

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 06/22/2015
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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 the investigation of complaint #IN00175587.</p> <p>Complaint #IN00175587: Substantiated, Federal/state deficiencies related to the allegations are cited at W102, W104, W122, W149, W153, W154, W156, W157, W189 and W249.</p> <p>Dates of Survey: June 16, 17, 18, 19 and 22, 2015.</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.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, the Governing Body failed to meet the</p>	W 0102	W 102 483.410 GOVERNING BODY AND MANAGEMENT	07/22/2015

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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	<p>Condition of Participation: Governing Body for 2 of 2 sampled clients (clients A and B). The Governing Body neglected to prevent neglect by not developing and/or implementing systematic policies and protocols in regard to allegations of staff neglect of clients A and B resulting in their elopement from the home. The Governing Body neglected to ensure the facility conducted thorough investigations in regard to alleged staff neglect.</p> <p>Findings include:</p> <p>1. Please refer to W122: The Governing Body failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (clients A and B). The Governing Body neglected to implement its written policy and procedures to prevent alleged neglect of clients, which resulted in their elopement from the home. The Governing Body neglected to ensure the facility conducted thorough investigations in regard to alleged staff neglect. The Governing Body neglected to provide/ensure oversight in regard to ensuring proper staff supervision of clients.</p> <p>2. Please refer to W104. The Governing Body neglected to exercise general policy and operating direction over the facility</p>		<p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this CONDITION, and ensure Agency's abuse/neglect Policy is implemented at all times, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff have will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p>	

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	<p>for 2 of 2 sampled clients (clients A and B), in a manner to provide oversight to ensure their abuse and neglect policy was implemented. The facility's Governing Body neglected to immediately report allegations of client neglect and failed to report the results of investigative findings in a timely manner. The facility's Governing Body neglected to exercise general operating direction in a manner to put measures in place to prevent staff neglect which resulted in their elopement from the home. The facility's Governing Body neglected to provide oversight to ensure clients A and B were provided supervision to prevent elopement. The facility's Governing Body neglected to exercise general operating direction in a manner to provide oversight to ensure staff showed competency in their job duties in regard to immediately reporting incidents of neglect, documentation, implementing clients A and B's Behavior Support Plans (BSPs) as written to prevent neglect and neglected to take effective/sufficient corrective action to prevent neglect of clients A and B which resulted in elopement from the home.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-1(a)</p>		<p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p>		

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			<p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each</p>	

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			<p>Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will</p>	

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 2 sampled clients (clients A and B), the facility's Governing Body neglected to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented. The facility's Governing Body neglected to immediately report allegations of neglect and failed to report the results of investigative findings in a timely manner. The facility's Governing Body neglected to exercise general operating direction in a manner to put measures in place to prevent staff neglect which resulted in elopement from the	W 0104	promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served. Will be completed by: 7/22/15 Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist W 104 483.410(a)(1) GOVERNING BODY In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy is implemented at all times, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and	07/22/2015	

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	<p>home. The facility's Governing Body neglected to provide oversight to ensure staff provided proper supervision of clients A and B. The facility's Governing Body neglected to exercise general operating direction in a manner to provide oversight to ensure staff showed competency in their job duties in regard to immediately contacting law enforcement, immediately reporting allegations of abuse/neglect, documentation, implementing clients A and B's Behavior Support Plans (BSPs) as written to prevent neglect and neglected to take effective/sufficient corrective action to prevent neglect of clients A and B which resulted in elopement from the home.</p> <p>Findings include:</p> <p>Please refer to W149: The Governing Body neglected to exercise general operating direction over the facility for 2 of 2 sampled clients (clients A and B), by not ensuring implementation of its written policy and procedure to prevent neglect of clients. The Governing Body neglected to ensure clients A and B did not elope from the home. The Governing Body neglected to conduct thorough investigations in regard to allegations of neglect.</p>		<p>appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ol style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. <p>C. All nurses have been trained on</p>	

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	<p>Please refer to W153: The Governing Body neglected to exercise general operating direction over the facility by not reporting for 2 of 2 sampled clients (clients A and B), an allegation of staff neglect immediately to the administrator.</p> <p>Please refer to W154: The Governing Body neglected to exercise general operating direction over the facility for 2 of 2 sampled clients (clients A and B), to provide written evidence thorough investigations were conducted in regard to allegations of neglect.</p> <p>Please refer to W156: The Governing Body failed to exercise general operating direction over the facility by failing to report the results of 1 of 1 reviewed investigations of an allegation of staff neglect, involving 1 of 2 sampled clients (client A), to the administrator within five business days.</p> <p>Please refer to W157: The Governing Body neglected to exercise general operating direction over the facility for 2 of 2 sampled clients (clients A and B), to take sufficient/effective corrective measures in regard to preventing/addressing staff neglect by not ensuring oversight to ensure proper supervision of clients.</p>		<p>consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure</p>		

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	<p>Please refer to W189: The Governing Body neglected to exercise general operating direction over the facility for 2 of 2 sampled clients (clients A and B), to ensure all staff who worked with clients A and B were sufficiently trained to assure competence in regard to the clients' behavioral needs/plans.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-1(a)</p>		<p>Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient</p>	

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			<p>observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program</p>	

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W 0122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (clients A and B). The facility neglected to implement its written policy and procedure to prevent neglect of clients A and B, which resulted in elopement from the home.</p> <p>Findings include:</p> <p>1. Please refer to W149: The facility neglected for 2 of 2 sampled clients (clients A and B), to ensure implementation of its written policy and procedure to prevent neglect of clients. The facility neglected to ensure clients A and B did not elope from the home. The facility neglected to conduct thorough investigations in regard to allegations of neglect.</p> <p>2. Please refer to W153: The facility neglected to report for 2 of 2 sampled clients (clients A and B), an allegation of staff neglect immediately to the administrator.</p>	W 0122	<p>Director/QDDP, Nurse, and Behaviorist</p> <p>W 122 483.420 CLIENT PROTECTIONS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this CONDITION, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was</p>	07/22/2015

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	<p>3. Please refer to W154: The facility neglected for 2 of 2 sampled clients (clients A and B), to provide written evidence thorough investigations were conducted in regard to allegations of neglect.</p> <p>4. Please refer to W156: The facility failed to report the results of 1 of 1 reviewed investigations of an allegation of staff neglect, involving 1 of 2 sampled clients (client A), to the administrator within five business days.</p> <p>5. Please refer to W157: The facility neglected for 2 of 2 sampled clients (clients A and B), to take sufficient/effective corrective measures in regard to preventing/addressing staff neglect by not ensuring oversight to ensure proper supervision of clients.</p> <p>6. Please refer to W189: The facility neglected for 2 of 2 sampled clients (clients A and B), to ensure all staff who worked with clients A and B were sufficiently trained to assure competence in regard to the clients' behavioral needs/plans.</p> <p>This federal tag relates to complaint #IN00175587.</p>		<p>determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are</p>	

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	9-3-2(a)		<p>provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an</p>	

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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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			<p>individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff</p>	

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W 0149 Bldg. 00	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 for 2 of 2 sampled	W 0149	working in the home. - B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director. - C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served. Will be completed by: 7/22/15 Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist W 149 483.420(d)(1) STAFF	07/22/2015	

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	<p>clients (clients A and B), to implement its written policy and procedure to prevent neglect of clients. The facility neglected to ensure clients A and B were sufficiently monitored/supervised by staff. The facility neglected to prevent clients A and B from elopement. The facility neglected to conduct thorough investigations in regard to 2 of 2 allegations of staff neglect.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-Non completed investigation record dated 6/12/15 involving client A indicated:</p> <p>"Investigation Witness Statement" from [Group Home name] neighbor indicated: "Voice mail left on office phone on 6/12/15 at 7:18 P.M....'Hi [Area Director name] it's [Neighbor name]. I just wanted to leave you a message. I saw the, um, police report from what happened in our neighborhood this</p>		<p>TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and</p>	

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	<p>morning, um, and, much to my dismay, I'm not lovin' that that happened, but you also need to know that I went for a bike ride at 4:15 and I saw that girl out at 4:15, so, whatever the workers were doing or not doing, um, they, she was missing for an hour and a half before they realized she was gone. Um, just wanted to let you know. Call me back on my cell phone if you need to, the number is (phone number given). Thank you. Bye Bye.' Area Director (AD) called her back and she said it was sometime between 4:15 and 4:30 A.M. that she saw an African American girl who was very polite and friendly and said hello...and she didn't think much of it at the time. Then she was talking with her cousin who also lives in the area and thought about it again and decided to call AD to inform. AD asked her how she knew it was the missing girl and she said she didn't see her picture but figured it was probably her based on the description in the article. She said she remembers her wearing something like pink sweatpants. AD visited with [client A] on 6/16/15 and asked her what she was wearing when she left the home to go to her mother's and she showed AD some red pajama type pants with thin white stripes and a red shirt. AD forwarded article on [client A] to see if she could identify her from the picture. [Neighbor name] and</p>		<p>Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and</p>	

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	<p>her husband confirmed that was the girl they saw around 4:15 A.M.."</p> <p>"Investigation Witness Statement" dated 6/12/15 from [client A] and [Client A's mother] indicated: "AD went to [Mother's name]'s home to talk with her and [client A] and to bring [client A]'s medications. AD asked [client A] how she got to her mother's house. She explained in detail that she left out of her bedroom window around 4:30 A.M. and walked out of the subdivision, ending up walking down the road on 500 or 900. She said a man stopped and asked if she needed a ride and she accepted. She said the man was very nice and said he needed to pick somebody up. He drove to a nursing home and then transported her to the train station. She said he bought her a ticket and gave her \$5.00 cash and said, 'God bless you and good luck.' AD asked her if the man or the man he picked up at the nursing home did anything like touch her, or be mean to her, or do anything to her. She emphatically stated 'No', that they were very nice to her and never touched her. She stated when she arrived to the Gary train station, she used the \$5.00 the man gave her to get on the bus, which took her to the [Shopping Center]. She stated she was in the shopping center, near the eyeglasses (sic) store when she called her mom to come pick</p>		<p>on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p>	

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	<p>her up. The AD asked her what time she took the train, what time she arrived in Gary, and what time she called her mom, and she said she doesn't remember. The AD asked her how she know (sic) what train to take, what bus to get on and how to get to her mother's and she stated that, 'People helped me.' She stated she left her train ticket on the train. Her mother did not know for sure what time [client A] called her for a ride or what time she picked her up, that she already deleted the call on her phone. But she stated, that when the AD called her the first time, [client A] was in the car with her and they were driving, she had picked her up shortly before that time. AD discussed with [client A] how dangerous it was to accept a ride from a stranger and that we could arrange for her to have home visits, that she just needed to let us know she wants to visit and we would transport her, no problem....[Client A] 'pinky swore' with the AD stating she would never do anything like this again. She stated she never breaks her 'pinky swear'."</p> <p>-Attached newspaper article no date noted involving client A indicated: "[County/State Police department names] pull out stops to find woman missing from group home; later found safe. An intensive ground search was launched on</p>		<p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p>	

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	<p>Friday after a resident at a group home in [Township name] left through her bedroom window and walked away. The 21 year old woman was subsequently found safe at her mother's home in Gary. According to police, at 6 A.M. a worker at the [Facility name] at [Group Home address] discovered that the woman described as as 'endangered adult' was missing. Thirty minutes later she called 911 to report the fact. When asked why 'there was such a significant delay in calling the authorities,' the worker stated that 'the group home doesn't have a good working relationship with area agencies,' police said. Among other things, the missing woman has been diagnosed with mental retardation, ADHD (Attention Deficit Hyperactivity Disorder), mood disorder, asthma, fetal alcohol syndrome, polypharmacy with syncope (partial or complete loss of consciousness) and a history of self harming, police said. Investigators discovered that the woman, who at 4 A.M. had been pacing her room and asking for food, had managed to pry open her window, which should have sounded an alarm but did not '(though it worked when officers repeatedly checked),' police said. The [County/State Police department names] took the following steps: Provided public information officers with information and photographs, which were</p>		<p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>	

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	<p>disseminated to the media. Dispatched four detectives to the scene. Activated 'A Child Is Missing' alert. Mustered the [County Police] Search and Rescue Team, which put ATVs into field. Also mustered the [Township Volunteer Fire Department] to stand by. Called the [County Fire Department]'s K-9 unit to attempt a track, which was unsuccessful. Requested the assistance of the [County #2 Sheriff's Police] helicopter and the [State Police] Aviation Unit, both of which were unable to respond due to low cloud ceiling. Asked the [State Police] to check the [State] toll road, which runs just to the north of the group home. Conducted door to door canvas and checked local businesses without results. And brought to the scene the Department of Homeland Security's district mobile command center. The woman was later found to have hitched a ride from a passer-by to her mother's home in Gary, police said, and a Gary police officer sent to verify her well-being found her unhurt. The woman police added, is an emancipated adult absent a court order requiring her to remain at the group home."</p> <p>-BDDS report dated 6/12/15 involving client A indicated: "At approximately 6:00 A.M., staff called the Area Director (AD) to inform that [client A] was not in</p>			

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	<p>her room and staff could not locate her. AD instructed staff to immediately call 911. Police arrived and began an investigation to locate [client A]. At 10:00 A.M., AD and Police simultaneously discovered [client A] was with her mother in Gary, Indiana. Staff followed protocol and notified AD and then Police. It was determined [client A] left out of her front window sometime between 4:30 A.M. and 6:00 A.M.. Both overnight staff on duty at the time were suspended pending investigation. AD brought [client A] her medications and talked with her mother. [Client A] stated she wanted to visit for the weekend. Facility will pick up [client A] from her mother's on Monday, after IDT (Interdisciplinary Team) meeting at 10 A.M. when Team will discuss revising her supervision protocol to ensure this does not recur, to ensure [client A]'s health and safety. AD will continue to update on investigation." Review of the record failed to indicate this incident of alleged staff neglect of providing supervision was immediately reported to the administrator. Review of the record failed to indicate staff immediately reported client A missing to the police. Review of the record failed to indicate all staff who worked at the group home and all clients who reside at the group home were interviewed. Review of this record</p>			
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	<p>failed to indicate this investigation of alleged staff neglect was concluded, and the findings were reported to the administrator within 5 business days.</p> <p>A review of the police report dated 6/12/15 involving client A was conducted at the police department on 6/16/15 at 3:30 P.M.. Review of the police report indicated: "On June 12, 2015, at 6:34 A.M., Officers were dispatched to [Group Home address] in reference to a missing person complaint. Upon my arrival, I spoke with [Direct Support Professional (DSP) #13]. [DSP #13] advised that she's a worker at the [Facility name]. [DSP #13] advised [client A] walked away from the group home at approximately 5:45 A.M.. [DSP #13] advised that she fled from her bedroom window. The window has an alarm but [DSP #13] advised that the alarm didn't sound (though it worked when Officers repeatedly checked) but the window was clearly pried open. [DSP #13] advised that at approximately 4:00 A.M., [client A] was asking for food but was advised to wait for breakfast. [Client A] was 'pacing the floor' and told to go back to her room. [DSP #13] last saw [client A] at 5:45 A.M.. At approximately 6:00 A.M., [DSP #13] found that [client A] was missing. Thirty minutes later, she telephoned 911. When asked why there</p>			

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	<p>was such a significant delay in calling the authorities, [DSP #13] advised that the group home doesn't have a good working relationship with area agencies. [DSP #13] did call [AD name]. [DSP #13] was at the home with another [DSP #14] who stated she reported for work at 3:00 P.M. on 6/11/15. At 7:06 A.M., [DSP #15] reported for work. [DSP #17] reported for work at 6:30 P.M. on 6/11/15. [Client A] suffers from the following: Mental retardation, ADHD, mood disorder, asthma, environmental allergies, nocturnal enuresis, fetal alcohol syndrome, hypothyroidism, polypharmacy with sedation and syncope. [Client A] has a history of self harming involving cutting of the wrists and neck....[Client A] moved to the home May 26, 2015. Prior to that she was in a more secure group home called [Facility #3 name]. [Sergeant name] and [Corporal name] were requested to respond to the scene and were apprised of the situation upon their arrival. The home was checked again by [Officer name] as well as the surrounding area. Dispatch was provided the necessary information to enter [client A] as a missing person. [Detective name] was notified and responded to the scene along with [Detective #2] and [Detective #3]. [Public Information Officer] was notified and photographs of [client A] were</p>			
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	<p>provided to them. [Sergeant name] activated a Child is Missing (ACIM) and an administrative page was sent. The [County Search and Rescue Team] was activated. [County Fire Department's Search and Rescue] team attempted to track from [client A]'s window but showed no interest. [County #2 Sheriff's Department]'s helicopter (Helicopter name) was requested to assist but was unable to due to a low ceiling. The State Police Aviation Unit had the same limitations. All terrain vehicles checked the wooded areas and trails by the transmission lines nearby. The State Police Toll Road District was requested to check the Toll Road. [Fire Department] personnel arrived on-scene to assist. Officers checked the neighborhood door to door with negative results. Local businesses were checked by Officers. Patrol Officers checked the roadways in the immediate area and spoke with area residents with negative results. The Mobile Command Center for District Task Force was brought on scene as a command center....[Detective #1] telephoned [client A]'s mother. She advised that she picked [client A] up from the [Shopping Center] in Gary, Indiana. Gary PD was sent to the mother's residence to verify [client A]'s well being. [Client A] is an emancipated adult absent court order requiring her to</p>			

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	<p>remain at the group home."</p> <p>An interview with the AD was conducted on 6/17/15 at 2:15 P.M.. The AD indicated through his question and answering he discovered client A had been missing from the group home since 4:15 A.M.. The AD indicated although staff documented the last time seeing client A was at 5:45 A.M., client A had been missing since 4:15 A.M., verified by client A and the two neighbors who witnessed her walking. The AD indicated staff did not immediately call him to make him aware client A was missing, but called him around 6:00 A.M.. The AD indicated he asked if the staff had notified police and was informed they had not, and that is when he prompted the staff to notify police. The AD indicated the investigation to this incident has not been completed and the results have not been reported to the administrator as of 6/19/15. The AD indicated there was no documentation available for review to indicate all staff who work at the group home and all clients who reside at the group home were interviewed in regard to this incident. The AD indicated staff are now to keep client A in eyesight at all times, conduct 5 minute checks and keep her bedroom door open at all times including bedtime. When asked how the facility</p>			

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 06/22/2015
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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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	<p>was overseeing and ensuring staff were documenting and implementing client A's supervision, the AD indicated through reviewing of staff written documentation. When asked if there was written documentation to indicate the administration was overseeing and ensuring proper supervision, the AD indicated there was not any documentation to indicate so. The AD indicated once the investigation is concluded a determination will be made whether DSP #13 will be terminated for failure to provide proper supervision, not immediately reporting to the administrator, failure to immediately notify police of a missing person and not properly documenting bedchecks.</p> <p>A group home observation was conducted on 6/17/15 from 3:15 P.M. until 4:15 P.M.. At 3:45 P.M., DSP #3 was asked to open client A's bedroom window. DSP #3 retrieved a window crank from the staff office and opened client A's bedroom window. The window alarm could not be heard in client A's bedroom or the living room area outside of client A's bedroom. This surveyor walked to the alarm keypad located in the open dining area and could hear a faint alarm sound coming from the alarm keypad located next to the exit door in the open dining area.</p>			

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 06/22/2015
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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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	<p>A review of client A's record was conducted on 6/19/15 at 11:30 A.M.. Review of client A's Behavioral Support Plan (BSP) dated 5/20/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Inappropriate Sexual Behavior...Stealing...Elopement:</p> <p>Self-Injurious Behavior: Using silverware to harm herself, swallowing inedible objects (screws), using her fingers to dig into a previous wound from an SIB episode. According to staff, [client A] is constantly on the lookout for objects to harm herself. This happens 4 times per month and is severe in nature. [Client A] has gone to the ER (Emergency Room) due to lacerations on her arms and neck which have led to the use of steri-strips and stitches. She has also had surgery to remove item(s) that she swallowed. The duration of the behavior is currently unknown.</p> <p>Physical Aggression: Towards staff and peers. [Client A] will punch people and rip their shirts. [Client A] will verbally threaten staff and peers.</p>			

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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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	<p>Inappropriate Sexual Behavior: Exposing herself to peer, blocking a peer from moving so she can have physical contact (for example kissing) with them, sneaking into a peer's room to engage in sexual activity with them (whether or not the peer wants to). This happens approximately 2 times per month and is severe in nature as this could lead to being charged for sexual assault.</p> <p>Stealing: Taking items that are not hers.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>5....f. Elopement: Intervention Steps: ...If [client A] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI (crisis intervention) technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming,</p>			

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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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	<p>talking as if she is upset about something or someone.</p> <p>g. If staff is following [client A] and loses sight of her, they should call local law enforcement. The individual's full first name, last name, as well as middle initial, a physical description, (e.g. color and/or type of clothing last seen in, color of hair and eyes, height and weight, etc.), and the group home address should be communicated to the police....</p> <p>BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's</p>			
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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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	<p>momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the</p>			

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 06/22/2015
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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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	<p>person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>"FOLLOW-UP:</p> <p>All of [client A]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client A]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client A]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>An interview with the AD was conducted on 6/19/15 at 1:15 P.M.. The AD</p>			

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 06/22/2015
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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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	<p>indicated the alarm system needed a louder speaker so staff can hear the alarm sounding if client A opens her room window and also the alarm will now stay constantly on as opposed to only alarming for a brief period of time.</p> <p>2. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/10/15 involving client B indicated: "On 6/10/15 at approximately 4:30 P.M., [client B] had expressed concern that she felt that she was not being watched well enough. Her designated 1 on 1 staff reassured her that they were there and concerned about her safety. [Client B] appeared to have calmed down and then she went to the office and asked another staff if she could have sugar for her rice. The staff advised her that she is pre-diabetic and offered her splenda because staff was under the impression that there was no sugar in the house. [Client B] became upset and walked outside. Staff followed and encouraged [client B] to talk to staff. She expressed her feelings and had seemed to</p>			
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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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	<p>calm down again. Staff directed [client B] to the office to take her 4 o clock meds. After taking her meds, she ran out of the office and ran out the front door with staff following right behind her. Staff called the house who sent another staff to assist in prompting [client B] back to her home. [Client B] walked very quickly and continued to the sub-division entrance ending up on the main road. [Client B] threatened both staff with rocks and sticks and threw them hitting one staff in the leg with a rock. She began walking down the middle of the road and when a car passed very close to her, staff called the police for assistance, to ensure [client B]'s health and safety. The police said there was nothing they could do. A 3rd staff and housemate were on their way back from an appointment, stopped to assist, and housemate talked with [client B] and she calmed down and walked back to the house with her while staff followed. Staff followed protocol to ensure [client B]'s health and safety and notified the supervisor promptly. [Client B]'s IDT will review this incident to determine if there is anything that can be revised in her plan/protocol to prevent a future occurrence, and revise the plan if necessary. [Client B]'s IDT will continue to monitor the effectiveness of her plan and do everything possible to ensure her</p>			

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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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(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>health and safety until a more appropriate placement is secured for her to ensure her health and safety." Review of the report failed to indicate an investigation was conducted in regard to this incident. No documentation was available to indicate why client B felt she was not being supervised appropriately. The report failed to indicate staff followed client B's BSP in regard to implementing a two person hold to prevent her from exiting out of the house and into the busy road located a distance from the home.</p> <p>A review of client B's record was conducted on 6/19/15 at 12:00 P.M.. Review of client B's Behavioral Support Plan (BSP) dated 2/23/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and</p>			

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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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(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>scratching her lower forearms and face to the point of skin breakdown. [Client B] has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>3. Elopement: Intervention Steps: ...If [client B] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>Proactive Strategies:</p> <p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home</p>			

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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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(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>from any community outing. This strategy was discussed at a team meeting and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p> <p>...Staff should always be mindful of observing [client B]'s affect for moods that correlate with this target behavior....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on</p>			

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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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(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>to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p>			

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 06/22/2015
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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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(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>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p>			

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 06/22/2015
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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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	A review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14 was conducted at the facility's administrative office on 6/17/15 at 2:30 P.M. and indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals' (sic) served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...Neglect is			

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 06/22/2015
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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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	<p>defined as failure to provide appropriate care, supervision, or training, failure to provide food and medical services as needed, failure to provide a safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)...The Supervisor, or Program Coordinator/Senior Director, or his/her delegate will conduct a thorough investigation of the reported incident. The investigation will include the following:</p> <ol style="list-style-type: none"> 1. Review of witnesses. 2. Any evidence or previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the charge." <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 6/19/15 at 1:15 P.M.. The AD indicated all clients should be free of abuse and neglect. The AD indicated thorough investigations should be completed in regard to all incidents of abuse and/or neglect. The AD indicated all incidents of abuse and/or neglect should be immediately reported to the administrator and within 24 hours to BDDS. When asked if any corrective measures were put in place by the IDT to</p>			

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 06/22/2015
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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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	<p>prevent recurrence, the AD indicated staff implemented the clients' BSPs as written and will continue to follow them as written. When asked if a two person wrist hold should be implemented to prevent client B from eloping into the busy road, the AD indicated staff should implement her BSP as written. When asked if there was any written documentation to indicate an investigation was conducted in regard to the documented incident and client B's concern of staff not properly supervising her, the AD indicated there was not documentation to indicate an investigation had been conducted.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-2(a)</p>			

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 06/22/2015
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W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>Based on record review and interview for 1 of 2 allegations of neglect, the facility failed for 1 of 2 sampled clients (client A), to report allegations of staff neglect immediately to the administrator in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 6/17/15 at 1:15 P.M..</p> <p>Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-Non completed investigation record dated 6/12/15 involving client A indicated:</p> <p>"Investigation Witness Statement" from [Group Home name] neighbor indicated: "Voice mail left on office phone on</p>	W 0153	<p>W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p>	07/22/2015

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 06/22/2015
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	6/12/15 at 7:18 P.M....'Hi [Area Director name] it's [Neighbor name]. I just wanted to leave you a message. I saw the, um, police report from what happened in our neighborhood this morning, um, and, much to my dismay, I'm not lovin' that that happened, but you also need to know that I went for a bike ride at 4:15 and I saw that girl out at 4:15, so, whatever the workers were doing or not doing, um, they, she was missing for an hour and a half before they realized she was gone. Um, just wanted to let you know. Call me back on my cell phone if you need to, the number is (phone number given). Thank you. Bye Bye.' Area Director (AD) called her back and she said it was sometime between 4:15 and 4:30 A.M. that she saw an African American girl who was very polite and friendly and said hello...and she didn't think much of it at the time. Then she was talking with her cousin who also lives in the area and thought about it again and decided to call AD to inform. AD asked her how she knew it was the missing girl and she said she didn't see her picture but figured it was probably her based on the description in the article. She said she remembers her wearing something like pink sweatpants. AD visited with [client A] on 6/16/15 and asked her what she was wearing when she left the home to go to her		<p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ul style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p>	

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	<p>mother's and she showed AD some red pajama type pants with thin white stripes and a red shirt. AD forwarded article on [client A] to see if she could identify her from the picture. [Neighbor name] and her husband confirmed that was the girl they saw around 4:15 A.M.."</p> <p>"Investigation Witness Statement" dated 6/12/15 from [client A] and [Client A's mother] indicated: "AD went to [Mother's name]'s home to talk with her and [client A] and to bring [client A]'s medications. AD asked [client A] how she got to her mother's house. She explained in detail that she left out of her bedroom window around 4:30 A.M. and walked out of the subdivision, ending up walking down the road on 500 or 900. She said a man stopped and asked if she needed a ride and she accepted. She said the man was very nice and said he needed to pick somebody up. He drove to a nursing home and then transported her to the train station. She said he bought her a ticket and gave her \$5.00 cash and said, 'God bless you and good luck.' AD asked her if the man or the man he picked up at the nursing home did anything like touch her, or be mean to her, or do anything to her. She emphatically stated 'No', that they were very nice to her and never touched her. She stated when she arrived to the Gary train station, she used the</p>		<p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently</p>	

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 06/22/2015
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	<p>\$5.00 the man gave her to get on the bus, which took her to the [Shopping Center]. She stated she was in the shopping center, near the eyeglasses (sic) store when she called her mom to come pick her up. The AD asked her what time she took the train, what time she arrived in Gary, and what time she called her mom, and she said she doesn't remember. The AD asked her how she know (sic) what train to take, what bus to get on and how to get to her mother's and she stated that, 'People helped me.' She stated she left her train ticket on the train. Her mother did not know for sure what time [client A] called her for a ride of what time she picked her up, that she already deleted the call on her phone. But she stated, that when the AD called her the first time, [client A] was in the car with her and they were driving, she had picked her up shortly before that time. AD discussed with [client A] how dangerous it was to accept a ride from a stranger and that we could arrange for her to have home visits, that she just needed to let us know she wants to visit and we would transport her, no problem....[Client A] 'pinky swore' with the AD stating she would never do anything like this again. She stated she never breaks her 'pinky swear'."</p> <p>-BDDS report dated 6/12/15 involving</p>		<p>provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program</p>	

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	<p>client A indicated: "At approximately 6:00 A.M., staff called the Area Director (AD) to inform that [client A] was not in her room and staff could not locate her. AD instructed staff to immediately call 911. Police arrived and began an investigation to locate [client A]. At 10:00 A.M., AD and Police simultaneously discovered [client A] was with her mother in Gary, Indiana. Staff followed protocol and notified AD and then Police. It was determined [client A] left out of her front window sometime between 4:30 A.M. and 6:00 A.M.. Both overnight on duty at the time were suspended pending investigation. AD brought [client A] her medications and talked with her mother. [Client A] stated she wanted to visit for the weekend. Facility will pick up [client A] from her mother's on Monday, after IDT (Interdisciplinary Team) meeting at 10 A.M. when Team will discuss revising her supervision protocol to ensure this does not recur, to ensure [client A]'s health and safety. AD will continue to update on investigation." Review of the record failed to indicate this incident of alleged staff neglect of providing supervision was immediately reported to the administrator.</p> <p>An interview with the Area Director/Qualified Intellectual</p>		<p>Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>				

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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 0154 Bldg. 00	<p>Disabilities Professional (AD/QIDP) was conducted on 6/19/15 at 1:15 P.M.. The AD indicated through his question and answering he discovered client A had been missing from the group home since 4:15 A.M.. The AD indicated although staff documented the last time seeing client A was at 5:45 A.M., client A had been missing since 4:15 A.M., verified by client A and the two neighbors who witnessed her walking. The AD/QIDP indicated the staff should have immediately reported the allegation of staff neglect to the administrator. The AD/QIDP further indicated the staff did not immediately report the allegation of staff neglect to him.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for</p>	W 0154		07/22/2015			

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 06/22/2015
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	<p>2 of 2 allegations of neglect, the facility for 2 of 2 sampled clients (clients A and B), to provide written evidence thorough investigations were conducted in regard to neglect.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-Non completed investigation record dated 6/12/15 involving client A indicated:</p> <p>"Investigation Witness Statement" from [Group Home name] neighbor indicated: "Voice mail left on office phone on 6/12/15 at 7:18 P.M....'Hi [Area Director name] it's [Neighbor name]. I just wanted to leave you a message. I saw the, um, police report from what happened in our neighborhood this morning, um, and, much to my dismay, I'm not lovin' that that happened, but you also need to know that I went for a bike ride at 4:15 and I saw that girl out at 4:15, so, whatever the workers were</p>		<p>W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p>	

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	<p>doing or not doing, um, they, she was missing for an hour and a half before they realized she was gone. Um, just wanted to let you know. Call me back on my cell phone if you need to, the number is (phone number given). Thank you. Bye Bye.' Area Director (AD) called her back and she said it was sometime between 4:15 and 4:30 A.M. that she saw an African American girl who was very polite and friendly and said hello...and she didn't think much of it at the time. Then she was talking with her cousin who also lives in the area and thought about it again and decided to call AD to inform. AD asked her how she knew it was the missing girl and she said she didn't see her picture but figured it was probably her based on the description in the article. She said she remembers her wearing something like pink sweatpants. AD visited with [client A] on 6/16/15 and asked her what she was wearing when she left the home to go to her mother's and she showed AD some red pajama type pants with thin white stripes and a red shirt. AD forwarded article on [client A] to see if she could identify her from the picture. [Neighbor name] and her husband confirmed that was the girl they saw around 4:15 A.M.."</p> <p>"Investigation Witness Statement" dated 6/12/15 from [client A] and [Client A's</p>		<p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation</p>	

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 06/22/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	mother] indicated: "AD went to [Mother's name]'s home to talk with her and [client A] and to bring [client A]'s medications. AD asked [client A] how she got to her mother's house. She explained in detail that she left out of her bedroom window around 4:30 A.M. and walked out of the subdivision, ending up walking down the road on 500 or 900. She said a man stopped and asked if she needed a ride and she accepted. She said the man was very nice and said he needed to pick somebody up. He drove to a nursing home and then transported her to the train station. She said he bought her a ticket and gave her \$5.00 cash and said, 'God bless you and good luck.' AD asked her if the man or the man he picked up at the nursing home did anything like touch her, or be mean to her, or do anything to her. She emphatically stated 'No', that they were very nice to her and never touched her. She stated when she arrived to the Gary train station, she used the \$5.00 the man gave her to get on the bus, which took her to the [Shopping Center]. She stated she was in the shopping center, near the eyeglasses (sic) store when she called her mom to come pick her up. The AD asked her what time she took the train, what time she arrived in Gary, and what time she called her mom, and she said she doesn't remember. The AD asked her how she know (sic) what		and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect. A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.				

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 06/22/2015
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	<p>train to take, what bus to get on and how to get to her mother's and she stated that, 'People helped me.' She stated she left her train ticket on the train. Her mother did not know for sure what time [client A] called her for a ride or what time she picked her up, that she already deleted the call on her phone. But she stated, that when the AD called her the first time, [client A] was in the car with her and they were driving, she had picked her up shortly before that time. AD discussed with [client A] how dangerous it was to accept a ride from a stranger and that we could arrange for her to have home visits, that she just needed to let us know she wants to visit and we would transport her, no problem....[Client A] 'pinky swore' with the AD stating she would never do anything like this again. She stated she never breaks her 'pinky swear'."</p> <p>-Attached newspaper article no date noted involving client A indicated: "[County/State Police department names] pull out stops to find woman missing from group home; later found safe. An intensive ground search was launched on Friday after a resident at a group home in [Township name] left through her bedroom window and walked away. The 21 year old woman was subsequently found safe at her mother's home in Gary.</p>		<p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the</p>	

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	<p>According to police, at 6 A.M. a worker at the [Facility name] at [Group Home address] discovered that the woman described as as 'endangered adult' was missing. Thirty minutes later she called 911 to report the fact. When asked why 'there was such a significant delay in calling the authorities,' the worker stated that 'the group home doesn't have a good working relationship with area agencies,' police said. Among other things, the missing woman has been diagnosed with mental retardation, ADHD (Attention Deficit Hyperactivity Disorder), mood disorder, asthma, fetal alcohol syndrome, polypharmacy with syncope (partial or complete loss of consciousness) and a history of self harming, police said. Investigators discovered that the woman, who at 4 A.M. had been pacing her room and asking for food, had managed to pry open her window, which should have sounded an alarm but did not '(though it worked when officers repeatedly checked),' police said. The [County/State Police department names] took the following steps: Provided public information officers with information and photographs, which were disseminated to the media. Dispatched four detectives to the scene. Activated 'A Child Is Missing ' alert. Mustered the [County Police] Search and Rescue Team, which put ATVs into field. Also</p>		<p>Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>		

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	<p>mustered the [Township Volunteer Fire Department] to stand by. Called the [County Fire Department]'s K-9 unit to attempt a track, which was unsuccessful. Requested the assistance of the [County #2 Sheriff's Police] helicopter and the [State Police] Aviation Unit, both of which were unable to respond due to low cloud ceiling. Asked the [State Police] to check the [State] toll road, which runs just to the north of the group home. Conducted door to door canvas and checked local businesses without results. And brought to the scene the Department of Homeland Security's district mobile command center. The woman was later found to have hitched a ride from a passer-by to her mother's home in Gary, police said, and a Gary police officer sent to verify her well-being found her unhurt. The woman police added, is an emancipated adult absent a court order requiring her to remain at the group home."</p> <p>-BDDS report dated 6/12/15 involving client A indicated: "At approximately 6:00 A.M., staff called the Area Director (AD) to inform that [client A] was not in her room and staff could not locate her. AD instructed staff to immediately call 911. Police arrived and began an investigation to locate [client A]. At 10:00 A.M., AD and Police</p>						

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	<p>simultaneously discovered [client A] was with her mother in Gary, Indiana. Staff followed protocol and notified AD and then Police. It was determined [client A] left out of her front window sometime between 4:30 A.M. and 6:00 A.M.. Both overnight staff on duty at the time were suspended pending investigation. AD brought [client A] her medications and talked with her mother. [Client A] stated she wanted to visit for the weekend. Facility will pick up [client A] from her mother's on Monday, after IDT (Interdisciplinary Team) meeting at 10 A.M. when Team will discuss revising her supervision protocol to ensure this does not recur, to ensure [client A]'s health and safety. AD will continue to update on investigation." Review of the record failed to indicate all staff who worked at the group home and all clients who reside at the group home were interviewed.</p> <p>A review of the police report dated 6/12/15 involving client A was conducted at the police department on 6/16/15 at 3:30 P.M.. Review of the police report indicated: "On June 12, 2015, at 6:34 A.M., Officers were dispatched to [Group Home address] in reference to a missing person complaint. Upon my arrival, I spoke with [Direct Support Professional (DSP) #13]. [DSP #13] advised that</p>						

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	<p>she's a worker at the [Facility name]. [DSP #13] advised [client A] walked away from the group home at approximately 5:45 A.M.. [DSP #13] advised that she fled from her bedroom window. The window has an alarm but [DSP #13] advised that the alarm didn't sound (though it worked when Officers repeatedly checked) but the window was clearly pried open. [DSP #13] advised that at approximately 4:00 A.M., [client A] was asking for food but was advised to wait for breakfast. [Client A] was 'pacing the floor' and told to go back to her room. [DSP #13] last saw [client A] at 5:45 A.M.. At approximately 6:00 A.M., [DSP #13] found that [client A] was missing. Thirty minutes later, she telephoned 911. When asked why there was such a significant delay in calling the authorities, [DSP #13] advised that the group home doesn't have a good working relationship with area agencies. [DSP #13] did call [AD name]. [DSP #13] was at the home with another [DSP #14] who stated she reported for work at 3:00 P.M. on 6/11/15. At 7:06 A.M., [DSP #15] reported for work. [DSP #17] reported for work at 6:30 P.M. on 6/11/15.</p> <p>[Client A] suffers from the following: Mental retardation, ADHD, mood disorder, asthma, environmental allergies, nocturnal enuresis, fetal alcohol syndrome, hypothyroidism,</p>			

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	<p>polypharmacy with sedation and syncope. [Client A] has a history of self harming involving cutting of the wrists and neck....[Client A] moved to the home May 26, 2015. Prior to that she was in a more secure group home called [Facility #3 name]. [Sergeant name] and [Corporal name] were requested to respond to the scene and were apprised of the situation upon their arrival. The home was checked again by [Officer name] as well as the surrounding area. Dispatch was provided the necessary information to enter [client A] as a missing person. [Detective name] was notified and responded to the scene along with [Detective #2] and [Detective #3]. [Public Information Officer] was notified and photographs of [client A] were provided to them. [Sergeant name] activated a Child is Missing (ACIM) and an administrative page was sent. The [County Search and Rescue Team] was activated. [County Fire Department's Search and Rescue] team attempted to track from [client A]'s window but showed no interest. [County #2 Sheriff's Department]'s helicopter (Helicopter name) was requested to assist but was unable to due to a low ceiling. The State Police Aviation Unit had the same limitations. All terrain vehicles checked the wooded areas and trails by the transmission lines nearby. The State</p>			
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	<p>Police Toll Road District was requested to check the Toll Road. [Fire Department] personnel arrived on-scene to assist. Officers checked the neighborhood door to door with negative results. Local businesses were checked by Officers. Patrol Officers checked the roadways in the immediate area and spoke with area residents with negative results. The Mobile Command Center for District Task Force was brought on scene as a command center....[Detective #1] telephoned [client A]'s mother. She advised that she picked [client A] up from the [Shopping Center] in Gary, Indiana. Gary PD was sent to the mother's residence to verify [client A]'s well being. [Client A] is an emancipated adult absent court order requiring her to remain at the group home."</p> <p>An interview with the AD was conducted on 6/17/15 at 2:15 P.M.. The AD indicated all incidents of neglect are to be thoroughly investigated. The AD indicated all staff who work at the group home and all clients who reside at the group home were not interviewed. The AD indicated once the investigation is concluded a determination will be made whether DSP #13 will be terminated.</p> <p>A review of the facility's records was conducted on 6/17/15 at 1:15 P.M..</p>			

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	<p>Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/10/15 involving client B indicated: "On 6/10/15 at approximately 4:30 P.M., [client B] had expressed concern that she felt that she was not being watched well enough. Her designated 1 on 1 staff reassured her that they were there and concerned about her safety. [Client B] appeared to have calmed down and then she went to the office and asked another staff if she could have sugar for her rice. The staff advised her that she is pre-diabetic and offered her splenda because staff was under the impression that there was no sugar in the house. [Client B] became upset and walked outside. Staff followed and encouraged [client B] to talk to staff. She expressed her feelings and had seemed to calm down again. Staff directed [client B] to the office to take her 4 o clock meds. After taking her meds, she ran out of the office and ran out the front door with staff following right behind her. Staff called the house who sent another staff to assist in prompting [client B] back to her home. [Client B] walked very quickly and continued to the</p>						

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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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	<p>sub-division entrance ending up on the main road. [Client B] threatened both staff with rocks and sticks and threw them hitting one staff in the leg with a rock. She began walking down the middle of the road and when a car passed very close to her, staff called the police for assistance, to ensure [client B]'s health and safety. The police said there was nothing they could do. A 3rd staff and housemate were on their way back from an appointment, stopped to assist, and housemate talked with [client B] and she calmed down and walked back to the house with her while staff followed. Staff followed protocol to ensure [client B]'s health and safety and notified the supervisor promptly. [Client B]'s IDT will review this incident to determine if there is anything that can be revised in her plan/protocol to prevent a future occurrence, and revise the plan if necessary. [Client B]'s IDT will continue to monitor the effectiveness of her plan and do everything possible to ensure her health and safety until a more appropriate placement is secured for her to ensure her health and safety." Review of the report failed to indicate an investigation was conducted in regard to this incident. No documentation was available to indicate why client B felt she was being supervised appropriately. The report failed to indicate staff followed client B's</p>			

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W 0156 Bldg. 00	<p>BSP in regard to implementing a two person hold to prevent her from exiting out of the house and into the busy road located a distance from the home.</p> <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 6/19/15 at 1:15 P.M.. When asked if there was any written documentation to indicate an investigation was conducted in regard to the documented allegation of neglect and client B's concern of staff not properly supervising her, the AD indicated there was no documentation to indicate an investigation had been conducted.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-2(a)</p> <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</p>				

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	<p>working days of the incident.</p> <p>Based on record review and interview, the facility failed to report the results of 1 of 1 reviewed investigation of an allegation of staff neglect, involving 1 of 2 sampled clients (client A), to the administrator within five business days.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-Non completed investigation record dated 6/12/15 involving client A indicated:</p> <p>"Investigation Witness Statement" from [Group Home name] neighbor indicated: "Voice mail left on office phone on 6/12/15 at 7:18 P.M....'Hi [Area Director name] it's [Neighbor name]. I just wanted to leave you a message. I saw the, um, police report from what happened in our neighborhood this morning, um, and, much to my dismay, I'm not lovin' that that happened, but you also need to know that I went for a bike</p>	W 0156	<p>W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p>	07/22/2015			

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	ride at 4:15 and I saw that girl out at 4:15, so, whatever the workers were doing or not doing, um, they, she was missing for an hour and a half before they realized she was gone. Um, just wanted to let you know. Call me back on my cell phone if you need to, the number is (phone number given). Thank you. Bye Bye.' Area Director (AD) called her back and she said it was sometime between 4:15 and 4:30 A.M. that she saw an African American girl who was very polite and friendly and said hello...and she didn't think much of it at the time. Then she was talking with her cousin who also lives in the area and thought about it again and decided to call AD to inform. AD asked her how she knew it was the missing girl and she said she didn't see her picture but figured it was probably her based on the description in the article. She said she remembers her wearing something like pink sweatpants. AD visited with [client A] on 6/16/15 and asked her what she was wearing when she left the home to go to her mother's and she showed AD some red pajama type pants with thin white stripes and a red shirt. AD forwarded article on [client A] to see if she could identify her from the picture. [Neighbor name] and her husband confirmed that was the girl they saw around 4:15 A.M.."		<p>B. All current and new staff will be retrained on the following:</p> <ul style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly</p>	

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	"Investigation Witness Statement" dated 6/12/15 from [client A] and [Client A's mother] indicated: "AD went to [Mother's name]'s home to talk with her and [client A] and to bring [client A]'s medications. AD asked [client A] how she got to her mother's house. She explained in detail that she left out of her bedroom window around 4:30 A.M. and walked out of the subdivision, ending up walking down the road on 500 or 900. She said a man stopped and asked if she needed a ride and she accepted. She said the man was very nice and said he needed to pick somebody up. He drove to a nursing home and then transported her to the train station. She said he bought her a ticket and gave her \$5.00 cash and said, 'God bless you and good luck.' AD asked her if the man or the man he picked up at the nursing home did anything like touch her, or be mean to her, or do anything to her. She emphatically stated 'No', that they were very nice to her and never touched her. She stated when she arrived to the Gary train station, she used the \$5.00 the man gave her to get on the bus, which took her to the [Shopping Center]. She stated she was in the shopping center, near the eyeglasses (sic) store when she called her mom to come pick her up. The AD asker her what time she took the train, what time she arrived in Gary, and what time she called her mom,		train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect. A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.	

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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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	<p>and she said she doesn't remember. The AD asked her how she know (sic) what train to take, what bus to get on and how to get to her mother's and she stated that, 'People helped me.' She stated she left her train ticket on the train. Her mother did not know for sure what time [client A] called her for a ride of what time she picked her up, that she already deleted the call on her phone. But she stated, that when the AD called her the first time, [client A] was in the car with her and they were driving, she had picked her up shortly before that time. AD discussed with [client A] how dangerous it was to accept a ride from a stranger and that we could arrange for her to have home visits, that she just needed to let us know she wants to visit and we would transport her, no problem....[Client A] 'pinky swore' with the AD stating she would never do anything like this again. She stated she never breaks her 'pinky swear'."</p> <p>-BDDS report dated 6/12/15 involving client A indicated: "At approximately 6:00 A.M., staff called the Area Director (AD) to inform that [client A] was not in her room and staff could not locate her. AD instructed staff to immediately call 911. Police arrived and began an investigation to locate [client A]. At 10:00 A.M., AD and Police</p>		<p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues,</p>	

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 06/22/2015
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>simultaneously discovered [client A] was with her mother in Gary, Indiana. Staff followed protocol and notified AD and then Police. It was determined [client A] left out of her front window sometime between 4:30 A.M. and 6:00 A.M.. Both overnight on duty at the time were suspended pending investigation. AD brought [client A] her medications and talked with her mother. [Client A] stated she wanted to visit for the weekend. Facility will pick up [client A] from her mother's on Monday, after IDT (Interdisciplinary Team) meeting at 10 A.M. when Team will discuss revising her supervision protocol to ensure this does not recur, to ensure [client A]'s health and safety. AD will continue to update on investigation." Review of this record failed to indicate this investigation of alleged staff neglect was concluded, and the findings were reported to the administrator within 5 business days.</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 6/19/15 at 1:15 P.M.. The AD/QIDP indicated the results of the investigations should have been reported to the administrator within 5 business days. The AD/QIDP further indicated the results of the investigation were not reported to the administrator within 5</p>		<p>concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>		

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 06/22/2015
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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 0157 Bldg. 00	<p>business days.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review and interview for 2 of 2 allegations of neglect, the facility failed for 2 of 2 sampled clients (clients A and B), to take sufficient/effective corrective measures in regard to preventing/addressing staff neglect by not ensuring oversight to ensure proper supervision of clients.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation</p>	W 0157	<p>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough</p>	07/22/2015

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 06/22/2015
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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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	<p>record indicated:</p> <p>-Non completed investigation record dated 6/12/15 involving client A indicated:</p> <p>"Investigation Witness Statement" from [Group Home name] neighbor indicated: "Voice mail left on office phone on 6/12/15 at 7:18 P.M....'Hi [Area Director name] it's [Neighbor name]. I just wanted to leave you a message. I saw the, um, police report from what happened in our neighborhood this morning, um, and, much to my dismay, I'm not lovin' that that happened, but you also need to know that I went for a bike ride at 4:15 and I saw that girl out at 4:15, so, whatever the workers were doing or not doing, um, they, she was missing for an hour and a half before they realized she was gone. Um, just wanted to let you know. Call me back on my cell phone if you need to, the number is (phone number given). Thank you. Bye Bye.' Area Director (AD) called her back and she said it was sometime between 4:15 and 4:30 A.M. that she saw an African American girl who was very polite and friendly and said hello...and she didn't think much of it at the time. Then she was talking with her cousin who also lives in the area and thought about it again and decided to call AD to</p>		<p>investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or</p>	

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	<p>inform. AD asked her how she knew it was the missing girl and she said she didn't see her picture but figured it was probably her based on the description in the article. She said she remembers her wearing something like pink sweatpants. AD visited with [client A] on 6/16/15 and asked her what she was wearing when she left the home to go to her mother's and she showed AD some red pajama type pants with thin white stripes and a red shirt. AD forwarded article on [client A] to see if she could identify her from the picture. [Neighbor name] and her husband confirmed that was the girl they saw around 4:15 A.M.."</p> <p>"Investigation Witness Statement" dated 6/12/15 from [client A] and [Client A's mother] indicated: "AD went to [Mother's name]'s home to talk with her and [client A] and to bring [client A]'s medications. AD asked [client A] how she got to her mother's house. She explained in detail that she left out of her bedroom window around 4:30 A.M. and walked out of the subdivision, ending up walking down the road on 500 or 900. She said a man stopped and asked if she needed a ride and she accepted. She said the man was very nice and said he needed to pick somebody up. He drove to a nursing home and then transported her to the train station. She said he bought her a</p>		<p>allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral</p>	

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	<p>ticket and gave her \$5.00 cash and said, 'God bless you and good luck.' AD asked her if the man or the man he picked up at the nursing home did anything like touch her, or be mean to her, or do anything to her. She emphatically stated 'No', that they were very nice to her and never touched her. She stated when she arrived to the Gary train station, she used the \$5.00 the man gave her to get on the bus, which took her to the [Shopping Center]. She stated she was in the shopping center, near the eyeglasses (sic) store when she called her mom to come pick her up. The AD asked her what time she took the train, what time she arrived in Gary, and what time she called her mom, and she said she doesn't remember. The AD asked her how she know (sic) what train to take, what bus to get on and how to get to her mother's and she stated that, 'People helped me.' She stated she left her train ticket on the train. Her mother did not know for sure what time [client A] called her for a ride or what time she picked her up, that she already deleted the call on her phone. But she stated, that when the AD called her the first time, [client A] was in the car with her and they were driving, she had picked her up shortly before that time. AD discussed with [client A] how dangerous it was to accept a ride from a stranger and that we could arrange for her to have home visits,</p>		<p>services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p>	

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 06/22/2015
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	<p>that she just needed to let us know she wants to visit and we would transport her, no problem....[Client A] 'pinky swore' with the AD stating she would never do anything like this again. She stated she never breaks her 'pinky swear'."</p> <p>-Attached newspaper article no date noted involving client A indicated: "[County/State Police department names] pull out stops to find woman missing from group home; later found safe. An intensive ground search was launched on Friday after a resident at a group home in [Township name] left through her bedroom window and walked away. The 21 year old woman was subsequently found safe at her mother's home in Gary. According to police, at 6 A.M. a worker at the [Facility name] at [Group Home address] discovered that the woman described as as 'endangered adult' was missing. Thirty minutes later she called 911 to report the fact. When asked why 'there was such a significant delay in calling the authorities,' the worker stated that 'the group home doesn't have a good working relationship with area agencies,' police said. Among other things, the missing woman has been diagnosed with mental retardation, ADHD (Attention Deficit Hyperactivity Disorder), mood disorder, asthma, fetal alcohol syndrome,</p>		<p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>	

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	<p>polypharmacy with syncope (partial or complete loss of consciousness) and a history of self harming, police said. Investigators discovered that the woman, who at 4 A.M. had been pacing her room and asking for food, had managed to pry open her window, which should have sounded an alarm but did not '(though it worked when officers repeatedly checked),' police said. The [County/State Police department names] took the following steps: Provided public information officers with information and photographs, which were disseminated to the media. Dispatched four detectives to the scene. Activated 'A Child Is Missing ' alert. Mustered the [County Police] Search and Rescue Team, which put ATVs into field. Also mustered the [Township Volunteer Fire Department] to stand by. Called the [County Fire Department]'s K-9 unit to attempt a track, which was unsuccessful. Requested the assistance of the [County #2 Sheriff's Police] helicopter and the [State Police] Aviation Unit, both of which were unable to respond due to low cloud ceiling. Asked the [State Police] to check the [State] toll road, which runs just to the north of the group home. Conducted door to door canvas and checked local businesses without results. And brought to the scene the Department of Homeland Security's district mobile</p>			

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 06/22/2015	
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	<p>command center. The woman was later found to have hitched a ride from a passer-by to her mother's home in Gary, police said, and a Gary police officer sent to verify her well-being found her unhurt. The woman police added, is an emancipated adult absent a court order requiring her to remain at the group home."</p> <p>-BDDS report dated 6/12/15 involving client A indicated: "At approximately 6:00 A.M., staff called the Area Director (AD) to inform that [client A] was not in her room and staff could not locate her. AD instructed staff to immediately call 911. Police arrived and began an investigation to locate [client A]. At 10:00 A.M., AD and Police simultaneously discovered [client A] was with her mother in Gary, Indiana. Staff followed protocol and notified AD and then Police. It was determined [client A] left out of her front window sometime between 4:30 A.M. and 6:00 A.M.. Both overnight staff on duty at the time were suspended pending investigation. AD brought [client A] her medications and talked with her mother. [Client A] stated she wanted to visit for the weekend. Facility will pick up [client A] from her mother's on Monday, after IDT (Interdisciplinary Team) meeting at 10 A.M. when Team will discuss revising</p>						

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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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	<p>her supervision protocol to ensure this does not recur, to ensure [client A]'s health and safety. AD will continue to update on investigation." Review of the record failed to indicate this incident of alleged staff neglect of providing supervision was immediately reported to the administrator. Review of the record failed to indicate staff immediately reported client A missing to the police. Review of the record failed to indicate all staff who worked at the group home and all clients who reside at the group home were interviewed. Review of this record failed to indicate this investigation of alleged staff neglect was concluded, and the findings were reported to the administrator within 5 business days.</p> <p>A review of the police report dated 6/12/15 involving client A was conducted at the police department on 6/16/15 at 3:30 P.M.. Review of the police report indicated: "On June 12, 2015, at 6:34 A.M., Officers were dispatched to [Group Home address] in reference to a missing person complaint. Upon my arrival, I spoke with [Direct Support Professional (DSP) #13]. [DSP #13] advised that she's a worker at the [Facility name]. [DSP #13] advised [client A] walked away from the group home at approximately 5:45 A.M.. [DSP #13] advised that she fled from her bedroom</p>				

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	<p>window. The window has an alarm but [DSP #13] advised that the alarm didn't sound (though it worked when Officers repeatedly checked) but the window was clearly pried open. [DSP #13] advised that at approximately 4:00 A.M., [client A] was asking for food but was advised to wait for breakfast. [Client A] was 'pacing the floor' and told to go back to her room. [DSP #13] last saw [client A] at 5:45 A.M.. At approximately 6:00 A.M., [DSP #13] found that [client A] was missing. Thirty minutes later, she telephoned 911. When asked why there was such a significant delay in calling the authorities, [DSP #13] advised that the group home doesn't have a good working relationship with area agencies. [DSP #13] did call [AD name]. [DSP #13] was at the home with another [DSP #14] who stated she reported for work at 3:00 P.M. on 6/11/15. At 7:06 A.M., [DSP #15] reported for work. [DSP #17] reported for work at 6:30 P.M. on 6/11/15. [Client A] suffers from the following: Mental retardation, ADHD, mood disorder, asthma, environmental allergies, nocturnal enuresis, fetal alcohol syndrome, hypothyroidism, polypharmacy with sedation and syncope. [Client A] has a history of self harming involving cutting of the wrists and neck....[Client A] moved to the home May 26, 2015. Prior to that she was in a</p>			
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	<p>more secure group home called [Facility #3 name]. [Sergeant name] and [Corporal name] were requested to respond to the scene and were apprised of the situation upon their arrival. The home was checked again by [Officer name] as well as the surrounding area. Dispatch was provided the necessary information to enter [client A] as a missing person. [Detective name] was notified and responded to the scene along with [Detective #2] and [Detective #3]. [Public Information Officer] was notified and photographs of [client A] were provided to them. [Sergeant name] activated a Child is Missing (ACIM) and an administrative page was sent. The [County Search and Rescue Team] was activated. [County Fire Department's Search and Rescue] team attempted to track from [client A]'s window but showed no interest. [County #2 Sheriff's Department]'s helicopter (Helicopter name) was requested to assist but was unable to due to a low ceiling. The State Police Aviation Unit had the same limitations. All terrain vehicles checked the wooded areas and trails by the transmission lines nearby. The State Police Toll Road District was requested to check the Toll Road. [Fire Department] personnel arrived on-scene to assist. Officers checked the neighborhood door to door with negative</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
(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>results. Local businesses were checked by Officers. Patrol Officers checked the roadways in the immediate area and spoke with area residents with negative results. The Mobile Command Center for District Task Force was brought on scene as a command center....[Detective #1] telephoned [client A]'s mother. She advised that she picked [client A] up from the [Shopping Center] in Gary, Indiana. Gary PD was sent to the mother's residence to verify [client A]'s well being. [Client A] is an emancipated adult absent court order requiring her to remain at the group home."</p> <p>An interview with the AD was conducted on 6/17/15 at 2:15 P.M.. The AD indicated through his question and answering he discovered client A had been missing from the group home since 4:15 A.M.. The AD indicated although staff documented the last time seeing client A was at 5:45 A.M., client A had been missing since 4:15 A.M., verified by client A and the two neighbors who witnessed her walking. The AD indicated staff did not immediately call him to make him aware client A was missing, but called him around 6:00 A.M.. The AD indicated he asked if the staff had notified police and was informed they had not, and that is when he prompted the staff to notify police.</p>				

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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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	<p>The AD indicated the investigation to this incident has not been completed and the results have not been reported to the administrator as of 6/19/15. The AD indicated there was no documentation available for review to indicate all staff who work at the group home and all clients who reside at the group home were interviewed in regard to this incident. The AD indicated staff are now to keep client A in eyesight at all times, conduct 5 minute checks and keep her bedroom door open at all times including bedtime. When asked how the facility was overseeing and ensuring staff were documenting and implementing client A's supervision, the AD indicated through reviewing of staff written documentation. When asked if there was written documentation to indicate the administration was overseeing and ensuring proper supervision, the AD indicated there was not any documentation to indicate so. The AD indicated once the investigation is concluded a determination will be made whether DSP #13 will be terminated for failure to provide proper supervision, not immediately reporting to the administrator, failure to immediately notify police of a missing person and not properly documenting bedchecks.</p> <p>A group home observation was</p>			

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	<p>conducted on 6/17/15 from 3:15 P.M. until 4:15 P.M.. At 3:45 P.M., DSP #3 was asked to open client A's bedroom window. DSP #3 retrieved a window crank from the staff office and opened client A's bedroom window. The window alarm could not be heard in client A's bedroom or the living room area outside of client A's bedroom. This surveyor walked to the alarm keypad located in the open dining area and could hear a faint alarm sound coming from the alarm keypad located next to the exit door in the open dining area.</p> <p>A review of client A's record was conducted on 6/19/15 at 11:30 A.M.. Review of client A's Behavioral Support Plan (BSP) dated 5/20/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Inappropriate Sexual Behavior...Stealing...Elopement:</p> <p>Self-Injurious Behavior: Using silverware to harm herself, swallowing inedible objects (screws), using her fingers to dig into a previous wound from an SIB episode. According to staff, [client A] is constantly on the lookout for</p>				

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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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	<p>objects to harm herself. This happens 4 times per month and is severe in nature. [Client A] has gone to the ER (Emergency Room) due to lacerations on her arms and neck which have led to the use of steri-strips and stitches. She has also had surgery to remove item(s) that she swallowed. The duration of the behavior is currently unknown.</p> <p>Physical Aggression: Towards staff and peers. [Client A] will punch people and rip their shirts. [Client A] will verbally threaten staff and peers.</p> <p>Inappropriate Sexual Behavior: Exposing herself to peer, blocking a peer from moving so she can have physical contact (for example kissing) with them, sneaking into a peer's room to engage in sexual activity with them (whether or not the peer wants to). This happens approximately 2 times per month and is severe in nature as this could lead to being charged for sexual assault.</p> <p>Stealing: Taking items that are not hers.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission</p>			

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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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	<p>to leave the area by staff.</p> <p>5....f. Elopement: Intervention Steps: ...If [client A] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI (crisis intervention) technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>g. If staff is following [client A] and loses sight of her, they should call local law enforcement. The individual's full first name, last name, as well as middle initial, a physical description, (e.g. color and/or type of clothing last seen in, color of hair and eyes, height and weight, etc.), and the group home address should be communicated to the police....</p> <p>BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of</p>			

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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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	<p>Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the</p>			

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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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	<p>need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p>			

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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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	<p>"FOLLOW-UP:</p> <p>All of [client A]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client A]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client A]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>An interview with the AD was conducted on 6/19/15 at 1:15 P.M.. The AD indicated the alarm system needed a louder speaker so staff can hear the alarm sounding if client A opens her room window and also the alarm will now stay constantly on as opposed to only alarming for a brief period of time.</p> <p>2. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/10/15 involving client B indicated: "On 6/10/15 at approximately 4:30 P.M., [client B] had expressed concern that she felt that she</p>						

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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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	<p>was not being watched well enough. Her designated 1 on 1 staff reassured her that they were there and concerned about her safety. [Client B] appeared to have calmed down and then she went to the office and asked another staff if she could have sugar for her rice. The staff advised her that she is pre-diabetic and offered her splenda because staff was under the impression that there was no sugar in the house. [Client B] became upset and walked outside. Staff followed and encouraged [client B] to talk to staff. She expressed her feelings and had seemed to calm down again. Staff directed [client B] to the office to take her 4 o clock meds. After taking her meds, she ran out of the office and ran out the front door with staff following right behind her. Staff called the house who sent another staff to assist in prompting [client B] back to her home. [Client B] walked very quickly and continued to the sub-division entrance ending up on the main road. [Client B] threatened both staff with rocks and sticks and threw them hitting one staff in the leg with a rock. She began walking down the middle of the road and when a car passed very close to her, staff called the police for assistance, to ensure [client B]'s health and safety. The police said there was nothing they could do. A 3rd staff and housemate were on their way back</p>			

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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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	<p>from an appointment, stopped to assist, and housemate talked with [client B] and she calmed down and walked back to the house with her while staff followed. Staff followed protocol to ensure [client B]'s health and safety and notified the supervisor promptly. [Client B]'s IDT will review this incident to determine if there is anything that can be revised in her plan/protocol to prevent a future occurrence, and revise the plan if necessary. [Client B]'s IDT will continue to monitor the effectiveness of her plan and do everything possible to ensure her health and safety until a more appropriate placement is secured for her to ensure her health and safety." Review of the report failed to indicate an investigation was conducted in regard to this incident. No documentation was available to indicate why client B felt she was not being supervised appropriately. The report failed to indicate staff followed client B's BSP in regard to implementing a two person hold to prevent her from exiting out of the house and into the busy road located a distance from the home.</p> <p>A review of client B's record was conducted on 6/19/15 at 12:00 P.M.. Review of client B's Behavioral Support Plan (BSP) dated 2/23/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED</p>			

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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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	<p>(CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and scratching her lower forearms and face to the point of skin breakdown. [Client B] has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>3. Elopement: Intervention Steps: ...If [client B] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI</p>			

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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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	<p>technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>Proactive Strategies:</p> <p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home from any community outing. This strategy was discussed at a team meeting and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p> <p>...Staff should always be mindful of observing [client B]'s affect for moods that correlate with this target behavior....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical</p>				

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	<p>Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should</p>			

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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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	<p>only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the</p>			
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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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	<p>individual."</p> <p>FOLLOW-UP:</p> <p>All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence.</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 6/19/15 at 1:15 P.M.. The AD indicated staff still implement clients A and B's plans as written. When asked if any measures were put in place to prevent recurrence, the AD indicated staff were retrained on the clients' BSPs.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-2(a)</p>			

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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 0189 Bldg. 00	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 2 of 2 sampled clients (clients A and B), the facility failed to ensure all staff who worked with clients A and B were sufficiently trained to assure competence in regard to the clients' behavioral needs/plans.</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/12/15 involving</p>	W 0189	<p>W 189 483.430(e)(1) TRAINING PROGRAM</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times (Including providing sufficient staff at all times for the needs of the individuals), to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or</p>	07/22/2015

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 06/22/2015
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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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	<p>client A indicated: "At approximately 6:00 A.M., staff called the Area Director (AD) to inform that [client A] was not in her room and staff could not locate her. AD instructed staff to immediately call 911. Police arrived and began an investigation to locate [client A]. At 10:00 A.M., AD and Police simultaneously discovered [client A] was with her mother in Gary, Indiana. Staff followed protocol and notified AD and then Police. It was determined [client A] left out of her front window sometime between 4:30 A.M. and 6:00 A.M.. Both overnight on duty at the time were suspended pending investigation. AD brought [client A] her medications and talked with her mother. [Client A] stated she wanted to visit for the weekend. Facility will pick up [client A] from her mother's on Monday, after IDT (Interdisciplinary Team) meeting at 10 A.M. when Team will discuss revising her supervision protocol to ensure this does not recur, to ensure [client A]'s health and safety. AD will continue to update on investigation." Review of the record failed to indicate this incident of alleged staff neglect of providing supervision was immediately reported to the administrator. Review of the record failed to indicate staff immediately reported client A missing to the police.</p>		<p>allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ul style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. v. Agency Policy and Procedure concerning reporting to supervisor when insufficient staff are 	

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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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	An interview with the AD was conducted on 6/17/15 at 2:15 P.M.. The AD indicated that through his question and answering he discovered client A had been missing from the group home since 4:15 A.M.. The AD indicated although staff documented the last time seeing client A was at 5:45 A.M., client A had been missing since 4:15 A.M., verified by client A and the two neighbors who witnessed her walking. The AD indicated staff did not immediately call him to make him aware client A was missing, but called him around 6:00 A.M.. The AD indicated he asked if the staff had notified police and was informed they had not, and that is when he prompted the staff to notify police. The AD indicated staff are now to keep client A in eyesight at all times, conduct 5 minute checks and keep her bedroom door open at all times including bedtime. When asked how the facility was overseeing and ensuring staff were documenting and implementing client A's supervision, the AD indicated through reviewing of staff written documentation. When asked if there was written documentation to indicate the administration was overseeing and ensuring proper supervision, the AD indicated there was not any documentation to indicate so. The AD indicated once the investigation is		on duty at any time. C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record. D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc. E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect. F. Area Director will work with HR Department and Agency Team to hire and retain sufficient staff, so that home will consistently have sufficient staff for client's needs. A trained Area Director, Program		

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 06/22/2015
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	<p>concluded a determination will be made whether DSP #13 will be terminated for failure to provide proper supervision, not immediately reporting to the administrator, failure to immediately notify police of a missing person and not properly documenting bedchecks.</p> <p>A review of client A's record was conducted on 6/19/15 at 11:30 A.M.. Review of client A's Behavioral Support Plan (BSP) dated 5/20/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Inappropriate Sexual Behavior...Stealing...Elopement:</p> <p>Self-Injurious Behavior: Using silverware to harm herself, swallowing inedible objects (screws), using her fingers to dig into a previous wound from an SIB episode. According to staff, [client A] is constantly on the lookout for objects to harm herself. This happens 4 times per month and is severe in nature. [Client A] has gone to the ER (Emergency Room) due to lacerations on her arms and neck which have led to the use of steri-strips and stitches. She has also had surgery to remove item(s) that</p>		<p>Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from</p>	

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	<p>she swallowed. The duration of the behavior is currently unknown.</p> <p>Physical Aggression: Towards staff and peers. [Client A] will punch people and rip their shirts. [Client A] will verbally threaten staff and peers.</p> <p>Inappropriate Sexual Behavior: Exposing herself to peer, blocking a peer from moving so she can have physical contact (for example kissing) with them, sneaking into a peer's room to engage in sexual activity with them (whether or not the peer wants to). This happens approximately 2 times per month and is severe in nature as this could lead to being charged for sexual assault.</p> <p>Stealing: Taking items that are not hers.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>5....f. Elopement: Intervention Steps: ...If [client A] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to</p>		<p>abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the</p>	

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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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	<p>the home or implement an approved DCI technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>g. If staff is following [client A] and loses sight of her, they should call local law enforcement. The individual's full first name, last name, as well as middle initial, a physical description, (e.g. color and/or type of clothing last seen in, color of hair and eyes, height and weight, etc.), and the group home address should be communicated to the police....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response</p>		<p>Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>		

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 06/22/2015
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	<p>Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side</p>			

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	<p>of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>All of [client A]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client A]'s behavior should be monitored by her behavior consultant on a weekly basis.</p>			

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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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	<p>[Client A]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>An interview with the AD was conducted on 6/19/15 at 1:15 P.M.. The AD indicated all staff who worked at the group home are trained on the clients BSP upon hire. The AD indicated the alarm system needed a louder speaker so staff can hear the alarm sounding if client A opens her room window and also the alarm will now stay constantly on as opposed to only alarming for a brief period of time.</p> <p>2. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/10/15 involving client B indicated: "On 6/10/15 at approximately 4:30 P.M., [client B] had expressed concern that she felt that she was not being watched well enough. Her designated 1 on 1 staff reassured her that they were there and concerned about her safety. [Client B] appeared to have calmed down and then she went to the</p>			

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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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	<p>office and asked another staff if she could have sugar for her rice. The staff advised her that she is pre-diabetic and offered her splenda because staff was under the impression that there was no sugar in the house. [Client B] became upset and walked outside. Staff followed and encouraged [client B] to talk to staff. She expressed her feelings and had seemed to calm down again. Staff directed [client B] to the office to take her 4 o clock meds. After taking her meds, she ran out of the office and ran out the front door with staff following right behind her. Staff called the house who sent another staff to assist in prompting [client B] back to her home. [Client B] walked very quickly and continued to the sub-division entrance ending up on the main road. [Client B] threatened both staff with rocks and sticks and threw them hitting one staff in the leg with a rock. She began walking down the middle of the road and when a car passed very close to her, staff called the police for assistance, to ensure [client B]'s health and safety. The police said there was nothing they could do. A 3rd staff and housemate were on their way back from an appointment, stopped to assist, and housemate talked with [client B] and she calmed down and walked back to the house with her while staff followed. Staff followed protocol to ensure [client</p>			

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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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	<p>B]'s health and safety and notified the supervisor promptly. [Client B]'s IDT will review this incident to determine if there is anything that can be revised in her plan/protocol to prevent a future occurrence, and revise the plan if necessary. [Client B]'s IDT will continue to monitor the effectiveness of her plan and do everything possible to ensure her health and safety until a more appropriate placement is secured for her to ensure her health and safety." The report failed to indicate staff followed client B's BSP in regard to implementing a two person hold to prevent her from exiting out of the house and into the busy road located a distance from the home.</p> <p>A review of client B's record was conducted on 6/19/15 at 12:00 P.M.. Review of client B's Behavioral Support Plan (BSP) dated 2/23/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses her body or a foreign object to inflict</p>						

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	<p>harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and scratching her lower forearms and face to the point of skin breakdown. [Client B] has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>3. Elopement: Intervention Steps: ...If [client B] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>Proactive Strategies:</p>			

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 06/22/2015
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	<p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home from any community outing. This strategy was discussed at a team meeting and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p> <p>...Staff should always be mindful of observing [client A]'s affect for moods that correlate with this target behavior....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response</p>			

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 06/22/2015
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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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	<p>Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side</p>			

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 06/22/2015
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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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	<p>of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis.</p>			

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 06/22/2015
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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 0249 Bldg. 00	<p>[Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 6/19/15 at 1:15 P.M.. The AD indicated all staff who work at the group home with clients A and B have been trained on their BSPs. The AD further indicated staff should have implemented their BSPs as written.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview, the facility failed for 2 of 2 sampled clients (clients A and B), to</p>	W 0249	W 249 483.440(d)(1) INDIVIDUAL PROGRAM PLAN	07/22/2015

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 06/22/2015
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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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	<p>properly implement their Behavior Support Plans (BSP).</p> <p>Findings include:</p> <p>1. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/12/15 involving client A indicated: "At approximately 6:00 A.M., staff called the Area Director (AD) to inform that [client A] was not in her room and staff could not locate her. AD instructed staff to immediately call 911. Police arrived and began an investigation to locate [client A]. At 10:00 A.M., AD and Police simultaneously discovered [client A] was with her mother in Gary, Indiana. Staff followed protocol and notified AD and then Police. It was determined [client A] left out of her front window sometime between 4:30 A.M. and 6:00 A.M.. Both overnight on duty at the time were suspended pending investigation. AD brought [client A] her medications and talked with her mother. [Client A] stated she wanted to visit for the weekend.</p>		<p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure all current ISP, BSP, and Risk Plans are filed in each Individuals' permanent file at the home, for easy reference for all staff. AD will ensure Agency's abuse/neglect Policy and Procedure is implemented at all times (Including providing sufficient staff at all times for the needs of the individuals), to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p>	

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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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	<p>Facility will pick up [client A] from her mother's on Monday, after IDT (Interdisciplinary Team) meeting at 10 A.M. when Team will discuss revising her supervision protocol to ensure this does not recur, to ensure [client A]'s health and safety. AD will continue to update on investigation."</p> <p>An interview with the AD was conducted on 6/17/15 at 2:15 P.M.. The AD indicated that through his question and answering he discovered client A had been missing from the group home since 4:15 A.M.. The AD indicated although staff documented the last time seeing client A was at 5:45 A.M., client A had been missing since 4:15 A.M., verified by client A and the two neighbors who witnessed her walking. The AD indicated staff did not immediately call him to make him aware client A was missing, but called him around 6:00 A.M.. The AD indicated he asked if the staff had notified police and was informed they had not, and that is when he prompted the staff to notify police. The AD indicated staff are now to keep client A in eyesight at all times, conduct 5 minute checks and keep her bedroom door open at all times including bedtime. When asked how the facility was overseeing and ensuring staff were documenting and implementing client A's</p>		<p>B. All current and new staff will be retrained on the following:</p> <ul style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. v. Agency Policy and Procedure concerning reporting to supervisor when insufficient staff are on duty at any time. <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to</p>	

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 06/22/2015
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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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	<p>supervision, the AD indicated through reviewing of staff written documentation. When asked if there was written documentation to indicate the administration was overseeing and ensuring proper supervision, the AD indicated there was not any documentation to indicate so. The AD indicated once the investigation is concluded a determination will be made whether DSP #13 will be terminated for failure to provide proper supervision, not immediately reporting to the administrator, failure to immediately notify police of a missing person and not properly documenting bedchecks.</p> <p>A group home observation was conducted on 6/17/15 from 3:15 P.M. until 4:15 P.M.. At 3:45 P.M., DSP #3 was asked to open client A's bedroom window. DSP #3 retrieve a window crank from the staff office and opened client A's bedroom window. The window alarm could not be heard in client A's bedroom or the living room area outside of client A's bedroom. This surveyor walked to the alarm keypad located in the open dining area and could hear a faint alarm sound coming from the alarm keypad located next to the exit door in the open dining area.</p> <p>A review of client A's record was</p>		<p>each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>F. Area Director will work with HR Department and Agency Team to hire and retain sufficient staff, so that home will consistently have sufficient staff for client's needs.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to</p>	

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 06/22/2015
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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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	<p>conducted on 6/19/15 at 11:30 A.M.. Review of client A's Behavioral Support Plan (BSP) dated 5/20/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Inappropriate Sexual Behavior...Stealing...Elopement:</p> <p>Self-Injurious Behavior: Using silverware to harm herself, swallowing inedible objects (screws), using her fingers to dig into a previous wound from an SIB episode. According to staff, [client A] is constantly on the lookout for objects to harm herself. This happens 4 times per month and is severe in nature. [Client A] has gone to the ER (Emergency Room) due to lacerations on her arms and neck which have led to the use of steri-strips and stitches. She has also had surgery to remove item(s) that she swallowed. The duration of the behavior is currently unknown.</p> <p>Physical Aggression: Towards staff and peers. [Client A] will punch people and rip their shirts. [Client A] will verbally threaten staff and peers.</p> <p>Inappropriate Sexual Behavior:</p>		<p>each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p>	

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 06/22/2015
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>Exposing herself to peer, blocking a peer from moving so she can have physical contact (for example kissing) with them, sneaking into a peer's room to engage in sexual activity with them (whether or not the peer wants to). This happens approximately 2 times per month and is severe in nature as this could lead to being charged for sexual assault.</p> <p>Stealing: Taking items that are not hers.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>5....f. Elopement: Intervention Steps: ...If [client A] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p>		<p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/22/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>		

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 06/22/2015
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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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(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>g. If staff is following [client A] and loses sight of her, they should call local law enforcement. The individual's full first name, last name, as well as middle initial, a physical description, (e.g. color and/or type of clothing last seen in, color of hair and eyes, height and weight, etc.), and the group home address should be communicated to the police....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p>			

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 06/22/2015
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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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	<p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural</p>			

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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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	<p>waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>All of [client A]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client A]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client A]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>An interview with the AD was conducted on 6/19/15 at 1:15 P.M.. The AD indicated through investigating into the incident, he determined the staff did not check on client A every 15 minutes</p>			

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 06/22/2015
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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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	<p>although they documented they did. The AD indicated the staff did not implement client A's elopement intervention steps. The AD indicated the alarm system needed a louder speaker so staff can hear the alarm sounding if client A opens her room window and also the alarm will now stay constantly on as opposed to only alarming for a brief period of time.</p> <p>2. A review of the facility's records was conducted on 6/17/15 at 1:15 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-BDDS report dated 6/10/15 involving client B indicated: "On 6/10/15 at approximately 4:30 P.M., [client B] had expressed concern that she felt that she was not being watched well enough. Her designated 1 on 1 staff reassured her that they were there and concerned about her safety. [Client B] appeared to have calmed down and then she went to the office and asked another staff if she could have sugar for her rice. The staff advised her that she is pre-diabetic and offered her splenda because staff was under the impression that there was no sugar in the house. [Client B] became upset and</p>			

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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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	walked outside. Staff followed and encouraged [client B] to talk to staff. She expressed her feelings and had seemed to calm down again. Staff directed [client B] to the office to take her 4 o clock meds. After taking her meds, she ran out of the office and ran out the front door with staff following right behind her. Staff called the house who sent another staff to assist in prompting [client B] back to her home. [Client B] walked very quickly and continued to the sub-division entrance ending up on the main road. [Client B] threatened both staff with rocks and sticks and threw them hitting one staff in the leg with a rock. She began walking down the middle of the road and when a car passed very close to her, staff called the police for assistance, to ensure [client B]'s health and safety. The police said there was nothing they could do. A 3rd staff and housemate were on their way back from an appointment, stopped to assist, and housemate talked with [client B] and she calmed down and walked back to the house with her while staff followed. Staff followed protocol to ensure [client B]'s health and safety and notified the supervisor promptly. [Client B]'s IDT will review this incident to determine if there is anything that can be revised in her plan/protocol to prevent a future occurrence, and revise the plan if			

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 06/22/2015	
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>necessary. [Client B]'s IDT will continue to monitor the effectiveness of her plan and do everything possible to ensure her health and safety until a more appropriate placement is secured for her to ensure her health and safety." The report failed to indicate staff followed client B's BSP in regard to implementing a two person hold to prevent her from exiting out of the house and into the busy road located a distance from the home.</p> <p>A review of client B's record was conducted on 6/19/15 at 12:00 P.M.. Review of client B's Behavioral Support Plan (BSP) dated 2/23/15 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and scratching her lower forearms and face to the point of skin breakdown. [Client B]</p>						

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	<p>has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>3. Elopement: Intervention Steps: ...If [client B] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>Proactive Strategies:</p> <p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home from any community outing. This strategy was discussed at a team meeting</p>						

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	<p>and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p> <p>...Staff should always be mindful of observing [client A]'s affect for moods that correlate with this target behavior....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS": Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's</p>			

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	<p>momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the</p>			

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	<p>person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>An interview with the Area Director (AD) was conducted on 6/19/15 at 1:15</p>			

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	<p>P.M.. The AD indicated staff should always implement clients' BSPs as written.</p> <p>This federal tag relates to complaint #IN00175587.</p> <p>9-3-4(a)</p>				