

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G750		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/09/2012	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 60680 LILAC RD SOUTH BEND, IN 46614			
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W0000	<p>This visit was for the investigation of complaints #IN00105379 and #IN00106355.</p> <p>COMPLAINT #IN00105379: SUBSTANTIATED, federal and state deficiency related to the allegation(s) is cited at W368.</p> <p>COMPLAINT #IN00106355: SUBSTANTIATED, federal and state deficiency related to the allegation(s) is cited at W149.</p> <p>Dates of Survey: April 4, 5 and 9, 2012.</p> <p>Provider Number: 15G750 AIM Number: 200908290 Facility Number: 011765</p> <p>Surveyor: Susan Reichert, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/19/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000					

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.

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview, for 1 of 7 incident reports reviewed involving clients A, B and C, the facility neglected to ensure the implementation of their abuse/neglect prevention policy by neglecting to protect client C from elopement behavior, and neglected to supervise clients A, B and C according to their identified needs.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disability Services (BDDS) reports from 1/12/12 through 4/4/12 were reviewed on 4/4/12 at 2:15 PM. A report dated 3/26/12 indicated client C had exited the van at a stop light during transport home from the day services. Staff got out of the van leaving clients A and B while the staff person pursued client C "as he was not paying attention to traffic." The police were called to assist in the incident. A follow up report dated 4/3/12 indicated client C "has a history of elopement from his residential and day program settings, but did not have a history of elopement from a vehicle such as in this case." The report indicated procedures had been</p>	W0149	<p>W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS Dungarvin has a written policy and procedures in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). All staff at the home will be retrained on policy B-2. The Program Director has been retrained on Policy B-2, including the expectation that the staffing while transporting individuals on the van should be at least two staff whenever there are two or more individuals being transported.</p> <p>The Program Coordinator will review the schedules at the ESN home to ensure that there is adequate staff at all times. Random checks will be done by the Program Director or other designee to also ensure that the staffing ratio is being met.</p> <p>System wide, all Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p>Completion Date: 5-9-12 Persons Responsible: Program Coordinator, Program</p>	04/09/2012	

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	<p>revised to ensure there were 2 staff available for transporting more than one person in the community, and "the IDT (interdisciplinary) are working to revise his BSP (Behavior Support Plan) to address this most recent incident. It was determined that [client C] was never out of staff sight and the police assisted in prompting him back to the van and home safely."</p> <p>The Program Director (PD) was interviewed on 4/4/12 at 3:02 PM and indicated client C had a history of elopement including an incident in which agency staff found him walking along the side of the road. He indicated the staff involved in the 3/26/12 incident made the decision to call the police to assist in the incident to keep the clients safe. He stated client C "needs constant supervision," and indicated the police had encouraged client C to the return to the van and he complied. He indicated calling the police for assistance with client C when he eloped at day services had been implemented since previous elopements from day services.</p> <p>Client A's record was reviewed on 4/4/12 at 3:25 PM. His record indicated he had a history or being verbally, physically and sexually aggressive, property destruction and displaying of sexually inappropriate</p>		Director/QMRP		

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	<p>behavior.</p> <p>Client B's record was reviewed on 4/4/12 at 3:15 PM. His record indicated he had a history of insufficient coping skills, stealing, elopement, verbal aggression and property destruction, refusals, self injurious behavior and lying. "Whenever possible, staff should be sitting between [client B] and his housemates on the van so as to intervene in any physical altercations."</p> <p>Client C's record was reviewed on 4/4/12 at 3:32 PM. His record indicated client C didn't like to be told "no," and he had a history of verbal aggression, physical aggression, property destruction, inappropriate sexual behavior and "presents significant danger to self." Target behaviors in his 11/2/11 Behavior Support Plan (BSP) included verbal aggression, physical aggression, property destruction, self injurious behavior, inappropriate sexual behavior and elopement. Proactive strategies in the plan included, "Staff should remain within close contact of [client C] when he is in the vicinity of others." For elopement, "If [client C] does elope, as many staff as are able to do so should assist in redirecting [client C] to return home or the staff van...If [client C] elopes, and staff is unable to locate him, staff members</p>						

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	<p>should call the supervisor on-call to decide whether police need to be called to assist..." A High Risk Plan for elopement at day services plan dated 9/29/11 indicated client C's staff was to notify day services staff of his arrival and group home staff would escort client C to his work area, and client C's day services supervisor would monitor his whereabouts.</p> <p>Additional BDDS reports were reviewed on 4/4/12 at 3:45 PM and indicated client C had eloped from day services on 11/14/11 and on 9/22/11. On 9/22/11 agency staff found client C walking in the road and on 11/14/11 day services staff pursued client C as he ran across the road.</p> <p>The PD was interviewed again on 4/4/12 at 4:10 PM and indicated during the incident of elopement for client C, clients A and B and C were not supervised as required for their needs. He indicated the home was staffed so that 2 staff would be available for transport, but due to client D's later arrival home, it had been practice for 1 staff person to leave to pick up clients A, B and C from day services and 1 staff to remain at the group home for client D's arrival. He stated the staffing ratio for transport had not been formalized prior to the incident and "We didn't foresee he would elope from the</p>						

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	<p>van." He indicated requiring 2 staff to be present during transport was implemented immediately after the incident.</p> <p>During interview on 4/5/12 at 1:15 PM, the PD indicated staff should have let him know they had not been using 2 staff during transport from day services to the group home and indicated he had informed them if they ever did not feel safe with staffing ratios they should call him.</p> <p>During interview on 4/5/12 at 2:45 PM, the PD indicated the staffing ratio for supervising clients during transport would be monitored via a system in place of active treatment observations made by administrative and supervisory staff.</p> <p>This federal tag relates to complaint #IN00106355.</p> <p>9-3-2(a)</p>				

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to assure medications were administered without error according to physician's orders for 1 of 7 reportable incidents reviewed affecting client B.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disability Services (BDDS) reports from 1/12/12 through 4/4/12 were reviewed on 4/4/12 at 2:15 PM. A report dated 3/7/12 indicated client B received client D's medications of Senna Laxative 8.6 mg (milligrams), Simvastin 40 mg (cholesterol), Risperidone 2 mg (antipsychotic), oxcarbazepine 600 mg (seizures), omeprazole DR 40 mg (gastrointestinal agent), olanzapine 20 mg (antipsychotic), lithium carbonate 600 mg (antipsychotic), benztropine MES (anti-Parkinson's agents), depakote ER 500 mg (anti-convulsant), propranolol ER 120 mg (cardiovascular), Seroquel 400 mg (antipsychotic), Klor-con (potassium chloride) no dosage indicated). The report indicated client B was taken to the emergency room where doctors decided to keep him for the rest of the night to monitor him. He was released the next</p>	W0368	<p>W 368 Drug Administration</p> <p>The staff person responsible for the medication error noted in this report has been counseled on this according to Dungarvin policy and procedure, and has also completed retraining on medication administration procedures. All staff at the home will review this standard and will complete additional retraining on medication passing procedures.</p> <p>Client B was taken to the hospital following this error and he was monitored for a period of time before being sent home. There were no ongoing negative reactions following a one day period of Client B being very tired and wanting to sleep. The Program Director, facility nurse, and designee's will conduct random medication passing observations at the home with the staff committing the error and with various staff to ensure consistency in the medication passing system.</p> <p>All ICF Program Directors will review this standard and assure that this issue is being evaluated as a possible concern in all ICF-MR's.</p>	04/09/2012			

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	<p>day after the doctor had cleared him of any adverse effects. Client B's staff was instructed to observe client B for drowsiness. The report indicated the staff person involved had been suspended pending the results of the investigation. Attached to the report was an investigation dated 3/18/12 which indicated staff #1 had prepared medications for client B and client B had refused to take the medication. Staff #1 set aside client B's medications and prepared client D's medications while client D went to the kitchen for a glass and spoon. Client B then decided to take his medications and staff #1 inadvertently gave him the medications prepared for client D. Staff #1 realized the mistake before giving client D his medication and the nurse was informed who advised client B go to the ER for evaluation. The investigation indicated staff #1 realized she had not followed medication procedures when administrating the medication and had not checked for accuracy before dispensing the medication. The report indicated staff #1 would not be administrating medication until she was retrained. A document attached to the report indicated staff #1 was scheduled for retraining on medication administration on April 10 and 11, 2012.</p>		<p>Completion Date: 5-9-12 Persons Responsible: Program Director /QMRP, Facility Nurse</p>				

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	<p>The Program Director was interviewed on 4/4/12 at 4:10 PM and indicated client B had not experienced any ill effects of the medication error.</p> <p>This federal tag relates to complaint #IN00105379.</p> <p>9-3-6(a)</p>						