

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G479	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/17/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 422 MARQUETTE TR MICHIGAN CITY, IN 46360
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 11, 12, 13, 14, and 17, 2015.</p> <p>Facility number: 000993 Provider number: 15G479 AIM number: 100244950</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<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 walls and doorways in the living room and hallway, and a reclining chair in the living room, were in good repair for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 of 4 additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p>	W 0104	<p>The walls of the hallways and main living areas will be repaired and painted by 09/16/15. The broken recliner was removed from the home and a new recliner was purchased and placed in the home. Maintenance has conducted a walk-thru of the home to ensure that there are no other items in the home in need of repair or replacement. All staff at the home will be retrained by 09/16/15 on the expectation that broken furniture or items in need of repair are reported to the QIDP in a timely manner. The QIDP</p>	09/16/2015

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 0186 Bldg. 00	<p>The group home where clients #1, #2, #3, #4, #5, #6,#7, and #8 resided was inspected during the 8/11/15 observation period from 5:03 A.M. until 7:30 A.M. Walls and doorways in the living room and hallway area of the facility were scraped and chipped with black marks on the walls and doorways. The back of a recliner in the living room was crushed. The living room and hallway areas of the facility, along with the recliner in the living room were utilized by clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>House manager #1 was interviewed on 8/13/15 at 11:45 A.M. House manager #1 stated, "The living room and hallway areas are on a list to be repaired and painted and a new recliner is going to be purchased."</p> <p>9-3-1(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a</p>		<p>will be retrained by 09/16/15 on the standard that the governing body must exercise general policy, budget, and operating direction over the facility. Going forward, staff maintenance requests will not only be sent to the maintenance department but also to the QIDP of the facility. This will ensure that the QIDP is able to monitor that the repair needs of the home are being completed in a timely manner. In addition, the QIDP will visit the home on a weekly basis and note any environmental or physical concerns for the facility. On a monthly basis, the QIDP (or designee) will conduct a walk-thru of the home and complete a site risk checklist. The monthly site risk checklists are submitted for tracking and review to the Safety Committee. The Area Director also completes an additional walk-thru of the home on at least a quarterly basis.</p>		

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	<p>24-hour period for each defined residential living unit.</p> <p>Based on observation and interview, the facility failed to provide sufficient staff to provide for the needs of 2 of 4 sampled clients (clients #2 and #4), during the morning observation period.</p> <p>Findings include:</p> <p>Clients #2 and #4 were observed at the group home during the 8/11/15 observation period from 5:03 A.M. until 7:30 A.M. At 5:33 A.M., clients #2 and #4 repeatedly indicated to direct care staff #1 they wanted to have breakfast. Direct care staff #1 repeatedly told clients #2 and #4, "I have to get other people (clients) up and ready. You're (clients #2 and #4) going to have to wait for breakfast." From 5:33 A.M. until 6:17 A.M., clients #2 and #4 wandered around the facility without interaction, training or active treatment services from direct care staff #1 and #2.</p> <p>Direct care staff #1 was interviewed on 8/11/15 at 7:35 A.M. Direct care staff #1 stated, "We need a third staff here (at the facility) in the mornings. She (direct care staff #2) and I can't take care of everything all at once. People (clients) are going to have to wait."</p>	W 0186	<p>The staff at the home will be retrained by 09/16/15 on the expectation that they are to provide for the needs of all clients in the home. Staff will be provided suggestions for additional teaching moments and active treatment areas that they may offer as choices for the individuals to complete in order for the staff to also meet any additional client needs in the home. The staffing levels will be evaluated by 09/16/15 to determine if additional staff is needed at the facility weekdays before 6:30am. Currently, applications are under review and interviews are being scheduled for a third staff position that starts at 6:30am. In the meantime, all efforts are being made to fill the shifts with current staff. In order to assess the potential need for additional staff (other than what is currently planned) the QIDP will conduct five observations at the home between 5am and 8am, during the weekdays prior to 09/16/15. If the observations indicate that it is insufficient to offer additional staff support at 6:30am, a recruitment request will be made by 09/16/15 for a 4th staff member to be on the morning schedule. Update: It has been identified that Monday through Friday the third staff person is needed at 6am instead of 6:30am for the facility to</p>	09/16/2015

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W 0262 Bldg. 00	<p>House manager #1 was interviewed on 8/13/15 at 11:45 A.M. House manager stated, "We've been having staffing problems at that home (facility). We usually have three staff working in the mornings but we are short one staff now."</p> <p>9-3-3(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the facility failed to assure the facility's Human Rights Committee reviewed and approved the use of psychotropic medications for 1 of 4 sampled clients receiving psychotropic medications (client #4). Findings include: Client #4's records were reviewed on</p>	W 0262	<p>adequately meet the needs of all clients in the home. This is not the case on weekends, as the individuals prefer to sleep in later on days that they are not attending day program. An employee was hired for the position and starts training on 09/21/15. The QIDP (or designee) will continue to ensure the sufficient staff coverage is provided in the interim. Going forward, the QIDP will ensure that three staff members are scheduled to be on duty for the early morning shifts on weekdays. If a staff member calls-off, the QIDP or on-call QIDP will arrange for coverage of the shift.</p> <p>The QIDP and the staff at the facility will be trained by 09/16/15 that all psychotropic medications must be reviewed and approved by the Human Rights Committee. Client #4's psychotropic medication; Trazadone (mood stabilizer), Sertraline (antidepressant), and Risperidone (antipsychotic) will be reviewed and approved by the Human Rights Committee by 09/16/15. An audit will be</p>	09/16/2015

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W 0314 Bldg. 00	<p>8/13/15 at 10:40 A.M. A review of the client's record indicated the client was admitted to the facility on 7/20/15. Upon admission, the facility continued the administration of the following psychotropic medications which the client had previously taken at another facility: Trazadone (mood stabilizer), Sertraline (antidepressant) and Risperidone (antipsychotic). Further review of the client's record failed to indicate the facility's Human Rights Committee reviewed and approved the use of these medications upon client #4's admission to the facility.</p> <p>Area Director #1 was interviewed on 8/13/15 at 8:37 A.M. Area Director #1 stated, "Our HRC (Human Rights Committee) did not review [client #4's] psych (psychotropic) medications."</p> <p>9-3-4(a)</p> <p>483.450(e)(4)(i) DRUG USAGE Drugs used for control of inappropriate behavior must be monitored closely in conjunction with the physician and the drug regimen review requirement at §483.460(j).</p>		<p>conducted by 09/16/15 to ensure that each individual at the facility that is receiving psychotropic medications has a current HRC reviewed and approved plan. Going forward, the QIDP, Lead DSP, and facility nurse will verify that all psychotropic medications have received human rights committee approval prior to being entered on the medication administration record for each individual in the facility.</p>	

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	<p>Based on record review and interview, the facility failed to assure psychotropic medication use was reviewed as recommended by 1 of 4 sampled clients' (client #3's)psychiatrist.</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 8/13/15 at 9:22 A.M. A review of a psychiatric follow along, dated 2/24/15, indicated client #3's had been seen by her psychiatrist and was taking Clonazepam and Clozapine (antipsychotic medications) for aggression and agitation. The review indicated client #3 was to return to her psychiatrist for evaluation and medication review "in 3 months." Further review of the client's record failed to indicate client #3 was seen by her psychiatrist for evaluation and medication review "in 3 months."</p> <p>House manager #1 was interviewed on 8/13/15 at 11:45 A.M. House manager #1 stated, "She (client #3) has an appointment with her psychiatrist next week."</p> <p>9-3-5(a)</p>	W 0314	<p>The QIDP and the staff at the facility will be trained by 09/16/15 that all drugs used for control of inappropriate behavior must be monitored closely in conjunction with the physician and the drug regimen reviewed as required by the standard. The QIDP and the staff at the facility will be trained by 09/16/15 that the recommendations by the medical provider must be followed as written and appointments must be scheduled in a timely manner. Client #3 will be seen for an evaluation and medication review on 9/21/15. Client #3's quarterly visits have been scheduled on time for the first, second, and third quarters of 2015. The Lead DSP has already demonstrated that she has implemented the standard and has corrected the error which occurred last year in the 4th quarter of 2014. Going forward, the QIDP, Lead DSP, and facility nurse will verify that all psychiatric appointments are scheduled within the timeframe of the medical provider's recommendation. The facility leadership team meets weekly, during the meeting all consultation forms for the previous week's appointments are reviewed and the master medical appointment schedule is updated. For quality assurance monitoring, the agenda (minutes) of the meetings are forwarded by the nurse to the Nursing Services Director and the Area Director.</p>	09/16/2015	

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W 0336 Bldg. 00	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>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 three months), within the month they were due, for 3 of 4 sampled clients (clients #1, #2, and #3.)</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 8/12/15 at 8:30 A.M. A review of the client's quarterly nursing assessments from 7/1/14 to 8/12/15 indicated quarterly nursing assessments were completed on 7/13/15, 3/21/15, 12/26/14, and 8/4/14. The review failed to indicate quarterly nursing assessments were conducted at least quarterly within the month they were due.</p> <p>Client #2's records were reviewed on 8/13/15 at 7:44 A.M. A review of the client's quarterly nursing assessments from 7/1/14 to 8/12/15 indicated quarterly nursing assessments were</p>	W 0336	<p>The QIDP and the staff of the home will be trained by 09/16/15 that the facility nurse is responsible to complete quarterly nursing assessments within the month they are due. The facility nurse of the home will be trained by 09/16/15 on the nursing services standard which states a review of the health status must be on a quarterly or more frequent basis depending on client need. Going forward, the quarterly nursing assessments for each individual in the home will be tracked on a master spreadsheet to ensure that the QIDP and Nurse are aware of the upcoming due dates for an assessment. This tracking sheet will be reviewed weekly at the QIDP, Nurse and Lead DSP team meeting. The master spreadsheet will be reviewed on a monthly basis by the nursing services supervisor for quality assurance monitoring.</p>	09/16/2015

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W 0382 Bldg. 00	<p>completed on 3/21/15, 1/4/15, and 8/4/14. The review failed to indicate quarterly nursing assessments were conducted at least quarterly within the month they were due.</p> <p>Client #3's records were reviewed on 8/13/15 at 9:22 A.M. A review of the client's quarterly nursing assessments from 7/1/14 to 8/12/15 indicated quarterly nursing assessments were completed on 3/21/15, 12/23/14, and 8/4/14. The review failed to indicate quarterly nursing assessments were conducted at least quarterly within the month they were due.</p> <p>House manager #1 was interviewed on 8/13/15 at 11:45 A.M. House manager #1 stated, "Some of the quarterly nursing assessments were not completed timely due to nursing problems we had."</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.</p>			

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W 0436 Bldg. 00	<p>Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 4 of 4 sampled clients (clients #1, #2, #3 and #4), and 4 additional clients (client #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed during the group home observation period on 8/11/15 from 5:03 A.M. until 7:30 A.M. Upon entering the facility, a box of medications was observed on a table in the dining room of the facility. The medications in the box were not locked and were accessible to clients #1, #2, #3, #4, #5, #6, #7, and #8 who lived in the group home.</p> <p>House Manager #1 was interviewed on 8/11/15 at 11:45 A.M. House manager #1 stated, "Medications are to be locked when they aren't being administered."</p> <p>6-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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</p>	W 0382	Direct Care Staff #1 and Direct Care Staff #2 will receive disciplinary action by 09/16/15 for failing to follow Dungarvin Policy for medication storage and administration. All staff that work in the home will be trained by 09/16/15 on the expectation that all drugs and biologicals are to be kept locked except when being prepared for administration. In addition, all staff will be trained on the process for unpacking and storing medications that are delivered to the home. This will ensure the clients of the home are not allowed to access medications or other potentially harmful substances when a package arrives from the pharmacy.	09/16/2015	

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	<p>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 assure 2 of 3 clients with adaptive equipment (clients #1 and #2) were prompted to wear their eyeglasses.</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed at the group home during the 8/11/15 observation periods from 5:03 A.M. until 7:30 A.M. During the observation period, clients #1 and #2 did not wear eyeglasses. Direct care staff #1 and #2 did not prompt or assist clients #1 and #2 to use or wear their respective eyeglasses</p> <p>Client #1's record was reviewed on 8/12/15 at 8:30 A.M. A reviewed of the client's 5/21/15 Vision Exam indicated the client was to wear eyeglasses.</p> <p>Client #2's record was reviewed on 8/13/15 at 7:44 A.M. A reviewed of the client's 7/14/14 Vision Exam indicated the client was to wear eyeglasses.</p> <p>House Manager #1 was interviewed on 8/13/15 at 11:45 A.M. House Manager #1 stated, "[Clients #1 and #2] are to be</p>	W 0436	<p>Direct Care Staff #1 and Direct Care Staff #2 will receive disciplinary action by 09/16/15 for failing to ensure Client#1 and Client #2 were prompted to wear their glasses. All staff at the facility will be retrained by 09/16/15 on the expectation that all clients that have adaptive equipment, such as glasses or hearing aids, will be prompted to utilize the adaptive equipment. The QIDP will complete a minimum of three observations a week at the home and will ensure the clients are utilizing the adaptive equipment as ordered. This additional monitoring will occur for four weeks or until staff routinely prompt the clients to wear their adaptive equipment. Once staff have demonstrated competency in adhering to this standard of care, we will taper the number of observations per week. The Area Director will conduct visits to the home on at least a quarterly basis and will observe the clients to ensure adaptive equipment is being used.</p>	09/16/2015

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W 0460 Bldg. 00	<p>prompted to wear their eyeglasses."</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 4 of 4 sampled clients (clients #1, #2, #3 and #4's) menu and diet recommendations were followed for the morning meal.</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed during the 8/11/15 group home observation period from 5:03 A.M. until 7:30 A.M. At 6:17 A.M., direct care staff #1 assisted clients #1, #2, #3, and #4 in preparing a bowl of cereal with milk. Clients #3 and #4 ate their bowl of cereal with milk and then left the dining area. Direct care staff #1 did not prompt or assist the clients in serving themselves juice of choice, hot or cold cereal, cinnamon toast, margarine, jelly, citrus sections, 1% milk, or beverage of choice.</p>	W 0460	<p>Direct Care Staff #1 and Direct Care Staff #2 will receive disciplinary action by 09/16/15 for failing to ensure the menu and diet recommendations were followed for the morning meal for Client#1, Client #2, Client #3, and Client #4 at the home. All staff will be retrained by 09/16/15 on the use of the menu, and involving the clients in menu choices. The QIDP (or designee) will conduct Active Treatment Observations to ensure that each staff is implementing the menu choices for all clients in the home. Three morning meals per week and three evening meals per week will be observed for four weeks. Once staff demonstrate competency in routinely adhering to the standard, the observations will be tapered. Immediate feedback will be given to the staff during the observations. The observations are documented on an Active Treatment Observation</p>	09/16/2015

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	<p>Client #1's records were reviewed on 8/12/15 at 8:30 A.M. Review of the client's 4/19/14 Nutritional Assessment indicated the client was on a regular diet with single portions.</p> <p>Client #2's records were reviewed on 8/13/15 at 7:44 A.M. Review of the client's 4/19/14 Nutritional Assessment indicated the client was on a regular diet.</p> <p>Client #3's records were reviewed on 8/13/15 at 9:22 A.M. Review of the client's 4/20/14 Nutritional Assessment indicated the client was on a regular diet with single portions.</p> <p>Client #4's records were reviewed on 8/13/15 at 9:22 A.M. Review of the client's record indicated he was admitted to the facility on 7/20/15. Admission records indicated client #4 was currently on a regular diet.</p> <p>The facility's records were reviewed on 8/11/15 at 5:45 P.M. A review of the facility's menu for the 8/11/15 morning meal indicated clients #3 and #4 were to be offered the following regular diet menu items for breakfast: "juice of choice, hot or cold cereal, cinnamon toast, margarine, jelly, citrus sections, 1% milk, or beverage of choice.</p>		<p>form. Copies of the Active Treatment Observation forms will be given to the Area Director for review and follow up. To maintain quality assurance, the QIDP will observe client involvement in menu selections during the weekly site visits.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G479	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/17/2015
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	House Manager #1 was interviewed on 8/13/15 at 1:45 A.M. House Manager #1 stated, "Staff (direct care staff) should have at least offered the items on the menu to [clients #1, #2, #3 and #4]." 9-3-8(a)				