards to the sprinkler system. The form also lacked what year it is documenting. During interview during the same time as record review, the Area Director agreed there was no year on the form and was also unsure as to what the form was to document. No additional documentation was provided prior	K S353	**Corrective action: The House Coordinator will complete a monthly site risk management checklist for the home. The checklist will be updated to include a check of the sprinkler valves and gauges are checked as well as the day, month, and year it was reviewed. The maintenance department will check the valves and gauges monthly to ensure they are in good working order. The Program Director will review the monthly site risk management checklist monthly and will sign off on the completion of the form. The signature page will be sent to the Office Manager in South Bend who will keep a master list ensuring all monthly site risk management checklists have been completed and reviewed. The master list will be reviewed by the Dungarvin Safety Committee monthly to ensure all appropriate checks are completed, including the check of the sprinkler valves**	07/10/2018

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	to exiting the facility at 12:35 p.m..		**and gauges. Systematic Correction: The Senior Director will send out the revised monthly site risk management checklist including a check on the sprinkler valves and gauges when applicable. The Senior Director will re-train all the QDDPs and AD/AMs on the expectation monthly site risk management checklists are completed and reviewed. The signature page verifying the site risk management checklist was completed will be sent to the Office Manager in South Bend, who will maintain a master list of all monthly site risk management checklists that have been completed and reviewed. The Safety Committee will review the master list monthly to ensure compliance at all Dungarvin locations**	
K S700 Bldg. 01	NFPA 101 Operating Features - Other Operating Features - Other List in the REMARKS section any LSC Section 32.7 and 33.7 Operating Features requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, observation and interview, the facility failed to maintain a complete written record of monthly generator load testing	K S700	**Corrective Action: The Area Manager will re-train all staff on the expectation there is a**	07/10/2018

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	for 12 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 requires Spark-ignited generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Area Director on 06/12/18 from 11:10 a.m. through 11:47 a.m, documentation for generator monthly testing was not available for review. A form titled "ICF Stand-By Generator Log" was observed , but the form lacked what year it was for. Based on an interview at the time of record review, the Area Director agreed there was no year on the form. No further documentation was provided prior to my exit at 12:35 p.m..		**weekly inspection of starting the battery for the generator. The documentation of the check will be updated to ensure there is documentation on what staff checked during the weekly inspection. The maintenance department will conduct a monthly load testing on the generator. The maintenance tech is being trained on how to safely conduct a load test on the generator and will ensure this is tested monthly. The Program Director will check the documentation of the weekly inspection of the starting batteries of the generator to ensure completion. The documentation will be reviewed to ensure the staff documented exactly what was inspected. Monthly the Area Manager will review the weekly inspections to ensure completion and compliance on what was tested along with the monthly load test completed by the maintenance department ensuring completion. At least quarterly the maintenance coordinator will be in the home ensuring the generator load was tested and documentation is available confirming the test. Systematic Correction: The Senior Director will re-train all Program Directors and AD/AMs**	

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DUNGARVIN INDIANA LLC	5138 GREENVIEW CT BATTLE GROUND, IN 47920

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			on the expectation staff are completing weekly starting battery checks on generators when one is present at the home. The training will include monitoring to ensure the staff document what was tested during the inspection. The maintenance tech is being trained on how to safely test the load of the generator. The maintenance tech will ensure each generator is tested monthly to ensure proper loaded of the generator. The Program Director will check the weekly to ensure staff checked the starting batteries of the generator and the staff documented exactly what was tested. The AM will check the documentation at least quarterly ensuring the weekly starting battery inspections have been completed and the documentation of the inspection shows exactly what was tested. The AM will ensure the monthly generator load tests were completed by the maintenance tech. The maintenance coordinator will review the weekly starting battery checks and the generator load testing quarterly to ensure compliance.	