

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G761	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/14/2014
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 60650 LILAC RD SOUTH BEND, IN 46614
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W000000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: October 8, 9, 10, and 14, 2014.</p> <p>Facility number: 011959 Provider number: 15G761 AIM number: 200970870</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 22, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure a dresser in the bedroom of 1 of 4 clients living in the facility (client #4) was in good repair.</p>	W000104	<p><b>W104 483.410(a)(1) GOVERNING BODY</b></p> <p>The Program Director will do a site visit and evaluate all of the furniture</p>	11/13/2014

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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W000149	<p>Findings include:</p> <p>The group home where client #4 resided was inspected during the 10/9/14 observation period from 2:46 P.M. until 5:30 P.M. The dresser in client #4's bedroom was missing a drawer.</p> <p>Program Director #1 was interviewed on 10/14/14 at 12:04 P.M. Program Director #1 stated, "We are going to have that (client #4's dresser drawer) fixed."</p> <p>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 mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement their abuse/neglect policy to: 1. Have evidence of a thorough investigation for 1 of 1 reviewed injury of unknown origin which affected 1 of 2 additional clients</p>			W000149	<p>in the home. For any furniture that is not in good repair, the Program Director will arrange to repair or replace the item. For two weeks and then until compliance has been demonstrated, the Program Director will do site-visits at least three times per week to ensure the home is free of any furniture in bad repair and arrange for it to be promptly replaced or repaired. The Lead DSP will be retrained on reporting to the PD any items that are not in good repair so they can be repaired or replaced promptly. Thereafter, the Program Director will complete these checks at least weekly.</p> <p><b>Will be completed by: 11/13/14</b></p> <p><b>Persons Responsible: Program Director and Lead DSP</b></p> <p><b>W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS</b></p> <p>The Program Director will review</p>		11/13/2014

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	<p>living in the group home (client #4), and,</p> <p>2. Protect 1 of 2 sampled clients (client #2), from client to client abuse, and to include in their abuse/neglect policy the findings of investigations are to be reported to the administrator within five business days.</p> <p>Findings include:</p> <p>1. The facility's incident reports and investigations from 10/1/13 to 10/8/14 were reviewed on 10/8/14 at 1:23 P.M. The review indicated the following injury of unknown origin to client #4:</p> <p>- "Date: 09/28/2014, Date of Knowledge: 09/29/2014, [Client #4] approached staff and stated that his finger was broken. [Client #4's] right pinkie finger was bent towards his other fingers. [Client #4] was asked how it happened and he said he did not know. He was also asked if he had presented that to other staff, [client #4] said he did not. [Client #4] was taken to (medical care facility). The doctor found that [client #4] had an abrasion with infection in his 5th finger. The doctor prescribed medication Augmentin (antibiotic) 875-125 MG (milligram). 1 {one} tablet every twelve hours. The doctor also wanted [client #4] to follow up with the doctor if symptoms worsen. Plan to</p>		<p>this Standard. 1. The Area Director will re-train Program Director in the investigative procedures of any incidents regarding injuries of unknown origin, including the procedure that any injury of unknown origin be thoroughly investigated and a summary of the investigation be completed and available for review. 2. The Area Director will recommend to the Administration Team, the abuse/neglect Policy be revised to include that the results of any investigation into abuse neglect, including client to client abuse, be reported to the administrator within five business days. All investigative findings will be submitted to administrator and BDDS as follow-up reports within five business days and copies will be maintained in the office for review.</p> <p>Area Director will monitor all allegations or incidents regarding abuse/neglect, client to client aggression/abuse, and Self-Injurious Behavior (SIB), and ensure a thorough investigation is conducted, that the results are forwarded to the Administrator and BDDS within five business days, and that an appropriate course of action to reduce any possible future occurrence of the incident is implemented, in order to ensure the health and safety of all Individuals served.</p>				

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	<p>Resolve: Staff will monitor and notified (sic) the on call nurse and the supervisor to report any changes in [client #4's] health everyday. Prescribed medication will be administered as required."</p> <p>Further review of the 9/29/14 incident, and facility investigations from 10/1/13 to 10/8/14, failed to indicate the facility investigated the incident to determine the probable cause of client #4's injury.</p> <p>Program Director #1 was interviewed on 10/14/14 at 12:04 P.M. Program Director #1 stated, "I have interviews of the investigation."</p> <p>The facility records were further reviewed on 10/14/14 at 12:10 P.M. Review of investigative records of the 9/29/14 injury of unknown origin indicated interviews of two direct care staff but failed to indicate a summation of evidence as to the probable cause of client #4's injury.</p> <p>The facility's records were further reviewed on 10/14/14 at 2:13 P.M. The facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation," dated 2/27/14, indicated, in part, the following: "The program director, area director or senior director or his/her designee will conduct a thorough investigation of any alleged,</p>		<p>System wide, all House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p><b>Will be completed by: 11/13/14</b></p> <p><b>Persons Responsible: Area Director, Program Director, Administrative Team</b></p>				

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	<p>suspected or actual abuse, neglect, or exploitation."</p> <p>2. 1. The facility's incident reports from 10/1/13 to 10/8/14 were reviewed on 10/8/14 at 1:23 P.M. The review indicated the following client to client abuse/staff neglect incident involving clients #2 and #4:</p> <p>- "Date: 09/19/2014, Date of Knowledge: 09/19/2014, [Client #2] was sitting outside on the porch with staff (direct care staff #9). [Client #2's] housemate (client #4) walked past [client #2] and his (client #2's) staff (direct care staff #9), then [client #4] walked to the mailbox. [Client #2's] staff needed to use the restroom. [Client #2's] staff (direct care staff #9) went into the house, while [client #2] stayed on the porch. Another staff (direct care staff #10) observed [client #2] and his housemate (client #4) through the window from inside the house. The staff that was in the house (direct care staff #10) was drying their hands from being in the kitchen. Staff from inside (direct care staff #10) went outside. As staff walked outside, they witnessed [client #2's] housemate, on the porch with his pants down and [client #2] starting to have oral sex on his (client #2's) housemate (client #4). Plan to Resolve: Staff (direct care staff #10)</p>						

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	<p>stopped this interaction between [client #2] and [client #4], by saying no as they (direct care staff #10) came outside and [client #2] backed off of his housemate [client #4]. [Client #2] went inside and returned to his daily routine. At this time, [client #2] did not exhibit any signs of distress from this incident. [Client #2's] housemate (client #4) is required to have staff with him at all times to ensure he isn't within 5 feet of any of his housemates for the safety of others. This did not happen this afternoon. The staff that was working with [client #2] and his housemate (client #4) have both been suspended pending further investigation."</p> <p>The facility's investigations from 10/1/13 to 10/8/14 were reviewed on 10/8/14 at 2:11 P.M. Review of the investigation of the 9/19/14 incident involving client #2 and client #4 indicated both direct care staff #9 and #10 were terminated by the facility for not providing appropriate supervision to clients #2 and #4 on 9/19/14, and all other staff who worked at the group home had been retrained on appropriate supervision of clients #2 and #4. Further review of the investigation indicated the investigation began on 9/19/14 and the administrator was not notified of the results of the investigation until 9/30/14.</p>			

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W000154	<p>Area Director #1 was interviewed on 10/14/14 at 12:04 P.M. Area Director #1 stated, "It (investigation results forwarded to the administrator within five business days) should be in our abuse/neglect policy but it isn't. I'll make sure it gets put in."</p> <p>The facility's records were further reviewed on 10/14/14 at 2:13 P.M. The facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation," dated 2/27/14, indicated, in part, the following: "C. Neglect is defined as failure to provide appropriate care, supervision or training . . ."</p> <p>Further review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation," dated 2/27/14, failed to indicate the facility was to have results of abuse/neglect investigations to the administrator within five business days.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all</p>						

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	<p>alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to implement their abuse/neglect policy to have evidence of a thorough investigation for 1 of 1 reviewed injury of unknown origin which affected 1 of 2 additional clients living in the group home (client #4).</p> <p>Findings include:</p> <p>The facility's incident reports and investigations from 10/1/13 to 10/8/14 were reviewed on 10/8/14 at 1:23 P.M. The review indicated the following injury of unknown origin to client #4:</p> <p>- "Date: 09/28/2014, Date of Knowledge: 09/29/2014, [Client #4] approached staff and stated that his finger was broken. [Client #4's] right pinkie finger was bent towards his other fingers. [Client #4] was asked how it happened and he said he did not know. He was also asked if he had presented that to other staff, [client #4] said he did not. [Client #4] was taken to (medical care facility). The doctor found that [client #4] had an abrasion with infection in his 5th finger. The doctor prescribed medication Augmentin (antibiotic) 875-125 MG (milligram). 1 {one} tablet every twelve hours. The doctor also</p>	W000154	<p><b>W154 483.420(d)(3) STAFF TREATMENT OF CLIENTS</b></p> <p>In conjunction with the Plan of Correction for W149, The Program Director will review this Standard. The Area Director will re-train Program Director in the investigative procedures of any incidents regarding injuries of unknown origin, abuse/neglect/exploitation, and client-to-client abuse, with a focus on how they must be thoroughly investigated and a summary of the investigation be completed and available for review.</p> <p>Area Director will monitor all allegations, incidents, or violations regarding abuse/neglect/exploitation, client to client aggression/abuse, and injuries of unknown origin, and ensure a thorough investigation is conducted, that the results are forwarded to the Administrator and BDDS within five business days, and that an appropriate course of action to reduce any possible future occurrence of the incident is implemented, in order to ensure the health and safety of all Individuals served.</p>	11/13/2014			

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	<p>wanted [client #4] to follow up with the doctor if symptoms worsen. Plan to Resolve: Staff will monitor and notified (sic) the on call nurse and the supervisor to report any changes in [client #4's] health everyday. Prescribed medication will be administered as required."</p> <p>Further review of the 9/29/14 incident, and facility investigations from 10/1/13 to 10/8/14, failed to indicate the facility investigated the incident to determine the probable cause of client #4's injury.</p> <p>Program Director #1 was interviewed on 10/14/14 at 12:04 P.M. Program Director #1 stated, "I have interviews of the investigation."</p> <p>The facility records were further reviewed on 10/14/14 at 12:10 P.M. Review of investigative records of the 9/29/14 injury of unknown origin indicated interviews of two direct care staff but failed to indicate a summation of evidence as to the probable cause of client #4's injury.</p> <p>9-3-2(a)</p>		<p>System wide, all House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p><b>Will be completed by: 11/13/14</b></p> <p><b>Persons Responsible: Area Director, Program Director</b></p>				

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 1 of staff neglect and client abuse investigations for 1 of 2 sampled clients (client #2) and 1 of 2 additional clients (client #4), the facility failed to forward findings of investigations to the administrator within five business days.</p> <p>Findings include:</p> <p>The facility's incident reports from 10/1/13 to 10/8/14 were reviewed on 10/8/14 at 1:23 P.M. The review indicated the following client to client abuse/staff neglect incident involving clients #2 and #4:</p> <p>- "Date: 09/19/2014, Date of Knowledge: 09/19/2014, [Client #2] was sitting outside on the porch with staff (direct care staff #9). [Client #2's] housemate (client #4) walked past [client #2] and his (client #2's) staff (direct care staff #9), then [client #4] walked to the mailbox. [Client #2's] staff needed to use the restroom. [Client #2's] staff (direct</p>	W000156	<p><b>W156 483.420(d)(4) STAFF TREATMENT OF CLIENTS</b></p> <p>In conjunction with the Plan of Correction for W149 and W154, the Program Director will review this Standard. The Area Director will re-train Program Director in the investigative procedures of any incidents regarding injuries of unknown origin, abuse/neglect/exploitation, and client-to-client abuse, with a focus on how they must be thoroughly investigated and a summary of the investigation be completed and available for review. The training will also stress the importance that the results of the investigation must be forwarded to the administrator within five business days.</p> <p>Area Director will monitor all allegations, incidents, or violations regarding abuse/neglect/exploitation, client to client aggression/abuse, and injuries of unknown origin, and</p>	11/13/2014			

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	<p>care staff #9) went into the house, while [client #2] stayed on the porch. Another staff (direct care staff #10) observed [client #2] and his housemate (client #4) through the window from inside the house. The staff that was in the house (direct care staff #10) was drying their hands from being in the kitchen. Staff from inside (direct care staff #10) went outside. As staff walked outside, they witnessed [client #2's] housemate, on the porch with his pants down and [client #2] starting to have oral sex on his (client #2's) housemate (client #4). Plan to Resolve: Staff (direct care staff #10) stopped this interaction between [client #2] and [client #4], by saying no as they (direct care staff #10) came outside and [client #2] backed off of his housemate [client #4]. [Client #2] went inside and returned to his daily routine. At this time, [client #2] did not exhibit any signs of distress from this incident. [Client #2's] housemate (client #4) is required to have staff with him at all times to ensure he isn't within 5 feet of any of his housemates for the safety of others. This did not happen this afternoon. The staff that was working with [client #2] and his housemate (client #4) have both been suspended pending further investigation."</p> <p>The facility's investigations from 10/1/13 to 10/8/14 were reviewed on 10/8/14 at</p>		<p>ensure a thorough investigation is conducted, that the results are forwarded to the Administrator and BDDS within five business days, and that an appropriate course of action to reduce any possible future occurrence of the incident is implemented, in order to ensure the health and safety of all Individuals served.</p> <p>System wide, all House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p><b>Will be completed by: 11/13/14</b></p> <p><b>Persons Responsible: Area Director, Program Director</b></p>		

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W000382	<p>2:11 P.M. Review of the investigation of the 9/19/14 incident involving client #2 and client #4 indicated both direct care staff #9 and #10 were terminated by the facility for not providing appropriate supervision to clients #2 and #4 on 9/19/14, and all other staff who worked at the group home had been retrained on appropriate supervision of clients #2 and #4. Further review of the investigation indicated the investigation began on 9/19/14 and the administrator was not notified of the results of the investigation until 9/30/14.</p> <p>Area Director #1 was interviewed on 10/14/14 at 12:04 P.M. Area Director #1 stated, "It (investigation results forwarded to the administrator within five business days) should be in our abuse/neglect policy but it isn't. I'll make sure it gets put in."</p> <p>9-3-2(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were</p>	W000382	W382 483.460(l)(2) Drug Storage and Recordkeeping	11/13/2014			

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	<p>locked except when they were being prepared for administration for 1 of 2 additional clients (client #3).</p> <p>Findings include:</p> <p>Direct care staff #8 was observed passing medications during the 10/9/14 observation period from 6:40 A.M. until 8:48 A.M. At 6:52 A.M. Direct care staff #8 retrieved client #3's medications and placed them on a desktop. Direct care staff #8 left the medication room for 30 seconds with medications open on the counter and client #3 sitting next to them.</p> <p>Program Director #1 was interviewed on 10/14/14 at 12:04 P.M. Program Director stated, "Medications are to be locked when they aren't being administered or being prepared to be administered."</p> <p>9-3-6(a)</p>		<p>All direct care staff at the site will be retrained in medication passing guidelines, which include ensuring that all drugs and biologicals are locked except during times of preparation for administration. Disciplinary action and retraining will be completed with the staff observed to not follow this practice on 10/9/14, according to Dungarvin policy and procedure. For two weeks and then until compliance has been demonstrated, the Program Director, facility nurse, or other designee will do daily active treatment observations during medication administration, to ensure policy and procedure is consistently adhered to, with a focus on ensuring all medications are locked except for during preparation. Immediate feedback will be given during these observations for any concerns noted. Once compliance has been demonstrated, the Program Director will complete weekly observations during medication administration. Medication errors including concerns of violations to the standard of ensuring all drugs and biologicals are to be locked except during times of preparation for administration will be handled through retraining and disciplinary action according the Dungarvin policy and procedure on Medication Administration.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G761	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/14/2014
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 60650 LILAC RD SOUTH BEND, IN 46614		
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W000436	<p>483.470(g)(2) <b>SPACE AND EQUIPMENT</b> The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed to assure 2 of 2 clients (clients #1 and #2) with prescribed eyeglasses, were encouraged to wear them.</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed at the group home during the 10/8/14 observation period from 2:46 P.M. until 5:30 P.M. and on 10/9/14 from 6:40 A.M. until 8:48 A.M. During the observation periods, clients #1 and #2 did</p>	W000436	<p>System wide, all Program Director/QDDP's, Lead DSPs, and nurses will review this standard and assure that this concern is being addressed at all Dungarvin ICF's.</p> <p><b>Will be completed by: 11/13/14</b></p> <p><b>Persons Responsible: Program Director and Lead DSP</b></p> <p><b>W436 483.470(g)(2) SPACE AND EQUIPMENT</b></p> <p>The Program Director will retrain staff on ensuring all Individual's adaptive equipment is being utilized by the Individuals, and that in the event they are refusing to do so, staff are documenting these refusals. For two weeks and then until compliance has been demonstrated, the Program Director, or other designee, will</p>	11/13/2014	

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	<p>not wear eyeglasses. Direct care staff #1, #2, #3, #4, #5, #6, #7, and #8 did not prompt or assist clients #1 and #2 to use or wear their eyeglasses.</p> <p>Client #1's record was reviewed on 10/10/14 at 10:13 A.M. A reviewed of the client's 11/8/13 Vision Exam indicated the client was to wear eyeglasses.</p> <p>Client #2's record was reviewed on 10/10/14 at 10:43 A.M. A reviewed of the client's 10/22/14 Vision Exam indicated the client would benefit from wearing eyeglasses.</p> <p>Program Director #1 was interviewed on 10/14/14 at 12:04 P.M. Program Manager #1 stated, "If [client #1 and client #2] have eyeglasses, staff should prompt them to wear them."</p> <p>9-3-7(a)</p>		<p>complete active treatment observations daily to ensure all Individuals are utilizing their adaptive equipment. The Program Director will review all Individuals' MARs on a daily basis to ensure all Individuals are using their adaptive equipment as prescribed and/or recommended per their ISP/IDT. After this, the Program Director will do weekly documentation reviews and site-visits to ensure all Individuals are using their adaptive equipment as prescribed and/or recommended per their ISP/IDT. If the Program Director notes any trend of regular refusal, the Program Director will address this need with the Individual's IDT in order to create a training goal for the Individual and train staff on its implementation to address this need and trend of refusals. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. <b>Will be completed by: 11/13/14</b> <b>Persons Responsible:</b> <b>Program Director, Nurse, Lead DSP, Medical Support DSP</b></p>		