

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/10/2016
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0000  Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: March 7, 8, 9, and 10, 2016.</p> <p>Facility number: 012557 Provider number: 15G791 AIM number: 201017960A</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/16/16.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to assure the walls in 1 of 2 sampled client's bedroom (client #1) were clean and in good condition.</p> <p>Findings include:</p>	W 0104	<p><b>W 104 483.410(a) (1) GOVERNING BODY</b></p> <p>The Program Director, Maintenance Coordinator, and Area Director (AD) will review this Standard.</p> <p>Client #1's bedroom walls that are, "...spotted and stained with a white</p>	04/09/2016

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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W 0217 Bldg. 00	<p>Client #1's bedroom was inspected during the 3/7/16 observation period from 6:17 A.M. until 8:20 A.M. All four walls in client #1's bedroom were spotted and stained with a white substance.</p> <p>Direct care staff #3 was interviewed on 3/7/16 at 8:22 A.M. Direct care staff #3 stated, "We (direct care staff) have asked maintenance to paint her (client #1's) room but they haven't got around to it yet. We asked them quite some time ago."</p> <p>Program Director #1 was interviewed on 3/9/16 at 11:21 A.M. Program Director #1 stated, "Maintenance should be painting that room (client #1's bedroom) soon. I just got off the phone from talking to them (maintenance)."</p> <p>9-3-1(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status. Based on record review and interview, the facility failed to assess the dietary needs of 1 additional client (client #3).</p>	W 0217	<p>substance" will be painted. The maintenance department will also inspect the entire home and repair any other noted maintenance issues.</p> <p>Ongoing, the Lead DSP and Program Director will inspect the home at least weekly, to ensure all damage in the home has been repaired timely and ensure all staff are following the procedure to notify the maintenance department of any new damage, or other issues that need repair. The results of these visits will be provided to the Area Director, and if any issues are noted, the Area Director will follow-up with the maintenance department and/or staff responsible, to ensure this Standard is maintained in the home.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director, Lead DSP, Maintenance Coordinator, and Area Director</b></p> <p>W 217 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The Program Director, Nurse, and</p>	04/09/2016	

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W 0259  Bldg. 00	<p><b>Findings include:</b></p> <p>Client #3's record was reviewed on 3/9/16 at 9:06 A.M. The review indicated client #3 was admitted to the facility on 12/31/15. Further review of the client's record failed to indicate the client's dietary needs had been assessed since her admittance to the facility.</p> <p>Program Director #1 was interviewed on 3/9/16 at 11:21 A.M. Program Director #1 stated, "She (client #3) has not yet been seen by the dietician and hasn't been assessed."</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must</p>		<p>Area Director (AD) will review this Standard.</p> <p>Client #3 will be assessed by the dietician and the results will be added to the individual's Comprehensive Functional Assessment. The PD and Nurse will review the CFA's of all other individuals in the home to ensure their dietary needs have been assessed at least annually and dining plans developed for any special dietary needs. PD will be retrained on ensuring all new admissions to the home are assessed by the dietician, and all current residents are assessed per Dungarvin policy and procedure and according to regulations.</p> <p>Ongoing, the PD will ensure all new admissions are assessed by the dietician, and all current residents are assessed per Dungarvin policy and procedure and according to regulations. The PD and Nurse will examine each individual's file at least quarterly, to ensure all individuals are routinely evaluated by the dietician per Dungarvin policy and procedure and according to regulations.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director and Nurse</b></p>		

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	<p>be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview, the facility failed to ensure the Comprehensive Functional Assessments for 2 of 2 sampled clients (clients #1 and #2) were reviewed at least annually.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/9/16 at 7:06 A.M. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/31/14.</p> <p>Client #2's record was reviewed on 3/9/16 at 8:20 A.M. The review indicated the client's most current Comprehensive Functional Assessment was dated 1/25/14.</p> <p>Program Director #1 was interviewed on 3/9/16 at 11:21 A.M. Program Director #1 stated, "I can't find where their (clients #1 and #2's) assessments had been reviewed or re-done."</p> <p>9-3-4(a)</p>	W 0259	<p><b>W 259 483.440(f)(2) PROGRAM MONITORING AND CHANGE</b></p> <p>The Program Director (PD) and Area Director (AD) will review this Standard.</p> <p>PD will be re-trained on ensuring all assessments are completed and updated per this Standard and Agency Policy and Procedure. PD will review, present to each individual's IDT, and update all Comprehensive Functional Assessments for all individuals in the home.</p> <p>Ongoing, the PD will ensure all new admissions have a complete CFA that was reviewed and revised by the individual's IDT per regulations and Agency Policy and Procedure, and that all current individuals served have a complete CFA that was reviewed and revised by the individual's IDT per regulations and Agency Policy and Procedure.</p> <p>The PD will examine each individual's file at least quarterly, to ensure all individuals' CFAs have been reviewed and updated per Dungarvin policy and procedure and according to regulations.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program</b></p>	04/09/2016			

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W 0263  Bldg. 00	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to obtain written consent from 1 of 1 additional client (client #3) prior to implementing a restrictive Behavior Plan.</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 3/9/16 at 9:06 A.M. The review indicated client #3 was an emancipated adult. Further review of client #3's record indicated the client had a restrictive behavior plan which addressed the management of client #3's behaviors of physical aggression, self injurious behaviors, and property destruction by the use of facility implemented techniques which included, but was not limited to, the use of psychotropic medication and physical restraints. Additional review of the client's 3/1/16 Behavior Plan failed to indicate the client had provided the facility with written consent for the plan's implementation.</p> <p>Behavior Clinician #1 was interviewed</p>	W 0263	<p><b>Director</b></p> <p><b>W 263 483.440(f)(3)(ii) PROGRAM MONITORING AND CHANGE</b></p> <p>The Program Director (PD), Behavior Clinician, and AreaDirector (AD) will review this Standard.</p> <p>PD and Behavior Clinician will be re-trained on ensuring all programs are consented to, per this Standard and Agency Policy and Procedure. PD and/or Behavior Clinician will review Client #3's BSP with Client #3 and obtain consent from Client #3 for implementation. If Client #3 objects to any portion of BSP, the plan will be suspended from implementation and revised as appropriate, and not implemented until Client #3 consents to the Plan. PD will then review all other individuals' program plans to ensure all necessary consents have been obtained from the individual and/or guardian(s) as appropriate.</p> <p>Ongoing, the PD will ensure all new admissions have consented to all Program Plans per regulations and</p>	04/09/2016	

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W 0336 Bldg. 00	<p>on 3/9/16 at 11:21 A.M. Behavior Clinician #1 stated, "[Client #3] did not sign for the implementation of her plan (3/1/16 Behavior Plan) behavior plan)."</p> <p>9-3-4(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to assure nursing assessments were conducted at least quarterly (every 90 days) for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 3/9/16 at 7:06 A.M. A review of the client's record failed to indicate quarterly nursing assessments had been completed from 1/1/15 through 3/9/16.</p>	W 0336	<p>Agency Policy and Procedure, and that all current individuals served have consented to all Program Plans, perregulations and Agency Policy and Procedure.</p> <p>The PD will examine each individual's file at least quarterly, to ensure all individuals' Program Plans have been consented to, perregulations and Agency Policy and Procedure</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director and Behavioral Clinician</b></p> <p><b>W 336 483.460(c)(3)(iii) NURSING SERVICES</b></p> <p>The Program Director (PD), Nurse, and Area Director (AD) will review this Standard.</p> <p>PD and Nurse will be re-trained on ensuring all individuals receive at least quarterly assessments of their health needs, and that these assessments are promptly filed and maintained in the individual's permanent chart, per this Standard and Agency Policy and Procedure.</p>	04/09/2016	

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W 0382 Bldg. 00	<p>Client #2's records were reviewed on 3/9/16 at 8:20 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 3/9/16 indicated quarterly nursing assessments were completed on 12/14/15, 9/25/15, and 2/20/15. The review failed to indicate the client's nursing assessments were completed at least quarterly (every 90 days).</p> <p>Program Director #1 was interviewed on 3/9/15 at 11:21 A.M. Program Director #1 stated, "We (the facility) had some nursing changes during the last year and some of those assessments (quarterly nursing assessments) may be missing."</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 2 of 2 sampled clients (clients #1 and #2), and 1 additional client (client #3).</p>	W 0382	<p>PD and Nurse will review all individuals' charts to ensure a quarterly nursing assessment has been completed within the current quarter and ensure one is completed if one is needed.</p> <p>Ongoing, the PD and Nurse will ensure all individuals served receive the required quarterly nursing assessments per regulations and Agency Policy and Procedure.</p> <p>The PD will examine each individual's file at least quarterly, to ensure all individuals have received a quarterly nursing assessment per regulations and Agency Policy and Procedure.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director and Nurse</b></p> <p><b>W 382 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</b></p> <p>The Program Director (PD) and Area Director (AD) will review this</p>	04/09/2016

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	<p>Findings include:</p> <p>Clients #1 and #2 were observed during the group home observation period on 3/7/16 from 6:17 A.M. until 8:20 A.M. At 7:08 A.M., direct care staff #1 was preparing medications to administer to client #1. Direct care staff #1 had client #1's medications on the medication room table when she left the medication room to locate client #1. The open medications were left on the table making them accessible to clients #1, #2, and #3. At 7:51 A.M., direct care staff #3 was preparing medications to administer to client #2. Direct care staff #3 had client #2's medications on the medication room table when she left the medication room to administer medications to client #2. The open medications were left on the table making them accessible to clients #1 and #3.</p> <p>Program Director #1 was interviewed on 3/9/16 at 11:21 A.M. Program Director #1 stated, "Medications are to be locked when they aren't being administered."</p> <p>9-3-6(a)</p>		<p>Standard.</p> <p>PD and all staff will be re-trained on this Standard and Medication Administration Policies and Procedures.</p> <p>For at least two weeks and until compliance has been demonstrated, the PD, AD, Nurse, or other trained trainer will be at the home daily to observe a medication administration of a different staff person on each occasion, to ensure compliance and competence.</p> <p>Ongoing, the PD, AD, Nurse, or other designated trained trainer will complete weekly random medication administration observations to ensure compliance of this Standard and Agency Policy and Procedure.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director, Nurse, Area Director, other designated trained trainer</b></p>		

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W 0436 Bldg. 00	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed to provide training for the care of eyeglasses for 1 of 2 sampled clients (client #1) who wore eyeglasses.</p> <p>Findings include:</p> <p>Client #1 was observed at the group home during the 3/9/16 observation period from 6:17 A.M. until 8:20 A.M. At 6:55 A.M., direct care staff #1 prompted client #1 to give her eyeglasses to her (direct care staff #3). Direct care staff then cleaned client #1's eyeglasses and gave them back to the client.</p> <p>Client #1's record was reviewed on 3/9/16 at 7:06 A.M. Review of the client's 7/15/15 Individual Program Plan failed to indicate the client had a training program for the use and care of her eyeglasses.</p> <p>Program Director #1 was interviewed on 3/9/16 at 11:21 A.M. The Program</p>	W 0436	<p><b>W 436 483.470(g)(2) SPACE AND EQUIPMENT</b></p> <p>The Program Director (PD) and Area Director (AD) will review this Standard.</p> <p>PD and all staff will be re-trained on this Standard. PD will review Client #1's ISP and develop a goal/objective to teach Client #1 how to clean their own glasses. Staff will then be trained on how to implement this goal/objective. PD will review all other individuals' ISPs to ensure a goal to teach the individual how to maintain their own adaptive equipment. If the individual is in need of a goal/objective, PD will develop, review with the individual's IDT, and then train staff on how to implement the goal/objective.</p> <p>Once the goal/objectives are implemented and all staff trained, for at least two weeks and until compliance has been demonstrated, the PD, AD, Behavioral Clinician, or other trained trainer will be at the home daily to observe and ensure</p>	04/09/2016

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W 0440 Bldg. 00	<p>Director stated, "[Client #1] doesn't have a program to care for her glasses (eyeglasses) but staff (direct care staff) should be teaching her (client #1) to clean her own glasses."</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the overnight shift (11:00 P.M. to 7:00 A.M.) for staff during the second quarter of 2015 (April 1st through June 30th) and during the afternoon shift (3:00 P.M. to 11:00 P.M.) for staff during the third quarter of 2015 (July 1st through September 30th) which affected 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3) living in the facility.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 3/8/16 at 7:58 A.M. The review failed to indicate the facility held evacuation drills</p>	W 0440	<p>these goals are being administered according to each individuals' ISP.</p> <p>Ongoing, the PD, AD, Behavioral Clinician, or other trained trainer will be at the home at least weekly to observe and ensure these goals are being administered according to each individuals' ISP.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director, Behavioral Clinician, or other designated trained trainer</b></p> <p><b>W 440 483.470(i) (1) EVACUATION DRILLS</b></p> <p>The Program Director (PD) and Area Director (AD) will review this Standard.</p> <p>PD, Lead DSP, and all staff will be re-trained on this Standard and Agency Policy and Procedure concerning evacuation drills. PD will develop a schedule to ensure evacuation drills are completed per this Standard and Agency Policy and Procedure. PD will train Lead DSP to ensure they are conducted per the schedule and all documentation filed and maintained in the home's emergency drill binder, and if not, the Lead will inform the</p>	04/09/2016

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W 0460 Bldg. 00	<p>for staff working the overnight shift during the second quarter of 2015, and for direct care staff working the afternoon shift during the third quarter of 2015. This affected clients #1, #2, and #3 who lived in the facility.</p> <p>Program Director #1 was interviewed on 3/9/16 at 11:21 A.M. Program Director #1 stated, "That's all we have (evacuation drills)."</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed to assure 2 of 2 sampled clients (clients #1 and #2), and 1 additional client (client #3) were offered meals per the clients' assessed dietary needs.</p> <p>Findings include:</p> <p>Client #1 was observed during the 3/7/16 group home observation period from 6:17 A.M. until 8:20 A.M. At 6:24 A.M., direct care staff #1 stated to client #1,</p>	W 0460	<p>PD.</p> <p>Ongoing, the PD will evaluate the emergency drill binder and home's life safety binder, at least monthly, to ensure all evacuation drills have been completed and all paperwork filed appropriately.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director, Lead DSP</b></p> <p><b>W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES</b></p> <p>The Program Director (PD) and Area Director (AD) will review this Standard.</p> <p>PD, Lead DSP, and all staff will be re-trained on this Standard and Agency Policy and Procedure concerning menus and dietary needs of the individuals. PD will ensure the dietician assesses Client #3's dietary needs and a dining plan</p>	04/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/10/2016	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>"You need to get yourself something to eat." Client #1 responded, "I don't want anything." Direct care staff #1 asked client #3 if she had anything to eat. Client #3 responded, "I had a Pop Tart (breakfast pastry)."</p> <p>Direct care staff #1, #2, and #3 were interviewed on 3/7/16 at 6:58 A.M. When asked if the facility had a meal menu which was followed to meet the dietary needs of clients #1, #2, and #3, Direct care staff # 1 stated, "They (menus) are in a book in the office." Direct care staff #3 stated, "We don't usually follow a menu. We just cook what they (clients #1, #2, and #3) like and they eat what they want." During further interview, direct care staff #1, #2, and #3 indicated they did not know what types of diets clients #1, #2, and #3 were to be following.</p> <p>Client #1's records were reviewed on 3/9/16 at 7:06 A.M. Review of the client's 12/30/15 diet review indicated client #1 was on a regular diet with lactose free milk.</p> <p>Client #2's records were reviewed on 3/9/16 at 8:20 A.M. Review of the client's 1/9/16 diet review indicated client #2 was on a regular diet with portion control.</p>		<p>developed based on the assessments. PD will ensure all staff are trained on the needs of Client #3.</p> <p>For at least two weeks and until compliance has been demonstrated, the PD, AD, Nurse, Behavioral Clinician, or other trained trainer will be at the home daily to observe a meal time, during the shift of a different staff person on each occasion, to ensure compliance and competence.</p> <p>Ongoing, the PD, AD, Nurse, Behavioral Clinician, or other trained trainer will complete weekly random meal time observations to ensure compliance of this Standard and Agency Policy and Procedure.</p> <p><b>Will be completed by: 4/9/16</b></p> <p><b>Persons Responsible: Program Director, Lead DSP</b></p>				

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	<p>Client #3's records were reviewed on 3/9/16 at 9:06 A.M. Review of the client's record failed to indicate the client's dietary needs had been assessed.</p> <p>Program Director #1 was interviewed on 3/9/16 at 11:121 A.M. Program Director #1 stated, "Staff (direct care staff) should have menus that they follow. [Client #3] hasn't seen the dietician yet so she (client #3) doesn't have a diet that staff (direct care staff) are to follow."</p> <p>9-3-8(a)</p>			