STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00195280. Complaint #IN00195280: Substantiated, Federal and state deficiencies related to the allegation are cited at W149, W153, W154, and W155. Unrelated deficiencies cited. Survey Dates: 3/15, 3/16 and 3/28/16. Facility Number: 011817 Provider Number: 15G757 AIM Number: 200940180 These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality review of this report completed on 3/31/16 by #09182.	W 0000		
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, record review and interview for 2 of 2 sampled clients (A	W 0125	**W 125 483.420 (a)(3) Protection of Client Rights**	04/27/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	and B) the facility failed to ensure the clients' rights were not violated by the use of door alarms with no plan in place to reduce the need for the door alarms. Findings include: During the 3/15/16 observation period between 4:00pm and 5:30pm and the 3/16/16 observation period between 8:30am and 9:45am, in the group home, there was an active door alarm on the doors. The alarm would sound whenever the doors leading to the outside would open. Client A's record was reviewed on 3/16/16 at 12:56pm. Client A's 3/16/15 BSP (Behavior Support Plan) indicated client A had the targeted behaviors of physical aggression, verbal aggression, property destruction, suicidal ideation, enuresis, and elopement. Client A's BSP indicated "Visual checks are necessary to ensure [client A] does not elope. Visual checks should be completed every 15 minutes. [Client A's] bedroom door must also remain open 6 inches while she sleeps in order to monitor that she does not elope during bedtime. [Client A's] IDT (Interdisciplinary Team) recommended 1:1 (1 staff working with 1 client) staff to be available during the middle of the day 10am-2pm and		House Manager, QDDP, and Behaviorist will review this Standard. Behaviorist and QDDP, in conjunction withclient A and B and their IDTs, will develop a plan for clients A and B toreduce the need for the window and door alarms. This agreed upon plan will be included in their BSPs. Behaviorist and QDDP will review the BSPs ofall other clients in the home to determine if they have a plan to reduce theneed for the door and window alarms. Ifa plan is not in place, Behaviorist and QDDP, in conjunction with the client'sIDT, will develop a plan for the client to reduce the need for the window anddoor alarms. This agreed upon plan willbe included in their BSPs and all staff will be trained on its implementation. Ongoing, the QDDP will complete an audit of each individuals' file atleast quarterly, to ensure there is a plan in place to reduce and/or eliminateany rights restrictions in place for the individuals. **Will be completed by: 4/27/16** **Persons Responsible: QDDP and Behaviorist**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	transition times (staff changes) to provide extra support and to reduce opportunities for [client A] to elope. When in the home, staff should be mindful to place themselves between [client A] and any exit doors. This will help reduce the likelihood that [client A] can exit the door before staff are able to respond." Client A's BSP indicated client A's "Freedom from exiting the home via window or door without notification via home security system" was restricted. Client A's BSP in regards to client A having the door alarms removed indicated "Services that will be provided to restore the right: will not have specific training in this area." Client A's BSP did not indicate client A had a plan to decrease depending on the door alarms. Client B's record was reviewed on 3/16/16 at 1:48pm. Client B's 12/7/15 BSP (Behavior Support Plan) indicated client B had the targeted behaviors of verbal aggression, suicidal threats, self-harm/suicide attempt, property destruction, psychopathology (mental or behavioral disorder) and elopement. Client B's BSP indicated "[Client B] recently eloped (10/9/15) and was walking down the highway for almost 3 hours. Client B's BSP indicated client B's "Freedom from exiting the home via window or door without notification via			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G757		03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	home security system" was restricted. Client B's BSP in regards to client B having the door alarms removed indicated "Services that will be provided to restore the right: will not have specific training in this area, as elopement has not been an identified area." Client B's BSP did not indicate client B had a plan to decrease depending on the door alarms. An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if clients A and B had plans to decrease dependency of the door alarms, the behaviorist stated "No". 9-3-2(a)			
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 interview and record review for 1 of 2 sampled clients (B), the facility neglected to implement its written policy and procedures to prevent neglect of client B when staff provided client B with a needle unsupervised when she has an identified suicide risk. The facility neglected to implement its written policy and procedures to report all allegations of	W 0149	**W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS** The Area Director (AD), QIDP, and House Manager will reviewthis Standard, and ensure Agency's abuse/neglect Policy and Procedure isimplemented at all times, to ensure all allegations of abuse, neglect, orexploitation of an individual are	04/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	abuse/neglect in a timely manner, to ensure all allegations of abuse and/or neglect were thoroughly investigated and to immediately suspend staff pending the investigation. Findings include: The facility's 6/1/2015 policy and procedure concerning abuse, neglect and exploitation was reviewed on 3/15/16 at 12:39pm. The policy indicated "Neglect is 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. [Name of Agency] employees are required by law to report suspected or actual abuse, neglect or exploitation. The first step is to immediately contact the program director for the individual, the on-call PD (program director) or any area director if the PD cannot be reached or is the suspected perpetrator. To protect the individual and the staff, the alleged perpetrator is immediately suspended pending the outcome of an investigation of the allegation." 1. The facility's reportable incident		reported in a timely manner, that the allegedaccused is suspended until completion of a thorough investigation, and that athorough investigation is conducted. 1.QIDP, Behaviorist, and House Manager will be retrainedon this Standard. 2.QIDP, Behaviorist, and House Manager will be retrainedon Agency Policy and Procedure concerning abuse, neglect, and exploitation ofan individual served. 3.All staff in the home will be retrained on AgencyPolicy and Procedure concerning abuse, neglect, and exploitation of anindividual served, with a focus on the requirement to immediately report anyactual or suspected abuse, neglect, or exploitation. 4.All staff will be retrained on all individuals' BSPswith a focus on each individuals' required supervision Protocol. Client B no longer lives in the home, nor receiving servicesfrom the Agency. However, to ensure Agency's abuse/neglect Policy andProcedure is implemented at all times, andthat all staff are following each individual's BSP and supervision protocol, theQIDP, House Manager, Behaviorist, AD,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	reports and/or investigations were reviewed on 3/15/16 at 12:41pm. The 3/7/16 reportable incident report indicated client B used a sewing needle to pierce her right cheek. Staff gave her the needle upon her request and also provided an alcohol swab once the piercing was done. The reportable incident report indicated the incident occurred on 3/5/16, was reported to the administrator on 3/6/16 and was reported to BDDS (Bureau of Developmental Disabilities Services) on 3/7/16. The reportable incident indicated no action was taken by the provider. The 3/8/16 follow up to the 3/7/16 reportable incident report indicated "Responsible staff is still under investigation. Staff have not been suspended as [client B] did not intend to engage in self abuse. The facility's investigation in regards to client B piercing her cheek indicated on 3/8/16 staff members #2, #7 and #8 were interviewed and on 3/9/16 staff members #4 and #9 were interviewed and that all staff interviewed had knowledge of the piercing but did not report it until a Sunday morning staff came in and called the nurse. There was a statement from client B but the interview did not indicate when the statement was given or if she was asked any questions regarding the piercing. The investigation indicated a		orother designated trained –trainer, will complete an active treatmentobservation daily in the home for twoweeks and until compliance is demonstrated by all staff. Thereafter, to ensure continued compliance,these observations will occur at least weekly, as needed, and at random. **Will be completed by: 4/27/16** **Persons Responsible: QDDP, House Manager, Behaviorist, or othertrained-trainer**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	3/5/16 progress note was entered into Therap (online documentation system) by staff #2 that indicated "From 2pm-3pm [client B] gaged (stretched an ear piercing to accommodate a large plug) her ears and is piercing her face (right cheek)." The investigation did not indicate who gave client B the needle, who was working with client B and should have had her within line of sight while she had a sharp. The investigation did not indicate how staff determined that she had no intentions of harming herself with the needle as indicated in the BDDS reports. Client B's record was reviewed on 3/16/16 at 1:48pm. Client B's 12/7/15 BSP (Behavior Support Plan) indicated client B had the targeted behaviors of verbal aggression, suicidal threats, self-harm/suicide attempt, property destruction, psychopathology (mental or behavioral disorder) and elopement. Client B's self-harm/suicide is defined as "any incident where [client B] engages in life threatening or high risk activity such as running into traffic, wrapping objects around her throat, cutting herself, or any other intentional harm to self." Client B's BSP indicated "[Client B] attempted to commit suicide by tying a string from her sweatshirt around herself and locking herself in her bedroom on 12/6/15. Staffs			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	(sic) were able to unlock the door and get her immediate medical and psychiatric attention; however, [client B] needs to have more restrictive measures set in place to deter her from engaging in self injurious behavior or suicidal attempts. Since moving into the ENS (Behavioral Home) home, [Client B] has stolen items in attempt to harm herself (razors), taken apart objects (pencil sharpener), used objects in her room to cut herself (name badges and pens) in attempts to serious (sic) harm herself." Client B's BSP indicated "[Client B] has a history of self harm and suicidal behavior. She will not have access to the sharps container. Staff will supervise her anytime she needs a knife for a meal or to use scissors to ensure her safety." An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if a needle was considered a sharp the behaviorist stated "yes." When asked who gave client B the needle, the HM stated "No one would confess." When asked if client B should have been given the needle without supervision, the HM stated "No." When asked why staff were not suspended during a neglect investigation, the HM stated "Our facility director told us not to suspend staff." When asked when suspected neglect			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	should be reported to the administrator the HM stated "right away." 2. The facility's reportable incident reports and/or investigations were reviewed on 3/15/16 at 12:41pm. The 2/21/16 reportable incident report indicated "[Client B's] peer became combative in the common area. Peer was trying to hit staff, threatened to hit peer, then did hit peer. [Client B] defended herself and tried to help staff, hitting peer. [Client B] had a small injury to her lip where her lip ring had been pulled out also scratches to her cheek and neck." The reportable incident report did not indicate the peer to peer abuse had been investigated by the facility. An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if the facility had conducted an investigation in regards to the peer to peer abuse, the HM stated "No." This federal tag relates to complaint #IN00195280. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G757		03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 2 allegations of abuse/neglect and/or injuries of unknown source reviewed, the facility failed to immediately report allegations of neglect to the administrator when the incidents occurred for client B. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 3/15/16 at 12:41pm. The 3/7/16 reportable incident report indicated client B used a sewing needle to pierce her right cheek. Staff gave her the needle upon her request and also provided an alcohol swab once the piercing was done. The reportable incident report indicated the incident occurred on 3/5/16, was reported to the administrator on 3/6/16 and was reported to BDDS (Bureau of Developmental Disabilities Services) on 3/7/16. Client B's record was reviewed on 3/16/16 at 1:48pm. Client B's 12/7/15	W 0153	**W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS** The Area Director (AD), QIDP, and House Manager will reviewthis Standard, and ensure Agency's abuse/neglect Policy and Procedure isimplemented at all times, to ensure all allegations of abuse, neglect, orexploitation of an individual or any injury of unknown origin are reported toall required entities in a timely manner: 1.QIDP, Behaviorist, and House Manager will be retrainedon this Standard. 2.QIDP, Behaviorist, and House Manager will be retrainedon Agency Policy and Procedure concerning abuse, neglect, and exploitation ofan individual served and injuries of unknown origin. 3.All staff in the home will be retrained on AgencyPolicy and Procedure concerning abuse, neglect, and exploitation of anindividual served, with a focus on the requirement to immediately report anyactual or	04/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G757		03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	BSP (Behavior Support Plan) indicated client B had the targeted behaviors of verbal aggression, suicidal threats, self-harm/suicide attempt, property destruction, psychopathology (mental or behavioral disorder) and elopement. Client B's self-harm/suicide is defined as "any incident where [client B] engages in life threatening or high risk activity such as running into traffic, wrapping objects round her throat, cutting herself, or any other intentional harm to self." Client B's BSP indicated "[Client B] attempted to commit suicide by tying a string from her sweatshirt around herself and locking herself in her bedroom on 12/6/15. Staffs (sic) were able to unlock the door and get her immediate medical and psychiatric attention; however, [client B] needs to have more restrictive measures set in place to deter her from engaging in self injurious behavior or suicidal attempts. Since moving into the ENS (Behavioral Home) home, [Client B] has stolen items in attempt to harm herself (razors), taken apart objects (pencil sharpener), used objects in her room to cut herself (name badges and pens) in attempts to serious (sic) harm herself." Client B's BSP indicated "[Client B] has a history of self harm and suicidal behavior. She will not have access to the sharps container. Staff will supervise her anytime she needs a knife for a meal or to use scissors to		suspected abuse, neglect, or exploitation or injury of unknownorigin. To ensure Agency'sabuse/neglect Policy and Procedure isimplemented at all times, and that all staff are following each individual'sBSP and supervision protocol, the QIDP, House Manager, Behaviorist, AD, or other designated trained–trainer, will complete an active treatment observation daily in the home for two weeks and until complianceis demonstrated by all staff. Thereafter, to ensure continued compliance, these observations willoccur at least weekly, as needed, and at random. **Will be completed by: 4/27/16** **Persons Responsible: QDDP, House Manager, Behaviorist, or othertrained-trainer**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	ensure her safety." An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if a needle was considered a sharp the behaviorist stated "yes." When asked when suspected neglect should be reported to the administrator the HM stated "right away." This federal tag relates to complaint #IN00195280. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 2 allegations of abuse/neglect the facility failed to ensure an allegation of staff to client abuse/neglect was thoroughly investigated for client B. The facility failed to investigate client to client aggression for client B. Findings include: 1. The facility's reportable incident reports and/or investigations were reviewed on 3/15/16 at 12:41pm. The	W 0154	**W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS** The Area Director (AD), QIDP, and House Manager will reviewthis Standard, and ensure Agency's abuse/neglect Policy and Procedure isimplemented at all times and that a thorough investigation is conducted. 1.QIDP, Behaviorist, and House Manager will be retrainedon this Standard. 2.QIDP, Behaviorist, and House Manager will be retrainedon	04/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	3/7/16 reportable incident report indicated client B used a sewing needle to pierce her right cheek. Staff gave her the needle upon her request and also provided an alcohol swab once the piercing was done. The reportable incident report indicated the incident occurred on 3/5/16, was reported to the administrator on 3/6/16 and was reported to BDDS (Bureau of Developmental Disabilities) on 3/7/16. The reportable incident indicated no action was taken by the provider. The 3/8/16 follow up to the 3/7/16 reportable incident report indicated "Responsible staff is still under investigation. Staff have not been suspended as [client B] did not intend to engage in self abuse. The facility's investigation in regards to client B piercing her cheek indicated on 3/8/16 staff members #2, #7 and #8 were interviewed and on 3/9/16 staff members #4 and #9 were interviewed and that all staff interviewed had knowledge of the piercing but did not report it until a Sunday morning staff came in and called the nurse. There was a statement from client B but the interview did not indicate when the statement was given or if she was asked any questions regarding the piercing. The investigation indicated a 3/5/16 progress note was entered into Therap (online documentation system) by		Agency Policy and Procedure concerning abuse, neglect, and exploitation ofan individual served. 3.All staff in the home will be retrained on AgencyPolicy and Procedure concerning abuse, neglect, and exploitation of anindividual served. 4.All staff will be retrained on all individuals' BSPswith a focus on each individual's required supervision Protocol. To ensure Agency'sabuse/neglect Policy and Procedure isimplemented at all times, and that all staff are following each individual'sBSP and supervision protocol and Agency Policy and Procedure concerning Abuse,Neglect, or Exploitation of an Individual Served, the QIDP, House Manager, Behaviorist, AD, or other designated trained–trainer, will complete an active treatment observation daily in the home for two weeks and untilcompliance is demonstrated by all staff. Thereafter, to ensure continued compliance, these observations willoccur at least weekly, as needed, and at random. **Will be completed by: 4/27/16** **Persons Responsible: QDDP, House Manager, Behaviorist, or othertrained-trainer**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	staff #2 that indicated "From 2pm-3pm [client B] gaged (stretched an ear piercing to accommodate a large plug) her ears and is piercing her face (right cheek)." The investigation did not indicate who gave client B the needle, who was working with client B and should have had her within line of sight while she had a sharp. The investigation did not indicate how staff determined that she had no intentions of harming herself with the needle as indicated in the BDDS reports. Client B's record was reviewed on 3/16/16 at 1:48pm. Client B's 12/7/15 BSP (Behavior Support Plan) indicated client B had the targeted behaviors of verbal aggression, suicidal threats, self-harm/suicide attempt, property destruction, psychopathology (mental or behavioral disorder) and elopement. Client B's self-harm/suicide is defined as "any incident where [client B] engages in life threatening or high risk activity such as running into traffic, wrapping objects around her throat, cutting herself, or any other intentional harm to self." Client B's BSP indicated "[Client B] attempted to commit suicide by tying a string from her sweatshirt around herself and locking herself in her bedroom on 12/6/15. Staffs (sic) were able to unlock the door and get her immediate medical and psychiatric			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	attention; however, [client B] needs to have more restrictive measures set in place to deter her from engaging in self injurious behavior or suicidal attempts. Since moving into the ENS (behavior home) home, [Client B] has stolen items in attempt to harm herself (razors), taken apart objects (pencil sharpener), used objects in her room to cut herself (name badges and pens) in attempts to serious harm herself." Client B's BSP indicated "[Client B] has a history of self harm and suicidal behavior. She will not have access to the sharps container. Staff will supervise her anytime she needs a knife for a meal or to use scissors to ensure her safety." An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if a needle was considered a sharp the behaviorist stated "yes." When asked if the investigation determined who gave client B the needle, the HM stated "No, no one would confess." When asked why staff were not suspended during a neglect investigation, the HM stated "Our facility director told us not to suspend staff." When asked when suspected neglect should be reported to the administrator the HM stated "right away." When asked if the investigation determined who was working with client B at the time, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	HM stated "No." When asked what the results of the investigation were, the HM stated "I don't know." 2. The facility's reportable incident reports and/or investigations were reviewed on 3/15/16 at 12:41pm. The 2/21/16 reportable incident report indicated "[Client B's] peer became combative in the common area. Peer was trying to hit staff, threatened to hit peer, then did hit peer. [Client B] defended herself and tried to help staff, hitting peer. [Client B] had a small injury to her lip where her lip ring had been pulled out also scratches to her cheek and neck." The reportable incident report did not indicate the peer to peer abuse had been investigated by the facility. An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if the facility had conducted an investigation in regards to the peer to peer abuse, the HM stated "No." This federal tag relates to complaint #IN00195280. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G757		03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
W 0155 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on interview and record review for 1 of 2 allegations of abuse and/or neglect reviewed, the facility failed to ensure facility staff were suspended/removed from working with client when staff to clients allegations of abuse/neglect were made for client B. Findings include: The facility's 6/1/2015 policy and procedure concerning abuse, neglect and exploitation was reviewed on 3/15/16 at 12:39pm. The policy indicated "Neglect is 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. [Name of Agency] employees are required by law to report suspected or actual abuse, neglect or exploitation. The first step is to immediately contact the program director for the individual, the on-call PD (program director) or any area direct if the PD cannot be reached or is the suspected perpetrator. To protect the individual and the staff, the alleged	W 0155	**W 155 483.420(d)(3) STAFF TREATMENT OF CLIENTS** The Area Director (AD), QIDP, and House Manager will reviewthis Standard, and ensure Agency's abuse/neglect Policy and Procedure isimplemented at all times and to ensure that the alleged accused is suspendeduntil completion of a thorough investigation, and that a thorough investigationis conducted. 1.QIDP, Behaviorist, and House Manager will be retrainedon this Standard. 2.QIDP, Behaviorist, and House Manager will be retrainedon Agency Policy and Procedure concerning abuse, neglect, and exploitation ofan individual served. 3.All staff in the home will be retrained on AgencyPolicy and Procedure concerning abuse, neglect, and exploitation of anindividual served. To ensure Agency'sabuse/neglect Policy and Procedure isimplemented at all times, and that if there is reported actual or suspectedabuse/neglect or exploitation the accused staff is	04/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G757		03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	perpetrator is immediately suspended pending the outcome of an investigation of the allegation." The facility's reportable incident reports and/or investigations were reviewed on 3/15/16 at 12:41pm. The 3/7/16 reportable incident report indicated client B used a sewing needle to pierce her right cheek. Staff gave her the needle upon her request and also provided an alcohol swab once the piercing was done. The 3/8/16 follow up to the 3/7/16 reportable incident report indicated "Responsible staff is still under investigation. Staff have not been suspended as [client B] did not intend to engage in self abuse. Client B's record was reviewed on 3/16/16 at 1:48pm. Client B's 12/7/15 BSP (Behavior Support Plan) indicated client B had the targeted behaviors of verbal aggression, suicidal threats, self-harm/suicide attempt, property destruction, psychopathology (mental or behavioral disorder) and elopement. Client B's self-harm/suicide is defined as "any incident where [client B] engages in life threatening or high risk activity such as running into traffic, wrapping objects around her throat, cutting herself, or any other intentional harm to self." Client B's BSP indicated "[Client B] attempted to commit suicide by tying a string from		immediately suspendedpending a thorough investigation, the Area Director will be made aware of theallegation immediately. The AD willensure the alleged staff is suspended pending a thorough investigation. The QIDP, House Manager, Behaviorist, AD, or other designated trained–trainer, will complete an active treatment observation daily in the home for two weeks and untilcompliance is demonstrated by all staff. Thereafter, to ensure continued compliance, these observations willoccur at least weekly, as needed, and at random. **Will be completed by: 4/27/16** **Persons Responsible: QDDP, House Manager, Behaviorist, or othertrained-trainer**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	her sweatshirt around herself and locking herself in her bedroom on 12/6/15. Staffs were able to unlock the door and get her immediate medical and psychiatric attention; however, [client B] needs to have more restrictive measures set in place to deter her from engaging in self injurious behavior or suicidal attempts. Since moving into the ENS (behavior home) home, [Client B] has stolen items in attempt to harm herself (razors), taken apart objects (pencil sharpener), used objects in her room to cut herself (name badges and pens) in attempts to serious harm herself." Client B's BSP indicated "[Client B] has a history of self harm and suicidal behavior. She will not have access to the sharps container. Staff will supervise her anytime she needs a knife for a meal or to use scissors to ensure her safety." An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if a needle was considered a sharp the behaviorist stated "yes." When asked who gave client B the needle, the HM stated "No one would confess." When asked why staff were not suspended during a neglect investigation, the HM stated "Our facility director told us not to suspend staff."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G757		03/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	304 3RD ST FLORA, IN 46929

(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
	This federal tag relates to complaint #IN00195280. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 2 of 2 sampled clients (A and B), the facility failed to complete effective corrective action to address continued medication errors. Findings include: The facility's reportable incident reports and/or investigations were reviewed on 3/15/16 at 12:41pm. The reportable incident reports indicated the following (not all inclusive): -1/16/16: "As staff prepared [client A's] 8:00 am meds (medications), staff noted that the 1/15 am dose of Gabapentin 300mg remained in the bubble pack. Staff to be retrained in med pass." -12/28/15: "Staff administered (client A's) 7:30am meds on 12/28 and noticed the 7:30am dose for 12/27 had not been popped. Responsible staff to be retrained."	W 0157	**W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS** The Area Director (AD), QIDP, House Manager, and Nurse willreview this Standard, and ensure Agency's Medication Administration Policy and Procedureis implemented at all times and that appropriate corrective action is takenafter a med error. 1.QIDP, House Manager, and Nurse will be retrained onthis Standard. 2.QIDP, House Manager, and Nurse will be retrained onAgency Policy and Procedure concerning Medication Administration. 3.QIDP and House Manager will be retrained on ensuringappropriate re-training and/or disciplinary action for each medication error,with consultation from the Area Director. 4.All staff in the home will be retrained on AgencyPolicy and	04/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 03/28/2016
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929	

(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
	-12/20/15: "On the morning of 12/20 as staff was prepared to prepare [client A's] meds, staff noticed that the 12/19 8:00 meds had not been administrated. Staff to be retrained." The reportable incident report did not indicate if the missed medication was 8:00am or 8:00pm. The facility's reportable incident reports did not indicate the staff were actually retrained on medication passes. An interview with the House Manager (HM) and the Behaviorist was conducted on 3/16/16 at 2:15pm. When asked if the staff were retrained on medication passes, the HM stated "We will get you copies." The facility did not provide trainings for review. 9-3-2(a)		Procedure concerning Medication Administration. To ensure Agency's Policy and Procedure concerningMedication Administration. is implemented at all times by all staff, the QIDP,House Manager, Behaviorist, AD, Nurse, orother designated trained –trainer, will complete a medication administration observationdaily in the home for two weeks anduntil compliance is demonstrated by all staff. Thereafter, to ensure continued compliance, these observations willoccur at least weekly, as needed, and at random. **Will be completed by: 4/27/16** **Persons Responsible: QDDP, House Manager, Behaviorist, or othertrained-trainer**	