

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G484	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/03/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 50605 WYANDOTTE GRANGER, IN 46530
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W 0000 Bldg. 00	<p>This visit was for the investigation of Complaint #IN00175648.</p> <p>COMPLAINT #IN00175648 - SUBSTANTIATED, Federal/State deficiencies related to the allegation are cited at W104, W149, and W156.</p> <p>Dates of Survey: July 28, 29, 30, 31, and August 3, 2015.</p> <p>Facility number: 000998 Provider number: 15G484 AIM number: 100239800</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure flooring and window blinds in the bedroom of 1 of 2 sampled clients (client B) were in</p>	W 0104	The remaining vinyl flooring was removed from the floor of client B's bedroom and new carpeting was put in place. The broken blinds were removed from the window and alternate window covering was put in place to ensure privacy for client B. This	09/02/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 0149 Bldg. 00	<p>good repair.</p> <p>Findings include:</p> <p>The group home where client B resided was inspected during the 7/29/15 observation period from 7:56 A.M. until 9:07 A.M. Half of the vinyl flooring in client B's bedroom had been torn from the floor and remnants of adhesive and vinyl underlayment remained on the floor. Window blinds in the room were torn and crushed.</p> <p>Program Director #1 was interviewed on 7/31/15 at 8:55 A.M. Program Director #1 stated, "[Client B] has been tearing his flooring off of the floor and he broke his window blinds. We are working on getting it fixed."</p> <p>This federal tag relates to complaint #IN00175648. 9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>		<p>was completed on 8/13/15. On 8/13/15, the Area Director, Lead DSP, and Maintenance Director completed a walk thru of the facility to ensure that needed Maintenance projects were scheduled and specifically that all bedrooms were in good repair. Going forward, the Lead DSP, Program Director, and Maintenance Director will all complete monthly site risk checks to ensure that any concerns have been reported in a timely fashion. In addition, all DSPs are being re-trained to report on any items in the home in need of repair on any shift worked. The Lead DSP will e-mail the Program Director at least weekly to report concerns as reported to Maintenance so that the Program Director can follow up on the scheduling of needed repairs. The Program Director also visits the home at least once weekly to complete additional observations of the physical structure and maintenance needs.</p>		

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	<p>mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement their "Policy and Procedure Concerning Abuse, Neglect and Exploitation" (abuse/neglect policy) to ensure clients were not neglected and to assure the results of 1 of 1 reviewed abuse/neglect allegation investigation involving 1 of 2 sampled clients (client B) were reported to the facility's administrator within five business days.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/28/15 at 8:55 A.M. A review of facility incident reports from 4/1/15 to 7/28/15 indicated the following abuse/neglect allegation involving client B:</p> <p>"Date: 06/12/2015, Time: 6:00 AM, Narrative: This morning around 6am, the morning staff went to ring the door bell, but the overnighter (staff who worked overnight) did not open the door. After about 5 minutes, (morning) staff went to the side door and rang the bell several times. The overnighter opened the garage door and while staff was waiting for the garage door to be completely opened, staff saw a woman walk by the lawn from the living room side/end towards the driveway clutching on what</p>	W 0149	<p>A review of this finding was completed. It was identified that the primary cause for the delay in completing the investigation was that the primary supervisor initiated the investigation, then left for vacation, leaving a covering supervisor to complete the investigation. This led to the delay in taking one particular witness statement. Going forward, we have identified that the Area Director will be responsible to monitor such investigations closely, particularly if multiple staff members are involved in completing the investigation, in order to ensure that we remain in compliance with the timeframe established in this standard. The Area Director and Program Director have been retrained on this standard in order to prevent recurrence of this deficiency.</p>	09/02/2015	

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	<p>seemed to be a blanket and had a scarf on. Staff checked on every individual (clients A, B, and C) and noticed that the individual whose room is adjacent to the med (medication) room (client B), his comforter was on the floor in the med room next to the therap (work) computer, folded as someone was sleeping on it. When staff went to greet the individual (client B), he was with no blanket, confirming the blanket was outside of his room was his (client B's). Staff went to check on the temperature of the house because it was cold, and the temperature was set on 68 degrees. The individuals were fine, no obvious signs of abuse. The overnighter staff was placed on suspension pending investigation. Plan to Resolve: Staff will continue to monitor all individuals for health and safety. [The facility] will take disciplinary actions according to the outcome of the investigation."</p> <p>The facility's records were further reviewed on 7/28/15 at 9:37 A.M. Review of the investigative findings of the 6/12/15 incident indicated the overnight staff did have a female friend that spent the night. The facility determined the overnight staff was neglectful of clients A, B, and C and the overnight staff was terminated from his employment at the facility. All other</p>			

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	<p>staff were retrained on the facility's abuse/neglect policy and procedures. Further review of the facility's investigation was concluded on 6/23/15 and the facility's administrator was notified of the investigative findings on 6/24/15.</p> <p>Program director #1 was interviewed on 7/31/15 at 8:55 A.M. Program Director #1 stated, "The investigation was not completed within five business days. It took time to get everyone interviewed."</p> <p>The facility's records were further reviewed on 7/31/15 at 8:37 A.M. Review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 6/1/15, indicated in part, the following: "Within five business days, the results and/or status of the investigation will be reported to the administrator."</p> <p>This federal tag relates to complaint #IN00175648. 9-3-2(a)</p>			

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W 0156 Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to assure the results of 1 of 1 reviewed abuse/neglect allegation investigation involving 1 of 2 sampled clients (client B) were reported to the facility's administrator within five business days.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/28/15 at 8:55 A.M. A review of facility incident reports from 4/1/15 to 7/28/15 indicated the following abuse/neglect allegation involving client B:</p> <p>"Date: 06/12/2015, Time: 6:00 AM, Narrative: This morning around 6am, the morning staff went to ring the door bell, but the overnighter (staff who worked overnight) did not open the door. After about 5 minutes, (morning) staff went to the side door and rang the bell several times. The overnighter opened the garage door and while staff was waiting for the garage door to be completely</p>	W 0156	<p>A review of this finding was completed. It was identified that the primary cause for the delay in completing the investigation was that the primary supervisor initiated the investigation, then left for vacation, leaving a covering supervisor to complete the investigation. This led to the delay in taking one particular witness statement. Going forward, we have identified that the Area Director will be responsible to monitor such investigations closely, particularly if multiple staff members are involved in completing the investigation, in order to ensure that we remain in compliance with the timeframe established in this standard. The Area Director and Program Director have been retrained on this standard in order to prevent recurrence of this deficiency.</p>	09/02/2015			

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	<p>opened, staff saw a woman walk by the lawn from the living room side/end towards the driveway clutching on what seemed to be a blanket and had a scarf on. Staff checked on every individual (clients A, B, and C) and noticed that the individual whose room is adjacent to the med (medication) room (client B), his comforter was on the floor in the med room next to the therap (work) computer, folded as someone was sleeping on it. When staff went to greet the individual (client B), he was with no blanket, confirming the blanket was outside of his room was his (client B's). Staff went to check on the temperature of the house because it was cold, and the temperature was set on 68 degrees. The individuals were fine, no obvious signs of abuse. The overnighter staff was placed on suspension pending investigation. Plan to Resolve: Staff will continue to monitor all individuals for health and safety. [The facility] will take disciplinary actions according to the outcome of the investigation."</p> <p>The facility's records were further reviewed on 7/28/15 at 9:37 A.M. Review of the investigative findings of the 6/12/15 incident indicated the overnight staff did have a female friend that spent the night. The facility determined the overnight staff was</p>			

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	<p>neglectful of clients A, B, and C and the overnight staff was terminated from his employment at the facility. All other staff were retrained on the facility's abuse/neglect policy and procedures. Further review of the facility's investigation was concluded on 6/23/15 and the facility's administrator was notified of the investigative findings on 6/24/15.</p> <p>Program director #1 was interviewed on 7/31/15 at 8:55 A.M. Program Director #1 stated, "The investigation was not completed within five business days. It took time to get everyone interviewed."</p> <p>This federal tag relates to complaint #IN00175648. 9-3-2(a)</p>				