

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G761		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/28/2012	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 60650 LILAC RD SOUTH BEND, IN 46614			
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W0000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: November 26, 27, and 28, 2012.</p> <p>Facility number: 011959 Provider number: 15G761 AIM number: 200970870</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/5/12 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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W0125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, the facility failed to assure 2 of 2 sampled clients (clients #1 and #2), assessed as capable of handling kitchen knives, had access to kitchen knives.</p> <p>Findings include:</p> <p>Observations of the group home where clients #1 and #2 resided were conducted on 11/26/12 from 2:37 P.M. until 6:00 P.M., and on 11/27/12 from 6:24 A.M. until 8:07 A.M.. During the observation periods, the kitchen knives were locked in a kitchen drawer. Clients #1 and #2 were not observed to have access to the kitchen knives.</p> <p>Direct care staff #3 was interviewed on 11/26/12 at 3:07 P.M.. When asked why the kitchen knives were locked, direct care staff #3 stated, "They are locked so the clients (clients #1, #2, #3, and #4) can't get them." When asked if clients #1 and #2 could utilize the kitchen knives, direct care staff #3 stated, "No, we (direct care staff) use the knives and we have the</p>	W0125	<p>A plan will be implemented to allow Client #1 and Client #2 the right to access the kitchen knives and scissors. This plan will specify criteria of how they will be given the right to access to the items that are currently restricted from their housemates. All staff will be retrained on this plan.</p> <p>The Program Director/QMRP for this site will review this standard and be trained on the expectation that any means of restricting of household or personal items must have a corresponding Behavior plan with specific criteria explaining the reason for having this restriction in place. For those housemates that do not have the same restriction criteria, a system for allowing those people to maintain access to those restricted items needs to be in place as well.</p> <p>Quarterly, Program Director/QMRP's will conduct audits of the client files. This audit will include assuring that criteria are in place to allow a means for people who do not require a restriction of specific</p>	12/28/2012			

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	<p>keys. The guys (clients #1, #2, #3, and #4) aren't allowed to use them."</p> <p>Direct care staff #4 was interviewed on 11/27/12 at 8:02 A.M.. Direct care staff #4 stated, "We (direct care staff) do all of the cutting with the use of knives and scissors. Clients do not."</p> <p>Client #1's records were reviewed on 11/27/12 at 8:34 A.M.. A review of the client's 5/1/12 Safety Assessment indicated the client "requires assistance in diet and food preparation." Review of client #1's 8/6/12 Comprehensive Functional Assessment indicated "Uses sharps (knives, scissors) with physical assistance." Review of the client's 5/20/12 Individual Program Plan failed to indicate the client was not capable of utilizing kitchen knives and further review of client's record failed to indicate the client was restricted from using the kitchen knives.</p> <p>Client #2's records were reviewed on 11/27/12 at 9:11 A.M.. A review of the client's 8/16/12 Safety Assessment indicated the client "requires assistance with cooking or food preparation." Review of client #2's 8/16/12 Comprehensive Functional Assessment indicated the client's needed training in the "use of a can opener, knives, coffee</p>		<p>items the ability to access those items if they are locked from housemates. This audit will be reviewed by the Area Director to assure the concerns are being addressed.</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><b>Persons Responsible:</b> <b>Program Director/ QMRP, Area Director</b></p>		

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	<p>maker, and appliances." Review of client #2's 4/15/12 Individual Program Plan failed to indicate the client was not capable of utilizing kitchen knives and further review of client's record failed to indicate the client was restricted from using the kitchen knives.</p> <p>Program Director #1 was interviewed on 11/27/12 at 11:09 A.M.. Program Director #1 indicated clients #1 and #2 were to have access to the facility's knives and scissors with staff supervision. Program Director #1 further indicated clients #1 and #2 did not have any assessed need which should restrict access to the facility's kitchen knives and scissors. 9-3-2(a)</p>				

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W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, the facility failed to assure 1 of 2 sampled clients (client #2) did not wear the same clothing for two consecutive days.</p> <p>Findings include:</p> <p>Client #2 was observed during the 11/26/12 observation period from 2:37 P.M. until 6:00 P.M.. Client #2 was wearing a tan tee shirt and blue jeans. Client #2 was noted to wear these clothes throughout the 11/26/12 observation period.</p> <p>Client #2 was observed during the 11/27/12 observation period from 6:24 A.M. until 8:00 A.M.. Client #2 wore the same tan tee shirt and blue jeans which he wore on 11/26/12. Direct care staff #4, #5, and #7 did not prompt or assist client #2 to change clothing.</p> <p>Program Director #1 was interviewed on 11/27/12 at 11:09 A.M.. Program Director #1 indicated direct care staff should have assured client #2 wore different clothing on 11/27/12.</p>	W0137	<p>All staff will be retrained on the expectation of assuring that each individual is appropriately dressed in clean and dry clothing at all time. Random observations will be conducted by the Program Director/QMRP or designee to ensure that this expectation is being carried out. Immediate feedback will be given to staff during these observations in regards to this issue.</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><b>Persons Responsible: Program Director/ QMRP</b></p>	12/28/2012	

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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. Based on record review and interview, the facility neglected to implement their abuse/neglect policy to report findings to the administrator within five business days for 1 of 1 reviewed investigation of an injury of unknown origin which involved 1 of 4 clients living at the group home (client #4).</p> <p>Findings include:</p> <p>The facility's incident reports from 11/26/11 to 11/26/12, were reviewed on 11/26/12 at 12:54 P.M.. The review indicated the following injury of unknown origin involving client #4: "Date: 06/07/2012, Name: [Client #4], Brief Description: On 6/7/12 at approximately 3:30pm, staff notified Program Director (Program Director #1) that [client #4] had a bruise on his inner thigh. Plan to Resolve: Staff followed protocol and notified the Program Director and nurse. The bruise, possibly an abrasion, is a light red in color and about 5" x 6" (5 inches by 6 inches). The bruise/abrasion was treated per the nurse's instructions. Program Director is investigating to try and determine how [client #4] sustained the bruise/abrasion. PD (Program</p>	W0149	<p>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 findings of all investigations of abuse and neglect must be reported to the facility administrator within 5 business days.</p> <p>The Area Director will review all incident reports and ensure that a summary of each investigation is submitted in a timely manner.</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><b>Persons Responsible: Program Director /QMRP, Area Director</b></p>	12/28/2012			

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	<p>Director) will continue investigation and follow up as necessary."</p> <p>Further review on 11/26/12 at 1:55 P.M. of the investigation of the 6/7/12 injury of unknown origin involving client #4 indicated a follow up report dated 6/13/12 which indicated "Program Director/QMRP (Qualified Mental Retardation Professional) is still investigating in an effort to determine the cause of the bruise/abrasion. PD/QMRP will follow-up with results and notify [client #4's] IDT (Inter-Disciplinary Team) and complete follow-up report."</p> <p>Review on 11/26/12 at 2:07 P.M. of the investigation of the 6/7/12 injury of unknown origin involving client #4 indicated investigative results dated 6/22/12 which indicated "After investigation, Program Director/QMRP is unable to determine the cause of the bruise/abrasion."</p> <p>Program Director #1 was interviewed on 11/27/12 at 11:09 A.M.. Program Director #1 indicated he was unsure if the results of the investigation into the 6/7/12 injuries of unknown origin incident involving client #4 were forwarded to the administrator within five days of the incident.</p>				

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	<p>The facility's records were further reviewed on 11/27/12 at 12:40 P.M.. Review of the facility's "Policy and Procedure Concerning Individual Abuse, Neglect, and Exploitation", dated 10/9/12, indicated, in part, the following: "II. Facility Investigation. D. The facility investigation will be completed within five (5) business days, and a summary of the investigation will be forwarded to the administrator within five (5) business days of the incident."</p> <p>9-3-2(a)</p>				

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W0156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to report findings to the administrator within five business days for 1 of 1 reviewed investigation of an injury of unknown origin which involved 1 of 4 clients living at the group home (client #4).</p> <p>Findings include:</p> <p>The facility's incident reports from 11/26/11 to 11/26/12, were reviewed on 11/26/12 at 12:54 P.M.. The review indicated the following injury of unknown origin involving client #4: "Date: 06/07/2012, Name: [Client #4], Brief Description: On 6/7/12 at approximately 3:30pm, staff notified Program Director (Program Director #1) that [client #4] had a bruise on his inner thigh. Plan to Resolve: Staff followed protocol and notified the Program Director and nurse. The bruise, possibly an abrasion, is a light red in color and about 5" x 6" (5 inches by 6 inches). The bruise/abrasion was treated per the nurse's instructions. Program Director is investigating to try and determine how [client #4] sustained</p>	W0156	<p>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 findings of all investigations of abuse and neglect must be reported to the facility administrator within 5 business days.</p> <p>The Area Director will review all incident reports and ensure that a summary of each investigation is submitted in a timely manner.</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><b>Persons Responsible: Program Director /QMRP, Area Director</b></p>	12/28/2012			

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	<p>the bruise/abrasion. PD (Program Director) will continue investigation and follow up as necessary."</p> <p>Further review on 11/26/12 at 1:55 P.M. of the investigation of the 6/7/12 injury of unknown origin involving client #4 indicated a follow up report dated 6/13/12 which indicated "Program Director/QMRP (Qualified Mental Retardation Professional) is still investigating in an effort to determine the cause of the bruise/abrasion. PD/QMRP will follow-up with results and notify [client #4's] IDT (Inter-Disciplinary Team) and complete follow-up report."</p> <p>Review on 11/26/12 at 2:07 P.M. of the investigation of the 6/7/12 injury of unknown origin involving client #4 indicated investigative results dated 6/22/12 which indicated "After investigation, Program Director/QMRP is unable to determine the cause of the bruise/abrasion."</p> <p>Program Director #1 was interviewed on 11/27/12 at 11:09 A.M.. Program Director #1 indicated he was unsure if the results of the investigation into the 6/7/12 injuries of unknown origin incident involving client #4 were forwarded to the administrator within five days of the incident.</p>						

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE 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 program for 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 11/27/12 at 8:34 A.M.. The review indicated client #1 had the services of a guardian. Review of the client's 6/1/12 Behavior Support Program indicated the client was receiving Buspar (anti-anxiety medication), Depakote (mood stabilizer medication), Elavil (mood stabilizer medication), and Zyprexa (anti-psychosis medication) for the management of targeted behaviors of Resistance, Incontinence, Physical Assault, Inappropriate Sexual Behavior, Temper outbursts, Verbal Abuse, and Vomiting. Further review of client #1's Behavior Support Program failed to indicate the client's guardian provided written consent for the use of the plan.</p> <p>Program Director #1 was interviewed on</p>	W0263	<p>The missing approvals noted in this survey have been obtained by the guardian for client #1. All of the other individuals Behavior Intervention Plans will be reviewed to assure that they also have the required approval signatures.</p> <p>The Program Director/QMRP will be retrained on assuring that the emancipated person served or their guardian approves any changes related to a Behavior Intervention Plan that is restrictive in nature, prior to implementing the program.</p> <p>Quarterly, Program Director/QMRP's will conduct audits of the client files. This audit will include assuring that approvals by the Person Served or their legal guardians are obtained for any restrictive Behavior Plans. These audits will be reviewed by the Area Director for follow up assurance.</p> <p>System wide, all Program Director/QMRP's will review this standard and the need to assure that this concern is being addressed at all Dunganvin ICF-MR's.</p>	12/28/2012	

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	<p>11/27/12 at 11:09 A.M.. Program Director #1 indicated he had sent client #1's Behavior Support Program to the client's guardian for approval but had not received it back from the guardian.</p> <p>9-3-4(a)</p>		<p><b>Persons Responsible:</b> <b>Program Director/ QMRP, Area Director</b></p>		