STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G452	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	52812 HIGHLAND DR SOUTH BEND, IN 46635

(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
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: August 12, 13, 14, and 15, 2013. Facility number: 000966 Provider number: 15G452 AIM number: 100244770 Surveyor: Tim Shebel, LSW The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/27/13 by Ruth Shackelford, QIDP.	W000000		

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.

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W000149	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 failed to implement their abuse/neglect policy to thoroughly investigate 1 of 3 reviewed incidents of injury of unknown origin involving 1 of 4 sampled clients (client #3). Findings include: The facility's records were reviewed on 8/12/13 at 1:22 P.M.. The following injury of unknown injury involving client #3 was reviewed: "Date: 02/07/2013, Narrative: Staff reported that while assisting [client #3] with his dressing, staff noticed a bruise on his (client #3's) right calf. When asked [client #3] states that he does not know how it happened. There were no falls or injuries in the night or at the home the day before. He spent the day yesterday at a winter retreat and was involved in various activities. According to staff at camp with him, there were not (sic) falls or injuries reported. At this point it is not possible to establish how that happened. [Client #3] has a fall prevention plan in place and uses a walker for all mobility. He is independent in ambulating. [Client	W000149	It is Dungarvin's intention to comply with the expectation that all injuries of unknown origin will be investigated thoroughly and in a timely fashion. We expect the Program Director/QDDP to keep a record of this investigation along with the incident and incident follow up as submitted to BQIS. This investigation is to include all related evidence, witness statements, a review of previous similar incidents and all pertinent information necessary to ascertain the cause or probable cause of the injury. In this case, there is evidence that the Program Director responsible for this ICF facility at the time of this incident was in the habit of conducting such investigations and retaining all related documentation together with the incident reports, based on proof of similar investigations in her records. However, at the time of the survey, this Program Director was on a leave of absence and out of the country. Thus, we were not able to ask if she had misplaced the documentation of this particular investigation. This will be addressed with the Program Director in question when she returns from her Leave of Absence in October. All other Program Directors working for the	09/13/2013

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	#3] attended day program today as scheduled and is active in his scheduled program. He had no complaints, is not in pain and not seen to be in distress. Staff followed the correct reporting procedure and will continue with doing daily body checks as ordered. Staff will continue to monitor to ensure that [client #3] is safe as outlined in his careplans (sic). Plan to Resolve: QMRP (Qualified Mental Retardation Professional) will continue to follow up and update." Further review of the 2/7/13 incident and investigation of the injury of unknown origin failed to indicate the facility included witness statements, presented any evidence of previous neglect or abuse, and failed to provide evidence to exclude possible abuse or neglect per the facility's 10/9/12 Abuse/Neglect policy. Area Director #1 was interviewed on 8/13/13 at 10:01 A.M.. Area Director #1 indicated she could not locate any additional information which was to be included in the investigation of the injury of unknown origin involving client #3. The facility's records were reviewed on 8/13/13 at 11:03 A.M.. A review of the facility's "Policy and Procedure Concerning Individual Abuse, Neglect, and Exploitation", dated 10/9/12, indicated, in part, the following: "B. The		agency were informed of this citation and retrained on Dungarvin's expectations regarding investigations of injuries of unknown origin at the Satewide Program Director meeting on 08/22/2013. System wide, all Program Director/QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.	

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	investigation will include the following: 1. Review of witnesses. 2 Any evidence of previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the the charge." 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to thoroughly investigate 1 of 3 reviewed incidents of injury of unknown origin involving 1 of 4 sampled clients (client #3). Findings include: The facility's records were reviewed on 8/12/13 at 1:22 P.M.. The following injury of unknown injury involving client #3 was reviewed: "Date: 02/07/2013, Narrative: Staff reported that while assisting [client #3] with his dressing, staff noticed a bruise on his (client #3's) right calf. When asked [client #3] states that he does not know how it happened. There were no falls or injuries in the night or at the home the day before. He spent the day yesterday at a winter retreat and was involved in various activities. According to staff at camp with him, there were not (sic) falls or injuries reported. At this point it is not possible to establish how that happened. [Client #3] has a fall prevention plan in place and uses a walker for all mobility. He is independent in ambulating. [Client	W000154	It is Dungarvin's intention to comply with the expectation that all injuries of unknown origin will be investigated thoroughly and in a timely fashion. We expect the Program Director/QDDP to keep a record of this investigation along with the incident and incident follow up as submitted to BQIS. This investigation is to include all related evidence, witness statements, a review of previous similar incidents and all pertinent information necessary to ascertain the cause or probable cause of the injury. In this case, there is evidence that the Program Director responsible for this ICF facility at the time of this incident was in the habit of conducting such investigations and retaining all related documentation together with the incident reports, based on proof of similar investigations in her records. However, at the time of the survey, this Program Director was on a leave of absence and out of the country. Thus, we were not able to ask if she had misplaced the documentation of this particular investigation. This will be addressed with the Program Director in question when she returns from her Leave of Absence in October. All other Program Directors working for the	09/13/2013

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	#3] attended day program today as scheduled and is active in his scheduled program. He had no complaints, is not in pain and not seen to be in distress. Staff followed the correct reporting procedure and will continue with doing daily body checks as ordered. Staff will continue to monitor to ensure that [client #3] is safe as outlined in his careplans (sic). Plan to Resolve: QMRP (Qualified Mental Retardation Professional) will continue to follow up and update." Further review of the 2/7/13 incident and investigation of the injury of unknown origin failed to indicate the facility included witness statements, presented any evidence of previous neglect or abuse, and failed to provide evidence to exclude possible abuse or neglect per the facility's 10/9/12 Abuse/Neglect policy. Area Director #1 was interviewed on 8/13/13 at 10:01 A.M.. Area Director #1 indicated she could not locate any additional information which was to be included in the investigation of the injury of unknown origin involving client #3. 9-3-2(a)		agency were informed of this citation and retrained on Dungarvin's expectations regarding investigations of injuries of unknown origin at the Satewide Program Director meeting on 08/22/2013. System wide, all Program Director/QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.	

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W000249	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 to implement medication objectives during times of opportunity for 2 of 4 sampled clients (clients #2 and #4). Findings include: Clients #2 and #4 were observed at the group home on 8/13/13 from 6:20 A.M. until 7:50 A.M. At 6:33 A.M., Direct care staff #5 was observed to retrieve client #4's prescribed medication punch cards, pop each pill out and hand the medications to client #4 to take. Direct care staff #5 did not prompt, nor was client #4 observed to identify his calcium pill. At 6:46 A.M., Direct care staff #5 was observed to retrieve client #2's medications, pop each pill out and hand the medications to client #2 to take. Direct care staff #5 did not prompt, nor was client #2 observed to state/learn about his Simvastatin medication (cholesterol medication)	W000249	All Highland house staff have been retrained on the objectives regarding self-administration of medications for clients #2 and #4. The house staff are also being retrained on the medication administration objectives for all other clients living at the Highland home. Active treatment observations are being conducted by the Program Director/QDDP, House Lead Counselor, and/or Administrative Coordinator at medication pass times to ensure that staff have learned the medication administration objectives and are implementing them on a regular basis. System wide, all Program Director/QDDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-MR's.	09/13/2013

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	Client #2's records were reviewed on 8/13/13 at 9:21 A.M. Client #2's Individual Program Plan dated 7/5/13 indicated the following medication administration objective: "Learn why he takes Simvastatin." Client #4's records were reviewed on 8/13/13 at 10:27 A.M. Client #4's Individual Program Plan dated 3/14/13 indicated the following medication administration objective: "I.D. (identify) Calcium Pill." Program Director #1 was interviewed on 8/13/13 at 10:38 A.M. Program Director #1 indicated clients #2 and #4's medication objectives should have been implemented by direct care staff #5 during the 8/13/13 morning observation period. 9-3-4(a)			

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W000264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. Based on observation, record review, and interview, the facility's human rights committee failed to review the facility's practice of motion sensors in the living room, family room, open office area, and kitchen/dining area which affected 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 of 4 additional clients (clients #5, #6, #7, and #8) living in the facility. Findings include: Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home during the 8/12/13 observation period from 3:37 P.M. until 6:00 P.M. and during the 8/13/13 observation period from 6:20 A.M. until 7:50 A.M.. During the above observation periods, the living room, family room, open office area, and kitchen/dining area were noted to have motion sensors. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to have unimpeded access to the living room, family room, open office area, and	W000264	At the time Dungarvin implemented Sengistix monitoring at the Highland home, Dungarvin took several steps to ensure that the process would be in compliance with all state and federal regulations. A senior manager also contacted ISDH to review our process. At that time, we were advised that review of the planned implementation and family and guardian approval would be sufficient. We held informational sessions with the families and obtained team and guardian approvals before the implementation of the sensors. We informed the Human Rights Committee and discussed the planned implementations, however we did not obtain formal approvals from the committee. The sensors at this home are only activated between the hours of 10 pm and 6 am. The sensors show only a pattern of motion in the home, and they do not record video or indicate who is moving. A call tree is triggered from the sensors only if there is a lack of movement for more than two	09/13/2013

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	kitchen/dining area of the facility where the motion sensors were located. House Manager #1 was interviewed on 8/12/13 at 5:45 P.M.. House Manager #1 indicated the motion sensors were operating and were to monitor direct care staff's movements throughout the home during the overnight hours to assure they were actively supervising the clients. When asked if the motion sensors also sense and monitor the movements of clients #1, #2, #3, #4, #5, #6, #7, and #8, House Manager stated, "Yes." The facility's records were reviewed on 8/13/13 at 9:10 P.M.. A review of the facility's Human Rights Committee minutes, from 8/1/12 to 8/13/13, failed to indicate the facility's Human Rights Committee had reviewed the facility's systemic practice of using motion sensors in the home where clients #1, #2, #3, #4, #5, #6, #7, and #8 lived. Area Director #1 was interviewed on 8/13/13 at 10:01 A.M.. Area Director #1 indicated the facility's Human Rights Committee had not reviewed the facility's systemic practice of using motion sensors in the home where clients #1, #2, #3, #4, #5, #6, #7, and #8 lived. 9-3-4(a)		hours during the overnight hours in the common areas of the home. This could be an indicator that the overnight staff was failing to perform bed checks and other overnight tasks as assigned. As such, there is nothing in the use of these sensors which we consider to be restrictive to any of the individuals in the home. That said, we are now in the process of obtaining Human Rights Approval for the use of the motion sensors in the open areas of the Highland group home. We have also instructed all Program Director/QDDPs at Dungarvin ICF-MRs currently using Sengistix monitors that they need to obtain Human Rights approvals for any monitors in place. System wide, all Program Director/QDDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-MR's.	

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W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to assure psychotropic drug usage was addressed in the Individual Program Plan of 1 of 2 sampled clients (client #2) with Behavior Intervention Programs Findings include: Client #2's medical records were reviewed on 8/13/13 at 6:48 A.M.. A review of the client's 8/13 Medication Administration Record indicated client #2 was receiving Wellbutrin 150 milligrams a day (anti-depression medication) for depression. Client #2's records were further reviewed on 8/13/13 at 9:21 A.M.. A review of the client's 7/5/13 Individual Program Plan and his 8/12 Behavior Intervention Program failed to indicate client #2's use of Wellbutrin was addressed. Program Director #1 was interviewed on 8/13/13 at 10:38 A.M.. Program Director #1 indicated client #2's use of Wellbutrin	W000312	The Behavior Intervention Program for client #2 is being revised to include all current psychotropic medications. The current QDDP has been retrained on the expectation that all psychotropic drug usage will be adressed in the Individual Program Plan through the Behavior Intervention Program. The previous QDDP who was responsible for the home at the time of the drug implementation will also be retrained on this expectation when she returns from her Leave of Absence in October 2013. System wide, all Program Director/QDDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-MR's.	09/13/2013

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	had not been incorporated into his Behavior Management Plan. 9-3-5(a)			

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W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation, record review, and interview, the facility failed to assure 2 of 4 sampled clients (clients #3 and #4) participated in family style dining. Findings include: Clients #3 and #4 were observed at the group home during the 8/13/13 observation period from 6:20 A.M. until 7:50 A.M.. During the observation, direct care staff #2 placed cereal bowls, drinking cups, and silverware on the table for clients #3 and #4. Direct care staff #3 filled client #3 and #4's bowls with rice crispies and placed unwrapped granola bars next to the bowls. Direct care staff #3 also put milk and juice onto the dining room table along with condiments. Direct care staff #3 did not prompt or assist clients #3 and #4 to participate in the preparation of their morning meal. Client #3's records were reviewed on 8/13/13 at 9:52 A.M.. A review of the client's 7/16/13 Life Skills Profile (Comprehensive Functional Assessment) indicated client #3 could assist with meal preparations and participating in the family style dining.	W000488	All Highland house staff have been retrained on the formal and informal objectives and learning opportunities regarding mealtimes for clients #3 and #4. The house staff have also been retrained on the concept of family style dining, using all learning moments during mealtimes, and the dining program objectives for all other clients living at the Highland home. Active treatment observations are being conducted by the Program Director/QDDP, House Lead Counselor, and/or Administrative Coordinator at family style dining times to ensure that staff have learned the mealtime program objectives and are implementing them on a regular basis. System wide, all Program Director/QDDPs have reviewed this standard and will ensure that this concern is being addressed at all Dungarvin ICF-MR's.	09/13/2013

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DUNGARVIN INDIANA LLC	52812 HIGHLAND DR SOUTH BEND, IN 46635

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	Client #4's records were reviewed on 8/13/13 at 10:27 A.M.. A review of the client's 3/13/13 Life Skills Profile (Comprehensive Functional Assessment) indicated client #4 could assist with meal preparations and participating in the family style dining. Program Director #1 was interviewed on 8/13/13 at 10:38 A.M.. Program Director #1 indicated clients #3 and #4 could participate in the preparation of their own meals with verbal prompts or hand over hand assistance from direct care staff. 9-3-8(a)			