

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G484	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/17/2014
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 50605 WYANDOTTE GRANGER, IN 46530
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 15, 16, and 17, 2014.</p> <p>Facility number: 000998 Provider number: 15G484 AIM number: 100239800</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY 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 ensure window blinds in 1 of 3 sampled client's rooms (client #2's) were repaired and windows in the facility were cleaned for 3 of 3 sampled clients (clients #1, #2, and #3),</p>	W000104	We have reviewed this finding for client #2 and determined the cause for this concern. Client #2 frequently pulls down his blinds, causing them to break. The team has determined that we will place a privacy window film in addition to decorative window treatments in his room. The broken blinds are being removed. We are	10/17/2014

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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W000149	<p>and 2 additional clients (clients #4 and #5) who lived at the facility.</p> <p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, and #5 resided was inspected during the 9/15/14 observation period from 2:52 P.M. until 5:57 P.M. Window blinds in client #2's bedroom were torn. Windows throughout the facility where clients #1, #2, #3, #4, and #5 lived were smudged and hazy with grease and dirt.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. Program Director #1 stated, "It is maintenance who is supposed to assure the window blinds are in good repair." Program Director #1 further stated, "Maintenance is also supposed to make sure the windows in the facility are cleaned."</p> <p>9-3-1(a)</p> <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. Based on record review and interview,</p>			W000149	<p>reviewing this concern in all bedrooms to ensure that window blinds in place for all 5 individuals residing at this facility are in good repair. All windows in the home are receiving a deep cleaning. This will address this concern for all 5 individuals living in this facility. Going forward, the Program Director will be responsible to ensure that the windows are cleaned according to a cleaning schedule. All staff for this home are being re-trained on this expectation and being re-trained on the procedure for reporting maintenance concerns to the Maintenance Director. The Program Director and Area Director will be responsible to ensure that future concerns are reported and addressed in a timely manner.</p> <p>All staff at the Wyandotte home</p>		10/17/2014

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	<p>the facility neglected to implement their abuse/neglect policy to immediately report to the administrator 1 of 1 reviewed abuse allegations which affected 1 of 3 sampled clients (client #3).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 9/15/14 at 11:02 A.M. A review of the facility's incident reports from 9/1/13 to 9/15/14 indicated the following abuse allegation:</p> <p>- "Date: 08/01/2014, Date of Knowledge: 07/31/2014, [Client #2] was in his room when his housemate (client #3) was sitting in the medication pass area on the floor crying loudly and putting her fingers into staff's shoes. [Client #2] came out of his room, reached toward staff and grabbed housemate's (client #3's) left breast. This happened on 7/31/14 at 7:30pm. There was no injury noted at the time that [client #2] grabbed his housemate. [Client #2] doesn't have a history of targeting anyone. [Client #2] didn't like the noise of this individual as housemate was crying. His housemate was right outside of his bedroom area. Staff did their best to redirect [client #2's] housemate (client #3), by following their behavioral plan. [Client #2] was able to</p>		<p>and the Program Director team are being re-trained in the expectation in Dungarvin Policy that all major incidents, including abuse allegations, are to be reported to a Program Director or Area Director immediately. This re-training will be completed by 10/17/2014. Going forward, all agency staff are re-trained on this expectation during their annual conditions of employment mandatory trainings. We are reviewing the concern of timely reporting for all individuals at the home in order to identify any staff members who may need additional training and/or disciplinary action in order to ensure compliance with this standard going forward.</p>				

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	<p>be less agitated as his housemate calmed down. Plan to Resolve: On 8/1/14, 2pm staff reported the previous night's incident and a bruise on housemate's (client #3's) left breast in the same area from where [client #2] grabbed from the previous night. The bruise is purple in color and the size of a half-dollar. [Client #2's] housemate (client #3) did not seek medical treatment for the bruise. Staff will continue to assist [client #2] when his housemate is upset to help [client #2] from becoming upset. Staff will continue to monitor and report any concerns immediately." Further review of the 7/31/14 incident indicated the Program Director, On-call Program Director, or Area Director (facility's administrators) were not notified of the incident until the afternoon of 8/1/14.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. Program Director #1 stated, "According to our policy, the program director should have been notified of the incident immediately."</p> <p>The facility's records were reviewed on 9/17/14 at 11:54 A.M. Review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14, indicated, in part, the following: "1. The first step is to immediately contact the program</p>			

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W000153	<p>director for the individual, the on-call PD (Program Director), or any area director if the PD cannot be reached or is the suspected perpetrator."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview, the facility neglected to immediately report to the administrator 1 of 1 reviewed abuse allegation which affected 1 of 3 sampled clients (client #3) in accordance with state law.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 9/15/14 at 11:02 A.M. A review of the facility's incident reports from 9/1/13 to 9/15/14 indicated the following abuse allegation:</p> <p>- "Date: 08/01/2014, Date of Knowledge: 07/31/2014, [Client #2] was</p>	W000153	All staff at the Wyandotte home and the Program Director team are being re-trained in the expectation in Dungarvin Policy that all major incidents, including abuse allegations, are to be reported to a Program Director or Area Director immediately. This re-training will be completed by 10/17/2014. Going forward, all agency staff are re-trained on this expectation during their annual conditions of employment mandatory trainings. We are reviewing the concern of timely reporting for all individuals at the home in order to identify any staff members who may need additional training and/or disciplinary action in order to ensure compliance with this standard going forward.	10/17/2014	

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	<p>in his room when his housemate (client #3) was sitting in the medication pass area on the floor crying loudly and putting her fingers into staff's shoes. [Client #2] came out of his room, reached toward staff and grabbed housemate's (client #3's) left breast. This happened on 7/31/14 at 7:30pm. There was no injury noted at the time that [client #2] grabbed his housemate. [Client #2] doesn't have a history of targeting anyone. [Client #2] didn't like the noise of this individual as housemate was crying. His housemate was right outside of his bedroom area. Staff did their best to redirect [client #2's] housemate (client #3), by following their behavioral plan. [Client #2] was able to be less agitated as his housemate calmed down. Plan to Resolve: On 8/1/14, 2pm staff reported the previous night's incident and a bruise on housemate's (client #3's) left breast in the same area from where [client #2] grabbed from the previous night. The bruise is purple in color and the size of a half-dollar. [Client #2's] housemate (client #3) did not seek medical treatment for the bruise. Staff will continue to assist [client #2] when his housemate is upset to help [client #2] from becoming upset. Staff will continue to monitor and report any concerns immediately." Further review of the 7/31/14 incident indicated the Program Director, On-call Program</p>						

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W000240	<p>Director, or Area Director (facility's administrators) were not notified of the incident until the afternoon of 8/1/14.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. Program Director #1 stated, "According to our policy, the program director should have been notified of the incident immediately."</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#2) to include interventions/methods in the client's individual support plan (ISP) in regards to staff assistance needs with adaptive eating equipment.</p> <p>Findings include:</p> <p>Client #2 was observed eating breakfast during the 9/16/14 group home observation period from 6:02 A.M. until 7:55 A.M. Client #2 ate his pancakes and scrambled eggs with his hands as direct care staff #4 sat next to him.</p>	W000240	<p>A new learning program is being developed by the QDDP for client #2 to address the need to use adaptive eating equipment as recommended by outside support services. All staff at the home are being trained on this program at the upcoming team meeting. The QDDP will be responsible to ensure that the program is being implemented through mealtime active treatment observations to be conducted at 4meals per week for the two weeks following the staff training. If the QDDP sees effective program implementation in that time, the observations will reduce to twice per month. If the QDDP observes that additional</p>	10/17/2014			

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W000263	<p>Client #2 had an adaptive spoon on his plate but direct care staff #4 did not prompt or assist the client in using it.</p> <p>Direct care staff #4 was interviewed on 9/16/14 at 7:57 A.M. When asked about client #2's use of his adaptive eating equipment, direct care staff #4 stated, "He (client #2) uses them if he wants to."</p> <p>Client #2's record was reviewed on 9/17/14 at 9:25 A.M. Review of the client's 7/18/13 dietician report indicated the client had an adaptive spoon and fork to use when eating his foods. Review of the client's 5/20/14 Individual Program Plan failed to indicate methods direct care staff were utilize for client #2 in his use of the fork and spoon.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. Program Director #1 stated, "We do not have any instructions in place for staff to use for [client #2] using his adaptive fork and spoon."</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE</p>		<p>training and observation is required, the observations will continue at 4 meals per week until staff have demonstrated competency in program implementation. The Program Director/QDDP is being re-trained on the expectation that IPP programs must describe all relevant interventions to support the individual towards independence. We are reviewing this concern for all 5 individuals living at the home to ensure that we are addressing adaptive equipment needs at meal times and that all relevant learning programs are in place to support the implementation of the interventions. Any additional needed programs are to be implemented with training and follow up coaching for the staff members as indicated above. Quarterly, Program Director/QDDP's will conduct audits of the client files. This audit will include assuring that all adaptive eating equipment is addressed in the ISP. These audits will be reviewed by the Area Director for follow up assurance.</p>				

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	<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 the guardian prior to implementing a restrictive Behavior Plan for 1 of 3 sampled clients (client #2) with a Behavior Plan.</p> <p>Findings include:</p> <p>Client #2's records were reviewed on 9/17/14 at 9:25 A.M. The review indicated client #2 had the services of a guardian. Review of client #2's records indicated the client had a restrictive behavior plan, dated 4/13/14 which addressed target behaviors of physical aggression and was receiving Risperdone medication (anti-psychosis medication) as part of the behavior plan. Further review failed to indicate client #2's guardian had approved the use of the plan.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. Program Director #1 stated, "We sent the plan (client #2's behavior plan) to his guardian to sign and approve but we have not received it back yet."</p>	W000263	<p>We have contacted the guardian for client #2 to obtain the written approval for his behavior support plan. We are also auditing all behavior support plans and restrictions in place for all clients at the home to ensure that all plans have written consent in place from the guardian or individual if the individual is emancipated. The Program Director/QDDP will be retrained on ensuring that the emancipated person served or their guardian approves any Behavior Intervention Plan that is restrictive in nature, prior to implementing the plan. Quarterly, Program Director/QDDP's will conduct audits of the client files. This audit will include assuring that written approvals by the Person Served or their Guardian has been obtained for any restrictive Behavior Plans. These audits will be reviewed by the Area Director for follow up assurance.</p>	10/17/2014			

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W000268	<p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure 2 of 3 sampled clients (clients #1 and #2) received haircuts.</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed during the group home observation period on 9/15/14 from 2:52 P.M. until 5:57 P.M. Clients #1 and #2's hair was noted to be long and over their ears and long on their necks and appeared unkempt.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. Program Director #1 stated, "We tried to get their (client #1 and #2's) hair cut before school started but were unable to. Yes, they (clients #1 and #2) are in need of hair cuts."</p> <p>9-3-5(a)</p>	W000268	Both clients #1 and #2 are receiving haircuts. We have reviewed this concern for all individuals residing at the home to ensure they have all received proper support in obtaining regular haircuts. All staff and the Program Director/QDDP of the home are receiving re-training on the expected frequency of provided haircuts and the responsibility of the facility in assisting the individuals in promoting their growth, development, and independence in the area of their own personal appearance. The Program Director/QDDP will be responsible, in conjunction with the Lead DSP, to ensure that haircuts are scheduled in a timely fashion going forward.	10/17/2014	

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W000436	<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 eyeglasses to 1 of 1 sampled client (client #1) who wore eyeglasses.</p> <p>Findings include:</p> <p>Client #1 was observed at the group home during the 9/15/14 observation period from 2:52 P.M. until 5:57 P.M., and during the morning observation period on 9/16/14 from 6:02 A.M. until 7:55 A.M. During the observation periods, client #1 did not wear eyeglasses.</p> <p>Client #1's record was reviewed on 9/17/14 at 8:57 A.M. A review of the client's 9/12/14 Vision Exam indicated the client was to wear eyeglasses.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. The Program</p>	W000436	<p>The eyeglasses for client #1 have been repaired and he has them at the home now. We are also pursuing the option of having a backup pair available at the home for situations such as these where the glasses need to be sent out for repair. We have reviewed this concern for all of the 5 individuals residing at this facility. All facility staff and the Program Director/QDDP are being retrained on the expectation that all adaptive equipment needs to be available and in good working order at all times. Going forward, the Program Director is to meet weekly with the facility nurse, Lead DSP, and the Medical Support DSP to review appointments and medical concerns. Adaptive equipment is one of the items reviewed at this weekly meeting. Agenda notes and task sheets are then sent to the Area Director for review. This system is in place to safeguard that all areas requiring follow up</p>	10/17/2014

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W000440	<p>Director stated, "[Client #1's] glasses have been broken and we are in the process of getting him new ones."</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 third quarter of 2013 (July 1st through September 30th) and during the overnight shift for staff during the second quarter (April 1st through June 30th) which affected 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients living in the facility (clients #4 and #5).</p> <p>Findings include:</p> <p>The facility's records were reviewed on 9/15/14 at 1:41 P.M. The review failed to indicate the facility held an evacuation drill for staff during the overnight shift during the third quarter of 2013 and the second quarter of 2014. This affected</p>	W000440	<p>are addressed in a timely fashion.</p> <p>The Area Director went to the Wyandotte facility to audit the fire drills from the third quarter of 2013. The following overnight drill was located in the drill book at the home, though it was held together with several other drills with a paper clip: July 27, 2013 at 12:40 a.m. A copy of this drill is attached to this plan of correction submission. However, the Program Director/QDDP was mistaken and thought the surveyor had seen this book. The surveyor had been shown our backup copies kept at the office. This was an oversight on the part of the Program Director. Going forward, the Program Director/QDDP has been re-trained on the expectation that the emergency drills at the house are considered the primary record and should be referenced for all future surveys. All staff are being</p>	10/17/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G484	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/17/2014
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(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	
	<p>clients #1, #2, #3, #4, and #5 who lived in the facility.</p> <p>Program Director #1 was interviewed on 9/17/14 at 11:35 A.M. Program Director #1 stated, "That's all we have (evacuation drills)."</p> <p>9-3-7(a)</p>		<p>retrained on the standard expectations for frequency of evacuation drills. Going forward, it is the responsibility of the Program Director/QDDP to ensure that drills are completed and filed in the book at the home at the expected frequency of at least quarterly for each shift of personnel. The Area Director is responsible to monitor this expectation as well during quarterly site visits.</p>		