

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G573	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 51778 TROWBRIDGE LN SOUTH BEND, IN 46637
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W000000	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Dates of Survey: April 1, 2, 3, 4 and 11, 2014.</p> <p>Facility number: 001087 Provider number: 15G573 AIM number: 100239960</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/28/14 by Ruth Shackelford, 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 record review and interview, the governing body failed for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8),</p>	W000104	<p>Dungarvin has a written policy and procedure in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). The Program Director has</p>	05/23/2014

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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	<p>to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented.</p> <p>Findings include:</p> <p>1. Please refer to W149: The governing body failed for 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), to implement written policy and procedures to prevent abuse and neglect in regards to client to client aggression, allegations of staff neglect, and by not conducting investigations of allegations of abuse/neglect and unknown injuries.</p> <p>2. Please refer to W154: The governing body failed for 1 of 4 sampled clients and 1 additional client (clients #1 and #8), to provide evidence investigations were completed in regards to an injury of unknown origin and allegations of abuse.</p> <p>9-3-1(a)</p>		<p>reviewed Policy B-2, including the need to prevent abuse and neglect in regards to client to client abuse and the need to conduct investigations into all allegations of abuse, neglect, exploitation, including client to client abuse allegations and injuries of unknown origin. This has been systematically reviewed for all individuals residing in the facility. In a few of the examples cited, the Program Director did complete an investigation, however she failed to print and place those investigation reports in the binder with the incident reports. We re-trained all Program Director/QIDPs on the importance of keeping thorough records of all investigations. We also have template investigation reports to use as a guide in completing investigations into injuries of unknown origin as well as client to client abuse investigations. We re-trained all Program Director/QIDPs on the use of these forms. The Program Director/QIDPs have been retrained in the investigative procedures of any allegations or complaints of abuse, mistreatment and neglect of the clients. The Area Director will monitor and supervise the Program Director/QIDP in the investigation of any allegations of abuse, mistreatment and neglect, including injuries of unknown origin and allegations of staff to client abuse. All investigative</p>		

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W000125	<p>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.</p> <p>Based on observation, record review and interview, for 1 additional client (client #8), the facility failed to ensure the client's rights by not obtaining a legally sanctioned decision maker to assist in financial decisions.</p> <p>Findings include:</p>	W000125	<p>reports will be maintained in the office for review. Going forward, the Program Director is to ensure that a copy of each completed investigation report is forwarded to the Area Director within five business days of the incident. The Area Director will keep this copy of the investigation report on file as a backup to the copy placed in the incident report binder. The Area Director will not finalize approval of the initial internal incident report until he or she has verified that any needed investigation report has been completed and submitted. System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p>The team for client #8 has convinced his mother to become his legal guardian. She is choosing between two local attorneys recommended by our local Protective Services Board. We are supporting them in any way possible to speed the process. Client #8 has sufficient funds at this time for the fees and</p>	05/23/2014	

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	<p>A morning observation was conducted at the group home on 4/1/14 from 7:15 A.M. until 8:40 A.M.. During the observation client #8 was non-verbal in communication in that the client did not speak.</p> <p>An evening observation was conducted at the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. During the observation client #8 was non-verbal in communication in that the client did not speak.</p> <p>A review of client #8's record was conducted at the facility's administrative office on 4/4/14 at 1:00 P.M.. Client #8's Individual Support Plan (ISP) dated 11/21/13 indicated: "Summary of Legal Status: Emancipated....Is current legal status appropriate?...No...If no, give recommendation: [Client #8] is in need of a guardian...Will learn to identify coins...Currently [client #8] does not communicate with staff."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was completed at the facility's administrative office on 4/4/14 at 2:00 P.M.. The QIDP indicated client #8 did not have a legally sanctioned decision maker to assist him with financial</p>		<p>if for any reason he does not, Dungarvin will assist him to complete the process.We have systematically reviewed this concern for all individuals residing at this facility. All other individuals currently have legal guardians in place, in accordance with their assessed need for advocacy and informed consent support.System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>				

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W000126	<p>decisions. The QIDP further indicated client #8 could not independently manage his finances and was unable to independently make financial decisions.</p> <p>9-3-2(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. Based on observation and interview, for 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to encourage and teach each client to access their personal finances.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/1/14 from 7:15 A.M. until 8:40 A.M.. At 7:30 A.M., Direct Support Professional (DSP) #2 was asked to reconcile clients #1, #2, #3, #4, #5, #6, #7 and #8's personal petty cash funds. DSP #2 indicated the clients' personal petty cash funds were locked in the manager's office. When asked how clients were able to utilize their personal</p>	W000126	<p>We have systematically reviewed this finding regarding all 8 of the individuals residing at this facility. The Lead DSP of the home has made available to all staff access to a portion of each individual's personal petty cash, in order to encourage and teach each client to access their personal finances. A regular system of auditing these funds is also in place as a safeguard. System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>	05/23/2014			

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W000136	<p>finances, DSP #2 indicated the group home manager would have to access their finances.</p> <p>An evening observation was conducted at the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. At 4:40 P.M., DSP #5 was asked to reconcile clients #1, #2, #3, #4, #5, #6, #7 and #8's personal petty cash funds. DSP #5 indicated the clients' personal petty cash funds were locked in the manager's office. When asked how clients were able to utilize their personal finances, DSP #5 indicated the group home manager would have to access their finances.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/4/14 at 2:00 P.M.. The QIDP indicated the clients should be taught how to manage their personal funds and should have access at all times to some of their money to make purchases they may want.</p> <p>9-3-2(a)</p> <p>483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure</p>				

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	<p>that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>Based on record review and interview, the facility failed to ensure the rights of 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), by not developing a documentation system to verify all clients had opportunities to participate in community activities.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted at the group home on 4/2/14 at 3:42 P.M.. There was no documentation available to review indicating when/if client #1 had opportunities to participate in community activities. A review of client #1's financial ledgers/records dated 4/1/13 to current date failed to indicate she had opportunities to participate in community activities.</p> <p>A review of client #2's record was conducted at the group home on 4/2/14 at 4:15 P.M.. There was no documentation available to review indicating when/if client #2 had opportunities to participate in community activities. A review of client #2's financial ledgers/records dated 4/1/13 to current date failed to indicate he</p>	W000136	<p>We have systematically reviewed this concern for all 8 individuals residing at the facility. An activity calendar is being put in place by the Lead DSP to ensure that each individual is afforded ample opportunities to participate in community activities. Participation in these activities will be documented for each individual in their daily shift narrative notes. The Program Director/QIDP will review this schedule and follow up on the participation of each individual during weekly site visits and also during the monthly review of program documentation. System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>	05/23/2014			

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	<p>had opportunities to participate in community activities.</p> <p>A review of client #3's record was conducted at the group home on 4/2/14 at 4:40 P.M.. There was no documentation available to review indicating when/if client #3 had opportunities to participate in community activities. A review of client #3's financial ledgers/records dated 4/1/13 to current date failed to indicate he had opportunities to participate in community activities.</p> <p>A review of client #4's record was conducted at the group home on 4/4/14 at 11:30 A.M.. There was no documentation available to review indicating when/if client #4 had opportunities to participate in community activities. A review of client #4's financial ledgers/records dated 4/1/13 to current date failed to indicate he had opportunities to participate in community activities.</p> <p>A review of client #5's record was conducted at the group home on 4/4/14 at 12:15 P.M.. There was no documentation available to review indicating when/if client #5 had opportunities to participate in community activities. A review of client #5's financial ledgers/records dated 4/1/13 to current date failed to indicate</p>			

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	<p>she had opportunities to participate in community activities.</p> <p>A review of client #6's record was conducted at the group home on 4/4/14 at 12:30 P.M.. There was no documentation available to review indicating when/if client #6 had opportunities to participate in community activities. A review of client #6's financial ledgers/records dated 4/1/13 to current date failed to indicate he had opportunities to participate in community activities.</p> <p>A review of client #7's record was conducted at the group home on 4/4/14 at 1:15 P.M.. There was no documentation available to review indicating when/if client #7 had opportunities to participate in community activities. A review of client #7's financial ledgers/records dated 4/1/13 to current date failed to indicate he had opportunities to participate in community activities.</p> <p>A review of client #8's record was conducted at the group home on 4/2/14 at 1:00 P.M.. There was no documentation available to review indicating when/if client #8 had opportunities to participate in community activities. A review of client #8's financial ledgers/records dated 4/1/13 to current date failed to indicate he</p>			

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	<p>had opportunities to participate in community activities.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/4/14 at 2:00 P.M.. The QIDP indicated the facility tries to get the clients out to church functions. When asked about documentation of community participation for clients #1, #2, #3, #4, #5, #6, #7 and #8, the QIDP indicated there was no documentation available for review to indicate when/if clients #1, #2, #3, #4, #5, #6, #7 and #8 had opportunities to participate in community activities.</p> <p>9-3-2(a)</p>						
W000149	<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 for 7 of 8 clients residing at the group home (clients #1, #2, #3, #5, #6, #7 and #8), the facility failed to implement written policy and procedures to prevent abuse and</p>	W000149	<p>Dungarvin has a written policy and procedure in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). The Program Director has reviewed Policy B-2, including the need to prevent abuse and</p>	05/23/2014			

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	<p>neglect in regards to client to client aggression, allegations of staff neglect, and by not conducting investigations of allegations of abuse/neglect and unknown injuries.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 4/1/14 at 1:45 P.M.. Review of the records indicated:</p> <p>Incidents involving client #1:</p> <p>-BDDS report dated 6/17/13 involving clients #1 and #7 indicated: "[Client #7] had gone on a van ride to pick up his housemates from day program. After arriving home [client #7] was sitting on a chair in the living room. [Client #7] then proceeded to get up from the chair and walked by his housemate [client #1]. As [client #7] walked past his house mate he smacked [client #1] on the left side of her head. Staff immediately intervened by verbally redirecting [client #7] out of the living room area."</p> <p>-BDDS report dated 8/1/13 involving client #1 at the outside day program indicated: "On 8/1/13, a staff person from [client #1]'s day program, [Staff</p>		<p>neglect in regards to client to client abuse and the need to conduct investigations into all allegations of abuse, neglect, exploitation, including client to client abuse allegations and injuries of unknown origin. In a few of the examples cited, the Program Director did complete an investigation, however she failed to print and place those investigation reports in the binder with the incident reports. We re-trained all Program Director/QIDPs on the importance of keeping thorough records of all investigations. We also have template investigation reports to use as a guide in completing investigations into injuries of unknown origin as well as client to client abuse investigations. We re-trained all Program Director/QIDPs on the use of these forms. We have systematically reviewed this finding for all individuals at the facility to ensure that we universally implement our written policy and procedure to prevent abuse and neglect. Going forward, the Program Director is to ensure that a copy of each completed investigation report is forwarded to the Area Director within five business days of the incident. The Area Director will keep this copy of the investigation report on file as a backup to the copy placed in the incident report binder. The Area Director will not finalize approval of the initial</p>		

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	<p>name], currently suspended and under investigation for a previous incident involving other individuals, reported that staff were neglecting to change [client #1] until after 1:30 P.M. to 2:00 P.M. in the afternoon, leaving her soiled. The allegation of physical abuse (or verbal or neglecting depending on the specific allegation for the specific client) was not substantiated." Further review of the record failed to indicate the facility conducted an investigation in regards to the allegation of neglect at the outside day program.</p> <p>-BDDS report from outside day program dated 12/27/13 involving client #1 indicated: "While assisting [client #1] with an activity, day program staff noticed a raised, red/pink area on her left wrist, about 1.5 inches long and 1/2 inch wide. The day program nurse examined [client #1] at 11:00 and did not assess that first aid was needed. About an hour later, the area was found to be flat, but there was one solid firm lump under the skin of the red areas, and the red areas were a more clearly defined line of circles; at 2:10, these observations were unchanged. Mid-day staff noted [client #1] was not using her left hand as much as usual and that if she grabbed her left wrist, she quickly released it; later in in (sic) the afternoon, she moved it more.</p>		<p>internal incident report until he or she has verified that any needed investigation report has been completed and submitted. System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>	

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	<p>Staff noted [client #1] had been wearing a watch with a segmented band on that arm the day before; it appeared she might have bumped her arm while wearing the watch. Based on the initial appearance of the red area and how it changed, day program nurse estimated the injury had occurred on the morning of 12/17/13." Further review of the record failed to indicate the facility conducted an investigation in regards to this injury of unknown injury.</p> <p>-BDDS report dated 1/23/14 involving clients #1 and #7 indicated: "On 1/23/14, Staff called Program Director to report that while [client #1] was sitting in her wheelchair waiting for her transport to day program, her roommate (client #7) grabbed and pulled her hair causing her to scream for help."</p> <p>Incident involving client #2:</p> <p>-BDDS report dated 8/25/13 involving clients #2 and #7 indicated: "On 8/25/13, [client #2] was grabbed in his crotch area by his roommate (client #7), as [client #2] was walking past his roommate in the livingroom. His roommate was sitting on the floor as he reached out to grab [client #2]."</p> <p>Incidents involving client #3:</p>			

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	<p>-BDDS report dated 6/6/13 involving client #3 indicated: "Throughout the night from 1 A.M. to 5:30 A.M., [client #3] is to receive two cans of [Nutritional drink] administered via g-tube. On 6/6/13, 1 A.M. feeding, there was one can available instead of the two cans ordered for [client #3]. [Client #3]'s house did not receive a recent supply order of [client #3]'s [Nutritional drink] from the pharmacy." There was no documentation submitted for review to indicate an investigation was conducted in regards to this incident of neglect.</p> <p>-BDDS report dated 8/26/13 involving clients #3 and #7 indicated: "[Client #3] and [client #7] were riding on the van after pickups from Day Program. [Client #7] began to yell and reached back and hit [client #3] on his head one time. [Client #3] did not experience any injury from being hit on his head...."</p> <p>Incidents involving client #5:</p> <p>-BDDS report at outside day program involving client #5 indicated: "[Day program peer] was non-provoked, he grabbed [client #5] and pulled her out of her chair. [Day program peer] was redirected from group. [Client #5] feel (sic) onto her buttocks, assisted to her</p>			

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	<p>feet, once no injury noted. [Day program peer] was directed to the gym area in preparation to transport home. [Client #5] did not have any indicators of injury, but bruising could be experienced?"</p> <p>-BDDS report dated 4/4/13 involving clients #5 and #7 indicated: "[Client #5] was sitting in the kitchen at the breakfast bar chatting with staff waiting for her van to pick her up for day program. House mate (client #7) walked past [client #5] and grabbed her face leaving a red mark on the left cheek."</p> <p>Incident involving client #6:</p> <p>-BDDS report dated 10/15/13 at the outside day program involving client #6 indicated: " [Client #6] brings his lunch to day program each day, prepared for him by residential staff. When staff was getting ready to give [client #6] his main course, which was a chicken salad sandwich puree, they stirred it so the puree would have a uniform consistency and they noted a 2" (inch) chicken bone in the puree. They removed it and checked for any additional bones. Finding none, they gave [client #6] his lunch to eat. Considering that [client #6] feeds himself this could have been a potential choking hazard." Further review failed to indicate an investigation</p>			

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	<p>was conducted in regards to this incident of neglect.</p> <p>Incidents involving client #7:</p> <p>-BDDS report dated 4/2/13 involving client #7 indicated: "[Client #7] came running out of his room to the dinning (sic) room and instantly grabbed his housemates food off of his plate. He began running around yelling and screaming and smacking himself very hard on his face and head. Staff tried to re-direct him to his room to calm down and wait while his breakfast was being made. [Client #7] smacked and kicked at staff yelling and screaming this went on till his breakfast was done which he ate most of and threw his spoon and bowl at staff. He began yelling and screaming again threw himself on the floor and was banging his head on the floor and trying to hit and kick staff."</p> <p>Incident involving client #8:</p> <p>-BDDS report at outside day program dated 10/18/13 involving client #8 indicated: "As a [Transportation company] driver was helping [client #8] out of his vehicle, one [Day Program] staff told another that normally drivers asked not to get individuals out that far back in the line because some individuals</p>						

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	<p>are at risk getting out that far from the entrance. The [Transportation company] driver became upset and said 'I'll push the son of a b---h myself', referring to [client #8]. Both [Day program] staff offered to take over pushing [client #8]'s chair to the door, but the driver would not let them. He continued to use foul language and to complain that he would not have to unload so far back if we would get the vans in front of him out of the way." Further review of the record failed to indicate the facility conducted an investigation in regards to this allegation of verbal abuse.</p> <p>A review of the facility's records was conducted at the facility's administrative office on 4/1/14 at 1:30 P.M.. Review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14, indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statues including intentionally touching another person in a</p>			

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	<p>rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...Neglect is defined as failure to provide appropriate care, supervision, or training, failure to provide food and medical services as needed, failure to provide a safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/4/14 at 1:30 P.M.. The PD/QIDP indicated staff should follow the facility's abuse/neglect policy. The PD/QIDP indicated the facility's abuse/neglect policy should be followed</p>			

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	<p>at all times. When asked if there was documentation available for review to indicate the facility conducted investigations in regards to the noted incidents, the PD/QIDP indicated if investigations are conducted, they are attached to the BDDS reports. When asked about the incidents of client to client aggression, the QIDP indicated staff immediately intervene and implement the clients' Behavior Support Plans (BSPs). When asked if client's diet orders should be followed as ordered, the QIDP indicated yes. No documentation was submitted for review to indicate investigations were conducted in regards to the mentioned incidents.</p> <p>9-3-2(a)</p>						

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients and 1 additional client (clients #1 and #8), to provide evidence investigations were completed in regards to an injury of unknown origin and allegations of staff to client abuse/neglect.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 4/1/14 at 1:45 P.M.. Review of the records indicated:</p>	W000154	<p>The Program Director/QIDPs have been retrained in the investigative procedures of any allegations or complaints of abuse, mistreatment and neglect of the clients. The Area Director will monitor and supervise the Program Director/QIDP in the investigation of any allegations of abuse, mistreatment and neglect, including injuries of unknown origin and allegations of staff to client abuse. All investigative reports will be maintained in the office for review. We have systematically reviewed this finding in regards to all individuals residing in the facility to ensure that all needed investigations are completed in a timely fashion going forward. Going forward, the</p>	05/23/2014

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	<p>-BDDS report dated 8/1/13 involving client #1 at the outside day program indicated: "On 8/1/13, a staff person from [client #1]'s day program, [Staff name], currently suspended and under investigation for a previous incident involving other individuals, reported that staff were neglecting to change [client #1] until after 1:30 P.M. to 2:00 P.M. in the afternoon, leaving her soiled. The allegation of physical abuse (or verbal or neglecting depending on the specific allegation for the specific client) was not substantiated." Further review of the record failed to indicate the facility conducted an investigation in regards to the allegation of neglect at the outside day program.</p> <p>-BDDS report from outside day program dated 12/27/13 involving client #1 indicated: "While assisting [client #1] with an activity, day program staff noticed a raised, red/pink area on her left wrist, about 1.5 inches long and 1/2 inch wide. The day program nurse examined [client #1] at 11:00 and did not assess that first aid was needed. About an hour later, the area was found to be flat, but there was one solid firm lump under the skin of the red areas, and the red areas were a more clearly defined line of circles; at 2:10, these observations were</p>		<p>Program Director is to ensure that a copy of each completed investigation report is forwarded to the Area Director within five business days of the incident. The Area Director will keep this copy of the investigation report on file as a backup to the copy placed in the incident report binder. The Area Director will not finalize approval of the initial internal incident report until he or she has verified that any needed investigation report has been completed and submitted. System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>				

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	<p>unchanged. Mid-day staff noted [client #1] was not using her left hand as much as usual and that if she grabbed her left wrist, she quickly released it; later in in the afternoon, she moved it more. Staff noted [client #1] had been wearing a watch with a segmented band on that arm the day before; it appeared she might have bumped her arm while wearing the watch. Based on the initial appearance of the red area and how it changed, day program nurse estimated the injury had occurred on the morning of 12/17/13." Further review of the record failed to indicate the facility conducted an investigation in regards to this injury of unknown injury.</p> <p>-BDDS report at outside day program dated 10/18/13 involving client #8 indicated: "As a [Transportation company] driver was helping [client #8] out of his vehicle, one [Day Program] staff told another that normally drivers asked not to get individuals out that far back in the line because some individuals are at risk getting out that far from the entrance. The [Transportation company] driver became upset and said 'I'll push the son of a b---h myself', referring to [client #8] Both [Day program] staff offered to take over pushing [client #8]'s chair to the door, but the driver would not let them. He continued to use foul language</p>			

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W000189	<p>and to complain that he would not have to unload so far back if we would get the vans in front of him out of the way." Further review of the record failed to indicate the facility conducted an investigation in regards to this allegation of verbal abuse.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/4/14 at 1:30 P.M.. When asked if there was documentation available for review to indicate the facility conducted investigations in regards to the noted incidents, the PD/QIDP indicated if investigations are conducted, they are attached to the BDDS reports. No documentation was submitted for review to indicate investigations were conducted in regards to the mentioned incidents.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee</p>						

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	<p>with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (client #3), to provide training to assure staff competence in the implementation of client #3's "G-Tube (gastrostomy tube) Monitoring Plan."</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. At 4:50 P.M., Direct Support Professional (DSP) #3 was observed during client #3's G tube (Gastrostomy Tube) medication administration. DSP #3 retrieved client #3's medications located in the medication area in the day room area of the group home and walked to client #3's bedroom where client #3 lay in bed. DSP #3 was observed to lift client #3's shirt and connect a clear plastic tube to his navel area. DSP #3 then poured a small amount of a clear liquid substance into the tube and placed a large syringe into the tube causing the small amount of liquid to go down the tube. DSP #3 then poured an orange colored liquid into the tube followed by a clear liquid. The liquid did not go down. DSP #3 then placed the large syringe into the tube, but</p>	W000189	<p>The care plan for client #3's G-Tube Monitoring has been updated and the facility nurse has provided specific training to facility staff on the expectations of this plan. Facility nurse and Program Director/QIDP have been monitoring the ongoing competency of facility staff in this area by conducting random, unannounced Medication Pass Observations. We have systematically reviewed this concern for all individuals living in the facility to ensure that all needed risk plans are in place and that all DSPs are trained on the correct implementation of those risk plans. Going forward, we will ensure that the DSPs comply with this re-training through medication pass and/or Active Treatment observations completed by the Lead DSP, the facility nurse, or the Program Director/QIDP. For the next 4 weeks, observations will be completed twice a week. Once staff have demonstrated compliance, medication pass and/or active treatment observations will be completed at least once per month. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director. System wide, all</p>	06/14/2014

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	<p>the liquid did not go down. DSP #3 tried several times to get the liquid to go down, but it did not. DSP #3 then stated "I have to call the nurse, it's not going down." When asked if he checked for positioning and residual prior to beginning client #3's medication administration, DSP #3 indicated he had not checked them. DSP #3 was not observed to sanitize client #3's abdomen and did not check for positioning or residual prior to administering medications to client #3. DSP #3 did not explain the procedure and purpose of meds and feedings to client #3.</p> <p>A review of client #3's record was conducted on 4/2/14 at 3:20 P.M.. A review of client #3's "G-Tube Monitoring Plan" dated 12/3/13 indicated: "Desired outcome: The staff will be able to monitor the G-Tube for placement, signs of infection and administer medication by G-Tube in accordance with state regulations. Staff are to find the g-tube location (by feeling outside of clothing) prior to lifting his shirt. I would also give a description of what his placement looks like prior to doing anything else....Procedure: 1. Confirm MAR (Medication Administration Record), assemble equipment, clean work area, wash hands. 2. Explain procedure and purpose of meds and feedings to client,</p>		<p>Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's. Update: Between 5/18/14 and 5/30/14, we have conducted two observations per week, providing immediate feedback to the DSPs. We are now revising this plan of action to increase the frequency of observations while the DSPs are re-trained. For the next two weeks, we will complete 10 observations per week. If the staff are able to demonstrate competency in that time, we will consider reducing the frequency of observations. If they do not demonstrate competency, we will continue at the rate of 10 observations per week until full competency is demonstrated. Once the team has demonstrated competency, we will continue to have one observation formally completed per week, with at least one per month completed by the QIDP.</p>		

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	<p>follow general policy for administration of medication....6. Place syringe tip into tube and pull back stomach content. Should be clear to yellowish. If comes back with residual of feeding 100 cc or more, return feeding into stomach and call nurse for instructions. If resistance when pull back on syringe or returned fluid black in color DO NOT give meds and call nurse."</p> <p>A review of the facility's employee records was conducted on 4/4/14 at 1:20 P.M.. Review of the employee training records indicated the Qualified Intellectual Disabilities Professional (QIDP) conducted a 15 minute training for staff who worked at the group home on 12/3/13.</p> <p>An interview with the QIDP was conducted on 4/4/14 at 2:00 P.M.. When asked who conducted the 12/3/13 training on client #3's risk plan, the QIDP indicated she had conducted the training. When asked if staff should have followed client #3's risk plan, the QIDP indicated the staff should have followed the plan. When asked if staff should check for residuals prior to administering medications, the QIDP indicated she was not sure, began reading client #3's risk plan, then began reading the risk plan out loud and then stated "Yes."</p>						

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W000218	<p>9-3-3(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development. Based on observation, record review and interview for 3 of 4 sampled clients and 4 additional clients (clients #1, #3, #4, #5, #6, #7 and #8), the facility failed to obtain sensorimotor assessments.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/1/14 from 7:15 A.M. until 8:40 A.M.. During the entire observation period clients #1, #3, #4, #6 and #8 utilized wheelchairs for mobility. Client #5 utilized a walker for mobility and client #7 walked with an unsteady gait.</p> <p>An evening observation was conducted at the group home on 4/1/14 from 6:00 P.M. until 6:30 P.M.. During the entire observation period clients #1, #3, #4, #6 and #8 utilized wheelchairs for mobility. Client #5 utilized a walker for mobility and client #7 walked with an unsteady gait.</p>	W000218	We have systematically reviewed this concern for all 8 individuals residing at the facility. Updates sensorimotor assessments are being scheduled for clients 1, 3, 4, 5, 6, 7, and 8 as well as for any other individual at the home with an identified need. Any recommendations obtained from these assessments will be addressed by the QIDP and facility nurse immediately. All nurses and Program Director/QIDPs have been retrained on the expectation that all individuals require a current sensorimotor assessment to evaluate their current status and to obtain recommendations from this outside support service in order to best support their health and safety. Going forward, the Program Director/QIDP, Facility nurse, Lead DSP and Medical Support DSP will document on their regular bi-weekly meeting agendas that they have reviewed all current appointments and the master medical schedule for each individual, in order to ensure that we do not miss scheduling these	05/23/2014	

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	<p>A review of client #1's record was conducted on 4/2/14 at 3:42 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #3's record was conducted on 4/2/14 at 4:40 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #4's record was conducted on 4/4/14 at 11:30 A.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #6's record was conducted on 4/4/14 at 12:30 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #7's record was conducted on 4/4/14 at 1:15 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>A review of client #8's record was conducted on 4/4/14 at 1:00 P.M.. Review of the record did not indicate a sensorimotor assessment.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was</p>		<p>assessments.System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>	

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W000220	<p>conducted on 4/4/14 at 2:00 P.M.. The PD/QIDP indicated clients #1, #3, #4, #6 and #8 used a wheelchair for ambulation. The PD/QIDP indicated client #5 used a walker for mobility and client #8 had an unsteady gait when walking. The PD/QIDP indicated she could not find documentation in clients #1, #3, #4, #5, #6, #7 and #8's records to indicate the clients had a sensorimotor assessment completed.</p> <p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. Based on observation, record review and interview, the facility failed for 2 of 4 sampled clients and 3 additional clients (clients #1, #4, #6, #7 and #8) to ensure a speech assessment was completed for clients who need assistance with communication skills.</p> <p>Findings include:</p>	W000220	<p>We have systematically reviewed this concern for all 8 individuals residing at the facility. Updated speech therapy assessments are being scheduled for clients 1, 4, 6, 7, and 8 as well as for any other individual with an identified need in this area at the home. Any recommendations obtained from these assessments will be addressed by the QIDP and facility nurse immediately. All</p>	05/23/2014			

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	<p>A morning observation was conducted at the group home on 4/1/14 from 7:15 A.M. until 8:40 A.M.. During the entire observation clients #1, #4, #6, #7 and #8 were non-verbal in communication in that the clients did not speak/communicate. There was no communication teaching or training for clients #1, #4, #6, #7 and #8 during this observation.</p> <p>An evening observation was conducted at the group home on 4/1/14 from 4:00 P.M. until 6:35 P.M.. During the entire observation clients #1, #4, #6, #7 and #8 were non-verbal in communication in that the clients did not speak/communicate. There was no communication teaching or training for clients #1, #4, #6, #7 and #8 during this observation.</p> <p>A review of client #1's record was conducted on 4/2/14 at 3:42 P.M.. Review of client #1's Individual Support Plan (ISP) dated 3/27/14 and/or record indicated she was non-verbal and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #4's record was conducted on 4/4/14 at 11:30 A.M.. Review of client #4's ISP dated 12/5/13</p>		nurses and Program Director/QIDPs have been retrained on the expectation that all individuals require a current speech and language assessment to evaluate their current status and to obtain recommendations from this outside support service in order to best support their health, safety, and to develop strategies to encourage expressive communication. Going forward, the Program Director/QIDP, Facility nurse, Lead DSP and Medical Support DSP will document on their regular bi-weekly meeting agendas that they have reviewed all current appointments and the master medical schedule for each individual, in order to ensure that we do not miss scheduling these assessments. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.				

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	<p>and/or record indicated he was non-verbal and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #6's record was conducted on 4/4/14 at 12:30 P.M.. Review of the record indicated client #6 was admitted to the facility on 8/1/07. Review of client #6's ISP dated 10/2/13 and/or record indicated he required assistance with communication and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #7's record was conducted on 4/4/14 at 1:15 P.M.. Review of client #7's ISP dated 10/29/13 and/or record indicated he required assistance with communication and did not indicate the client's speech and/or language skills had been assessed.</p> <p>A review of client #8's record was conducted on 4/4/14 at 1:00 P.M.. Review of client #8's ISP dated 11/21/13 and/or record indicated he required assistance with communication and did not indicate the client's speech and/or language skills had been assessed.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 4/4/14 at 2:00</p>			

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W000240	<p>P.M.. The QIDP indicated there was no documentation to indicate clients #1, #4, #6, #7 and #8's speech and/or language skills had been assessed.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview, the facility failed to develop written instruction related to how 3 of 4 sampled clients and 2 additional clients (clients #1, #3, #4, #6 and #8), who required assistance with mobility and who used wheelchairs for mobility, were to be transferred in and out of their wheelchairs</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/1/14 from 7:15 A.M. until 8:40 A.M.. During the entire observation period clients #1, #3, #4, #6 and #8 utilized a wheelchair for mobility.</p> <p>An evening observation was conducted at</p>	W000240	<p>The facility nurse developed written risk plans regarding transfers and mobility for clients #1, 3, 4, 6, and 8. In addition, we completed a systematic review of each individual at the home requiring assistance with mobility to ensure that any needed safety protocols were in place. All staff at the home have been trained on the newly developed safety protocols. The Program Director/QIDP and facility nurse have been monitoring the implementation of these plans through random, unannounced observations at the home. Going forward, we will ensure that the DSPs comply with this re-training through Active Treatment observations completed by the Lead DSP, the facility nurse, or the Program Director/QIDP. For the next 4 weeks, observations</p>	06/14/2014			

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	<p>the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. During the entire observation period clients #1, #3, #4, #6 and #8 utilized a wheelchair for mobility. At 4:30 P.M., Direct Support Professional (DSP) #4 was observed lifting client #4 from his wheelchair while toileting, using a Hoyer lift.</p> <p>A review of client #1's record was reviewed on 4/2/14 at 3:42 P.M.. Review of client #1's record did not indicate a protocol/guidelines on how to transfer client #1 in and out of her wheelchair. Review of her Individual Support Plan (ISP) dated 3/27/14 did not indicate how to transfer client #1 in and out of her wheelchair.</p> <p>A review of client #3's record was reviewed on 4/2/14 at 4:40 P.M.. Review of client #3's record did not indicate a protocol/guidance on how to transfer client #3 in and out of his wheelchair. Review of his ISP dated 4/11/13 did not indicate how to transfer client #3 in and out of his wheelchair.</p> <p>A review of client #4's record was reviewed on 4/4/14 at 11:30 A.M.. Review of client #4's record did not indicate a protocol/guidance on how to transfer client #4 in and out of his wheelchair. Review of his ISP dated</p>		<p>will be completed twice a week. Once staff have demonstrated compliance, active treatment observations will be completed at least once per month. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's. Update: Between 5/18/14 and 5/30/14, we have conducted two observations per week, providing immediate feedback to the DSPs. We are now revising this plan of action to increase the frequency of observations while the DSPs are re-trained. For the next two weeks, we will complete 10 observations per week. If the staff are able to demonstrate competency in that time, we will consider reducing the frequency of observations. If they do not demonstrate competency, we will continue at the rate of 10 observations per week until full competency is demonstrated. Once the team has demonstrated competency, we will continue to have one observation formally completed per week, with at least one per month completed by the QIDP.</p>				

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	<p>12/5/13 did not indicate how to transfer client #4 in and out of his wheelchair.</p> <p>A review of client #6's record was reviewed on 4/4/14 at 12:30 P.M.. Review of client #6's record did not indicate a protocol/guidance on how to transfer client #6 in and out of his wheelchair. Review of his ISP dated 10/2/13 did not indicate how to transfer client #6 in and out of his wheelchair.</p> <p>A review of client #8's record was reviewed on 4/4/14 at 1:00 P.M.. Review of client #8's record did not indicate a protocol/guidance on how to transfer client #8 in and out of his wheelchair. Review of his ISP dated 11/21/13 did not indicate how to transfer client #8 in and out of his wheelchair.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 4/4/14 at 1:30 P.M.. When asked if there was a plan in place to give guidance when and how staff were to transfer clients #1, #3, #4, #6 and #8 in and out of their wheelchairs, the LPN stated "No, there aren't plans in place." When asked if clients #4's ISP gave written instruction to staff for the use of a lift, the LPN stated "I'm not sure."</p> <p>An interview with the Qualified</p>						

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W000249	<p>Intellectual Disabilities Professional (QIDP) was conducted on 4/4/14 at 2:00 P.M.. The QIDP indicated clients #1, #3, #4, #6 and #8's records did not contain plans/written instruction to give staff guidance on how and when staff were to transfer the clients in and out of their wheelchairs.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview, the facility failed to implement written objectives during times of opportunity for 4 of 4 sampled clients and 3 additional clients (clients #1, #2, #3, #4, #6, #7 and #8).</p> <p>Findings include:</p>	W000249	All staff working at the site have been retrained on each of these seven individuals' goals and objectives as identified in their Individual Program Plans. Random observations have been conducted by the Program Director or designee to ensure that each staff is implementing those goals and objectives. Systematically, we	06/14/2014

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	<p>A morning observation was conducted at the group home on 4/1/14 from 7:15 A.M. until 8:40 A.M.. During the entire observation period, client #3 stayed in his room with no activity or interaction. Clients #1 and #8 sat in their wheelchairs in the living room with no activity or interaction. Clients #2 and #5 sat on the couch in the living room with no activity or interaction. Client #4 sat in his wheelchair in the day room and client #6 lay on the couch in the day room with no activity or interaction. Client #7 walked back and forth from the hallway to the kitchen area. Direct Support Professionals (DSPs) #1, #2 and #3 would walk through the facility and visually check on clients #1, #2, #3, #4, #5, #6, #7 and #8 but did not offer meaningful active treatment activities or implement client objectives. DSP #1 prepared clients' lunches. Client #4 did not pack his lunch. DSP #2 administered medications and DSP #3 walked back and forth from the bedroom area to the living room area.</p> <p>An evening observation was conducted at the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. Clients #1 and #8 sat in their wheelchairs in the living room with no activity or interaction. Clients #2 and #5 sat on the couch in the living room</p>		<p>also reviewed this concern for all individuals living at the facility to ensure that staff are trained on the goals and objectives in place, as well as reminding staff that all informal opportunities for active learning should be utilized to promote dignity and independence. Going forward, we will ensure that the DSPs comply with this re-training through Active Treatment observations completed by the Lead DSP, the facility nurse, or the Program Director/QIDP. For the next 4 weeks, observations will be completed twice a week. Once staff have demonstrated compliance, active treatment observations will be completed at least once per month. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director. System wide, all Program Director/QIDPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's. Update: Between 5/18/14 and 5/30/14, we have conducted two observations per week, providing immediate feedback to the DSPs. We are now revising this plan of action to increase the frequency of observations while the DSPs are re-trained. For the next two weeks, we will complete 10 observations per week. If the staff are able to demonstrate competency in that time, we will</p>		

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	<p>with no activity or interaction. Client #4 sat in his wheelchair in the day room and client #6 lay on the couch in the day room with no activity or interaction. Client #7 walked back and forth from the hallway to the kitchen area. DSPs #2, #3, #4 and #5 would walk through the facility and visually check on clients #1, #2, #3, #4, #5, #6, #7 and #8 but did not offer meaningful active treatment activities or implement client objectives. DSP #5 prepared dinner. At 5:30 P.M. DSP #2 administered medications to client #1. Client #1 did not bring her applesauce to the medication area. DSPs #3 and #4 walked back and forth from the bedroom area to the living room area, toileting clients.</p> <p>A review of client #1's record was conducted on 4/2/14 at 3:42 P.M.. Review of client #1's Individual Support Plan (ISP) dated 3/27/14 indicated the following training objectives which could have been implemented: "Will participate in making a choice between two items...Will identify a coin by pointing to it...Will bring her applesauce with her to the medication area during medication times."</p> <p>A review of client #2's record was conducted on 4/2/14 at 4:15 P.M.. Review of client #2's ISP dated 4/8/13</p>		<p>consider reducing the frequency of observations. If they do not demonstrate competency, we will continue at the rate of 10 observations per week until full competency is demonstrated. Once the team has demonstrated competency, we will continue to have one observation formally completed per week, with at least one per month completed by the QIDP.</p>	

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	<p>indicated the following training objectives which could have been implemented: "Will use sign language to say either 'yes' 'no' and 'more'...Will help with the chore of vacuuming...Will separate coins in the correct piles."</p> <p>A review of client #3's record was conducted on 4/2/14 at 4:40 P.M.. Review of client #3's ISP dated 4/11/13 indicated the following training objectives which could have been implemented: "Will identify a quarter...Will tell staff what his Jevity is for...Will hold his G-Tube while staff is giving his feeding."</p> <p>A review of client #4's record was conducted on 4/4/14 at 11:30 A.M.. Review of client #4's ISP dated 12/5/13 indicated the following training objectives which could have been implemented: "Will perform his daily exercises...Will identify a quarter...Will put his items in his lunch box."</p> <p>A review of client #6's record was conducted on 4/4/14 at 12:30 P.M.. Review of client #6's ISP dated 5/20/13 indicated the following training objectives which could have been implemented: "Will sign 'drink'...Will learn how to swipe his purchasing card."</p>			

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	<p>A review of client #7's record was conducted on 4/4/14 at 1:15 P.M.. Review of client #7's ISP dated 10/29/13 indicated the following training objectives which could have been implemented: "Will communicate a need using sign language."</p> <p>A review of client #8's record was conducted on 4/4/14 at 1:00 P.M.. Review of client #8's ISP dated 11/21/13 indicated the following training objectives which could have been implemented: "Will identify coins with staff assistance...Will communicate a his need/want using picture symbols."</p> <p>The Program Director/Qualified Intellectual Disabilities Professional Designee (PD/QIDP) was interviewed on 4/4/14 at 2:00 P.M.. The PD/QIDP indicated client objectives should be implemented at all times. The PD/QIDP further indicated clients #1, #2, #3, #4, #6, #7 and #8 should have been provided with meaningful active treatment activities during the observation periods.</p> <p>9-3-4(a)</p>						

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W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (clients #2 and #3), to have a vision evaluation/assessment as recommended.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 4/2/14 at 4:15 P.M.. Client #2's record indicated a most current vision evaluation dated 10/1/11 which indicated "Follow-Up Appointment date: 1 to 2 years." Further review of the record did not indicate client #2 returned for a vision evaluation/assessment as recommended by the optometrist.</p> <p>A review of client #3's record was conducted on 4/2/14 at 4:30 P.M.. Client #3's record indicated a most current vision evaluation which was not dated by the optometrist but was signed and dated that it was reviewed by the nurse on 6/17/09 which indicated "Return in 2 years." Further review of the record did not indicate client #3 returned for a</p>	W000323	<p>A vision exam is being scheduled for clients #2 and #3. The Program Director and Facility Nurse have been retrained on the expectation that follow up vision evaluations are to be completed as recommended by the optometrist. Going forward, the Program Director/QIDP, Facility nurse, Lead DSP and Medical Support DSP will document on their regular bi-weekly meeting agendas that they have reviewed all current appointments and the master medical schedule for each individual, in order to ensure that we do not miss scheduling these assessments. We have systematically reviewed this concern for all 8 individuals residing at the facility to ensure that all other vision evaluations have been completed as recommended. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF's.</p>	05/23/2014			

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W000331	<p>vision evaluation as recommended by the optometrist.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/4/14 at 2:00 P.M.. The PD/QIDP indicated clients #2 and #3 should have gone for the follow up appointment as recommended by the optometrist. The PD/QIDP indicated there was no evidence clients #2 and #3 returned to the optometrist in two years as recommended.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility failed for 4 of 4 sampled clients and 4 additional clients (clients #1, #2, #3, #4, #5, #6, #7 and #8), by not ensuring they received nursing services according to their medical needs.</p> <p>Findings include:</p> <p>1. An evening observation was</p>	W000331	Dungarvin Indiana is committed to providing nursing services according to the needs of each individual we support. The care plan for client #3's G-Tube Monitoring has been updated and the facility nurse has provided specific training to facility staff on the expectations of this plan. Facility nurse and Program Director/QIDP have been monitoring the ongoing competency of facility staff in this	06/14/2014

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	<p>conducted at the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. At 4:50 P.M., Direct Support Professional (DSP) #3 was observed during client #3's G tube (Gastrostomy Tube) medication administration. DSP #3 retrieved client #3's medications located in the medication area in the day room area of the group home and walked to client #3's bedroom where client #3 lay in bed. DSP #3 was observed to lift client #3's shirt and connect a clear plastic tube to his navel area. DSP #3 then poured a small amount of a clear liquid substance into the tube and placed a large syringe into the tube causing the small amount of liquid to go down the tube. DSP #3 then poured an orange colored liquid into the tube followed by a clear liquid. The liquid did not go down. DSP #3 then placed the large syringe into the tube, but the liquid did not go down. DSP #3 tried several times to get the liquid to go down, but it did not. DSP #3 then stated "I have to call the nurse, it's not going down." When asked if he checked for positioning and residual prior to beginning client #3's medication administration, DSP #3 indicated he had not checked them. DSP #3 was not observed to sanitize client #3's abdomen and did not check for positioning or residual prior to administering medications to client #3. DSP #3 did not</p>		<p>area by conducting random, unannounced Medication Pass Observations. Going forward, we will ensure that the DSPs comply with this re-training through medication pass and/or Active Treatment observations completed by the Lead DSP, the facility nurse, or the Program Director/QIDP. For the next 4 weeks, observations will be completed twice a week. Once staff have demonstrated compliance, medication pass and/or active treatment observations will be completed at least once per month. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director. All staff have been re-trained on the expectations regarding re-ordering of medications when the supply is low. We expect that a five day supply of each medication will be available in the home. All staff working are expected to notify the pharmacy when a medication is running low. Risk plans addressing cellulitis, septic arthritis and MRSA risks for client #6 have been developed by the facility nurse and all staff have been trained on these plans. Systematically, we have reviewed these concerns for all individuals at the facility to ensure that they will receive nursing services according to their medical need. System wide, all Program Director/QIDPs and</p>				

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	<p>explain procedure and purpose of meds and feedings to client #3.</p> <p>A review of client #3's record was conducted on 4/2/14 at 3:20 P.M.. A review of client #3's "G-Tube Monitoring Plan" dated 12/3/13 indicated: "Desired outcome: The staff will be able to monitor the G-Tube for placement, signs of infection and administer medication by G-Tube in accordance with state regulations. Staff are to find the g-tube location (by feeling outside of clothing) prior to lifting his shirt. I would also give a description of what his placement looks like prior to doing anything else....Procedure: 1. Confirm MAR (Medication Administration Record), assemble equipment, clean work area, wash hands. 2. Explain procedure and purpose of meds and feedings to client, follow general policy for administration of medication....6. Place syringe tip into tube and pull back stomach content. Should be clear to yellowish. If comes back with residual of feeding 100 cc or more, return feeding into stomach and call nurse for instructions. If resistance when pull back on syringe or returned fluid black in color DO NOT give meds and call nurse."</p> <p>A review of the facility's employee records was conducted on 4/4/14 at 1:20</p>		<p>Facility Nurses will review this standard and ensure that these concerns are being addressed at all Dungarvin ICF's.Update: Between 5/18/14 and 5/30/14, we have conducted two observations per week, providing immediate feedback to the DSPs. We are now revising this plan of action to increase the frequency of observations while the DSPs are re-trained. For the next two weeks, we will complete 10 observations per week. If the staff are able to demonstrate competency in that time, we will consider reducing the frequency of observations. If they do not demonstrate competency, we will continue at the rate of 10 observations per week until full competency is demonstrated. Once the team has demonstrated competency, we will continue to have one observation formally completed per week, with at least one per month completed by the QIDP.</p>				

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	<p>P.M.. Review of the employee records failed to indicate the facility's nursing staff trained all staff who worked at the group home on client #3's "G-Tube Monitoring Plan."</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 4/4/14 at 1:30 P.M.. When asked if there was documentation to indicate the facility's nursing services provided training to all staff who worked at the group home in regards to client #3's G-Tube protocol, the LPN indicated there was no documentation.</p> <p>2. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 4/1/14 at 1:45 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 4/23/13 involving client #1 indicated: [Client #1]'s Vimpat (seizures) 200 mg (milligram) tablets were out for her evening dose on 4/23/13 and her morning dose on 4/24/13. [Client #1] was out of refills as of 4/23/13. Staff contacted the pharmacy to have her meds sent to the site, but since [client #1] was out of refills the pharmacy could not send any. The pharmacy was not able to send a small supply, since the medication is a narcotic.</p>						

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	<p>The pharmacy required a new script from [client #1]'s doctor. The doctor was already out of the office at the time [client #1] needed her medication. [Client #1]'s doctor was contacted several times on 4/24/13 requesting for a refill. In the afternoon of 4/24/13, [client #1]'s doctor sent the script to the pharmacy. [Client #1]'s medication was delivered to her home on 4/24/13 at approximately 5 P.M.. Staff will closely monitor [client #1] for any side effects of missing two dosages of her Vimpat and will report any incidents immediately. Staff will also maintain [client #1]'s medication to ensure her medications do not run out of refills prior to needing more medication and will order them in a more prompt manner. [Facility name]'s nurse and Program Director will oversee that staff will follow through to monitor as refills are needed."</p> <p>-BDDS report dated 5/7/13 involving client #1 indicated: "[Client #1]'s Clonazepam (seizures) 2 mg tablets were out for the morning dose on 5/7/13. [Client #1] was out of refills as of 5/7/13 and the Pharmacy could not send an emergency supply since the medication is a narcotic and the Pharmacy required a new script from [client #1]'s Doctor. [Client #1]'s Doctor was contacted and a script was sent to the Pharmacy. [Client</p>			

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	<p>#1]'s medication was picked up and she will be on her regular medication schedule on the evening of 5/7/13. Staff will closely monitor [client #1] for any side effects of missing dose of her Clonazepam 2 mg and will report any incidents immediately. Staff will maintain [client #1]'s medication to ensure her medications do not run out of refills and will order them in a timely manner. [Facility name]'s nurse and Program Director will oversee that staff will follow through to monitor as refills are needed."</p> <p>-BDDS report dated 6/6/13 involving client #3 indicated: "Throughout the night from 1 A.M. to 5:30 A.M., [client #3] is to receive two cans of [Nutritional drink] administered via g-tube. On 6/6/13, 1 A.M. feeding, there was one can available instead of the two cans ordered for [client #3]. [Client #3]'s house did not receive a recent supply order of [client #3]'s [Nutritional drink] from the pharmacy."</p> <p>An interview with the facility's Licensed Practical Nurse (LPN) was conducted on 4/4/14 at 1:30 P.M.. When asked how the facility is to ensure clients' medications are available for administration, the LPN indicated there should always be a five day supply of</p>			

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	<p>available medications. When asked who is responsible for ensuring clients' medications are available for administration, the LPN indicated the group home staff are to order medications and make sure a five day supply is available. When asked who is responsible for making sure staff are ensuring a five day supply is available for all administrations, the LPN indicated the nurse should ensure medications are available.</p> <p>3. A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 4/1/14 at 1:45 P.M.. Review of the records indicated:</p> <p>-BDDS report date 8/3/13 involving client #6 indicated: Staff called to report to Program Director on call that while assisting [client #6] with a shower he noticed that his right elbow was swollen and there were scratches around the area...While at [Medical facility], [client #6] was evaluated by the doctor and was diagnosed with Cellulitis on right arm."</p> <p>-BDDS report dated 8/5/13 involving client #6 indicated: "[Client #6] had been taken to [Medical facility] on Saturday, August 3, 2013 for his right elbow that was red and swollen. The ER</p>			

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	<p>(Emergency Room) doctor had ordered antibiotics and said if the area appears to get worse to take him to the ER. [Client #6]'s arm and elbow area appeared more swollen and red on 8/5/13 and [client #6] was taken to [Hospital name] ER. [Client #6] was discharged from the hospital on Friday, August 9th. [Client #6] was given a diagnosis of having MRSA (methicillin resistant Staphylococcus aureus) in his synovial fluid (serves as lubricant to joints) that was withdrawn from his right elbow area. [Client #6] was on IV (Intravenous) antibiotics while he was hospitalized. Upon returning home, he was prescribed bactrim antibiotic."</p> <p>-BDDS report dated 8/22/13 involving client #6 indicated: "On 8/22/13, it was reported by [Outside day program] that [client #6] came in with an area on his left elbow that is about 1 1/2 " (inches) long and varies in width from about 1/4"-1/2". It is a closed wound, but appears to look red and inflamed. [Client #6] has not had any reported injuries that would cause a reddened area on his elbow. Due to recent hospitalization from 8/5/13 to 8/9/13, for similar redness and swelling of opposite elbow, [client #6] was transported by staff, to [Hospital name] ER for examination. Previously on 8/5/13, it was determined that [client</p>			

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	<p>#6] had MRSA in his synovial fluid from his right elbow area. [Client #6] was readmitted into the hospital upon examination at the ER. [Client #6] will receive continued IV antibiotic treatment, while being hospitalized....[Client #6] was discharged from the hospital on 8/26/13. He was diagnosed with septic arthritis in both elbows. The culture results showed MRSA. He was given Vancomycin IV (antibiotic), in the hospital and will be taking Zyvox (MRSA) at home. There is a contraindication to taking this medication with his current prescribed Carbamazepine (mood stabilizer); however, [Doctor name] wants him on it. Staff is to monitor his blood pressure frequently for high blood pressure. [Facility name] nurse instituted vital signs every 4 hours."</p> <p>-BDDS report dated 10/7/13 involving client #6 indicated: "10/7/13, [Client #6] awoke with his right elbow red, warm, swollen and showed signs of being tender. [Client #6]'s eyes were red all around the eye and eye lid and rash on right wrist was present. [Client #6] saw his doctor on 9/30/13 in the office concerning the rash on his wrist and his face. At that time [client #6] was prescribed Bactrim. [Client #6]'s doctor instructed for staff to take [client #6] to</p>				

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	<p>the ER should his conditions worsen, due to recent history of MRSA within his elbow joint fluid area. [Facility name] nurse also examined [client #6] on 10/7/13 and stated [client #6] should be examined by the ER....[Client #6]'s doctor diagnosed [client #6] with Olecranon Bursitis (inflammation behind elbow) and Facial Felliculitis (sic) (infection of hair follicles)...."</p> <p>-BDDS report dated 1/28/14 involving client #6 indicated: "[Client #6] displayed signs of not feeling well in the afternoon on 1/28/14. [Client #6] seemed to be weak and was not able to assist with his transfer from his chair to wheelchair as he usually would. [Client #6]'s body started to shake and he was warm to touch. Staff completed vital assessments by checking his blood pressure and temperature. [Client #6] had a temperature of 100.2 degrees. Staff called 911, because of [client #6]'s physical appearance of being weak and having a temperature. EMS (Emergency medical Services) arrived and transported [client #6] to [Hospital name] ER. [Client #6] was examined in the ER and was admitted into the hospital, with the diagnosis of pneumonia. [Client #6] will remain hospitalized at this time."</p> <p>A review of client #6's record was</p>			

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	<p>conducted on 4/4/14 at 12:30 P.M.. Review of client #6's record failed to indicate the facility's nursing services developed risk plans in regards to client #6's diagnoses of MRSA and septic arthritis.</p> <p>A review of the facility's employee records was conducted on 4/4/14 at 1:20 P.M.. Review of the employee records failed to indicate the facility's nursing staff trained all staff who worked at the group home on client #6's diagnoses of MRSA, cellulitis and septic arthritis.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 4/4/14 at 1:30 P.M.. The LPN indicated the facility's nursing services did not develop risk plans in regards to client #6's diagnoses of MRSA, cellulitis and septic arthritis. The LPN further indicated all staff who worked with client #6 were trained on MRSA and septic arthritis.</p> <p>9-3-6(a)</p>				

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W000336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview for 2 of 4 sampled clients (clients #1 and #3), the facility's nursing services failed to conduct quarterly nursing assessments of clients' health status and medical needs.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 4/2/14 at 3:42 P.M.. Client #1's record indicated nursing quarterlies were completed on 9/1/13, 11/26/13 and 2/20/14. There was no evidence in her record to indicate nursing quarterlies were completed for 6/13. Client #1's most current annual physical was dated 12/10/13. Client #1's 3/27/14 Individual Support Plan (ISP) indicated client #1's diagnoses included, but were not limited to, seizure disorder, rhett syndrome (autism), history of aspiration pneumonia</p>	W000336	<p>We have systematically reviewed this concern for all 8 individuals residing at the facility. The nursing quarterlies from 6/13 have been located and placed in the client files again. The last staff to purge forms from the medical file into overflow was under the incorrect assumption that only 3 quarterlies and the annual needed to be in the book. The Lead DSP, the Medical Support DSP, the Program Director/QIDP, and the facility nurse are all being retrained on the expectation that a full year of nursing quarterlies are expected to be filed in the medical file at any given time. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF's.</p>	05/23/2014

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	<p>and scoliosis. Client #1's 1/14 physician orders indicated client #1 received routine medications.</p> <p>A review of client #3's record was conducted on 4/2/14 at 4:40 P.M.. Client #3's record indicated nursing quarterlies were completed on 9/1/13, 11/26/13 and 2/20/14. There was no evidence in his record to indicate a nursing quarterly was completed for 6/13. Client #3's most current annual physical was dated 11/12/13. Client #3's 4/13/13 Individual Support Plan (ISP) indicated client #3's diagnoses included, but were not limited to, seizure disorder, cerebral palsy, blindness, g tube, ventricular shunt, autism, spastic quadriplegia. Client #3's 1/14 physician orders indicated client #3 received routine medications.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 4/4/14 at 1:30 P.M.. When asked how often nursing quarterlies are to be completed, the LPN stated "Nursing quarterlies are to be completed every three months." The LPN further indicated she did not know why the nursing quarterlies were not in the record.</p> <p>9-3-6(a)</p>						

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W000367	<p>483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration. Based on observation, record review and interview, the facility failed to keep medications for 1 of 3 sampled clients observed during the morning medication administration (client #3), identified until the point of administration.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. At 4:50 P.M., Direct Support Professional (DSP) #3 was observed during client #3's G tube (Gastrostomy Tube) medication administration. DSP #3 prepared client #3's medications in the medication area in the day room area of the group home and walked to client #3's bedroom where client #3 lay in bed. DSP #3 was observed to lift client #3's shirt and connect a clear plastic tube to his navel area. DSP #3 then poured a small amount of a clear liquid substance into the tube and placed a large syringe into</p>	W000367	<p>The system for administering medications to client #3 has been revised to ensure both that adequate privacy is provided to him and that the medications administered are identified until the point of administration. All staff are being trained on this system of medication administration. We have systematically reviewed the organized system for medication administration for each individual at the home and ensured that we are able to comply with the expectation that each medication remains identified until the point of administration. Going forward, we will ensure that the DSPs comply with this re-training through medication pass and/or the medical section of the Active Treatment observations completed by the Lead DSP, the facility nurse, or the Program Director/QIDP. For the next 4 weeks, observations will be completed twice a week. Once staff have demonstrated compliance, medication pass and/or active treatment</p>	06/14/2014

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	<p>the tube causing the small amount of liquid to go down the tube. DSP #3 then poured an orange colored liquid into the tube followed by a clear liquid. DSP #3 did not pour any of the medications administered to client #3 from their original packaging at the time of administration while in client #3's bedroom.</p> <p>A review of client #3's record was conducted on 4/2/14 at 3:20 P.M.. A review of client #3's "G-Tube Monitoring Plan" dated 12/3/13 indicated: "Procedure: 1. Confirm MAR (Medication Administration Record), assemble equipment, clean work area, wash hands. 2. Explain procedure and purpose of meds and feedings to client, follow general policy for administration of medication."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted at the facility's administrative office on 4/4/14 at 2:00 P.M.. The PD/QIDP indicated the medications should be administered directly from the original packaging while administering. The PD/QIDP indicated medications should never be prepared prior to administration. The PD/QIDP further indicated staff should follow client #3's</p>		<p>observations will be completed at least once per month. These observations will include immediate feedback to the DSPs and the observation forms will be submitted to the Area Director. System wide, all Program Director/QIDPs and facility nurses will review this standard and the need to ensure that this concern is being addressed at all Dungarvin ICF-MR's. Update: Between 5/18/14 and 5/30/14, we have conducted two observations per week, providing immediate feedback to the DSPs. We are now revising this plan of action to increase the frequency of observations while the DSPs are re-trained. For the next two weeks, we will complete 10 observations per week. If the staff are able to demonstrate competency in that time, we will consider reducing the frequency of observations. If they do not demonstrate competency, we will continue at the rate of 10 observations per week until full competency is demonstrated. Once the team has demonstrated competency, we will continue to have one observation formally completed per week, with at least one per month completed by the QIDP.</p>				

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W000383	<p>protocol as written.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 8 of 8 clients residing at the group home (clients #1, #2, #3, #4, #5, #6, #7 and #8), to ensure only authorized persons had access to the keys to the medication lock box and cabinet.</p> <p>Findings include:</p> <p>An evening observation was conducted at client #1, #2, #3, #4, #5, #6, #7 and #8's home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. During the entire observation Direct Support Professionals (DSPs) #2, #3, #4 and #5 walked in and out of the open/unsecured day room, where the medication cabinet was located and where clients #4 and #8 sat. At 5:30 P.M., DSP #2 began administering client #1's prescribed medications. After administering the medications, DSP #2</p>	W000383	We have systematically reviewed this concern for all 8 individuals residing at the facility. All staff at the home have been retrained on the expectation that the keys to the locked medication cabinets are to be kept secured at all times. We have purchased a wearable keychain for these keys to be kept on the designated med passer during each shift. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF's.	05/23/2014	

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W000436	<p>placed the medication keys on top of the desk and wheeled client #1 back to the living room. At 5:40 P.M., DSP #2 retrieved the medication cabinet keys from the desk and administered client #5's prescribed medications. After administering the medications, DSP #2 placed the keys on top of the desk and assisted client #5 back to the living room. At 5:50 P.M., DSP #2 began administering client #6's prescribed medications. After administering the medications, DSP #2 placed the keys on top of the desk and wheeled client #6 back to his bedroom.</p> <p>An interview with the Licensed Practical Nurse (LPN) was conducted on 4/4/14 at 1:30 P.M.. The LPN indicated the keys should only be available to authorized persons and further indicated the person responsible for administering medications should have the keys on them at all times.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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</p>						

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	<p>team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 4 sampled clients and 2 additional clients (clients #4, #6 and #8) to ensure client #4's wheelchair fit properly, to encourage and teach the use of footrests for client #6's wheelchair when transporting him in and out of the group home and to ensure client #8's personalized wheelchair was available for use.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 4/1/14 from 7:15 A.M. until 8:40 A.M.. During the entire observation client #4 sat in a standard wheelchair leaned over to the left. The wheelchair looked to be too small for client #4. Client #8 sat in a standard wheelchair during the entire observation. During the entire observation Direct Support Professionals (DSPs) #1, #2 and #3 wheeled client #6 around the group home with no footrests as his feet were dragging on the floor. At 8:20 A.M., DSP #3 wheeled client #6 to the van to transport to his day program with no footrests on his wheelchair with his feet dragging on the ground. DSPs #1, #2 and #3 did not prompt and did not assist client #4 with repositioning in his wheelchair and did not use footrests</p>	W000436	<p>Client #6 has had all repairs completed on his chair, including the addition of footrests to protect him when he is being assisted by staff with his mobility. Client #4's wheelchair is being completed right now. We anticipate receiving it any day now. Client #8 has had the work to his wheelchair completed. We have completed a systematic inspection of the wheelchairs, walkers, and other adaptive equipment for all other individuals in the home to ensure that they are meeting the needs of the individual, that they are clean, and that they are in good repair. All staff are responsible to monitor the wheelchairs and all adaptive equipment. Each night, the overnight staff are tasked with cleaning all wheelchairs, walkers, or other mobility aids. As they clean them, they are responsible to document any needed repairs on a maintenance work order, which is sent to the maintenance director and the Program Director. In addition, the Lead DSP is responsible to fill out a monthly site risk management checklist. Any outstanding needed repairs are to be listed on that form. The Program Director is responsible to determine in conjunction with the Maintenance Director and the Lead DSP whether the maintenance department can complete the repair needed or if our outside vendor will be involved in the</p>	05/23/2014	

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	<p>while wheeling client #6 in his wheelchair.</p> <p>An evening observation was conducted at the group home on 4/1/14 from 4:00 P.M. until 6:30 P.M.. At 4:10 P.M., DSP #3 wheeled client #6 into the group home from transporting from day program with no footrests on his wheelchair, with his feet dragging on the ground. During the entire observation period client #4 sat in a standard wheelchair leaned over to the left. The wheelchair looked to be too small for client #4. Client #8 sat in a standard wheelchair during the entire observation. DSPs #2, #3, #4 and #5 did not prompt and did not assist client #4 with repositioning in his wheelchair and did not use footrests while wheeling client #6 in his wheelchair.</p> <p>An interview with DSP #2 was conducted on 4/1/14 at 4:25 P.M.. DSP #2 indicated staff did not use foot rests on client #6's wheelchair. DSP #2 indicated clients #4 and #8's wheelchairs needed repairs.</p> <p>An outside day program observation was conducted on 4/4/14 from 8:00 A.M. until 10:00 A.M.. During the entire observation client #8 sat in a standard wheelchair.</p>		<p>repair. The Program Director is responsible to develop and implement an action plan for any needed repair identified for the adaptive equipment in the home. The Program Director monitors the completion of these proactive safety measures by reviewing maintenance requests on a daily basis as they are submitted, by reviewing the site risk management checklist on a monthly basis, and by direct observation of the individuals using their adaptive equipment during weekly site visits and monthly active treatment observations. System wide, all Program Director/QIDPs and facility nurses will review this standard and the need to ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>		

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	<p>An interview with Day Program staff #1 was conducted on 4/4/14 at 9:50 A.M.. Day Program staff #1 indicated client #8's wheelchair was broken and required repairs. When asked how long client #8 was without his wheelchair, Day Program staff #1 indicated it had been broken over a month.</p> <p>A review of client #4's record was conducted on 4/4/14 at 11:30 A.M.. Review of client #4's Individual Support Plan (ISP) dated 12/5/13 indicated client #4 had stiffness, spasticity and limited range of motion. The ISP indicated client #4 has a degenerative condition in which he is losing his abilities and uses a wheelchair for mobility at all times. The ISP further indicated: "[Client #4]'s wheelchair has had extended maintenance throughout this year and at times has had to have a 'loner' chair in place of his."</p> <p>A review of client #6's record was conducted on 4/4/14 at 12:30 P.M.. Review of client #6's ISP dated 10/2/13 indicated he used a wheelchair for mobility at all times. The ISP indicated: "[Client #6] is scheduled for a wheelchair evaluation and assessment for a new wheelchair that could possibly better fit his body. Along with checking on the possibility of having a tilt wheelchair to</p>			

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	<p>take pressure off of his elbow areas. [Client #6] tends to lean to one side while sitting in his wheelchair and will lean on his elbow causing pressure. Staff will work with [client #6] to sit up straight and maintain proper body posture alignment." Further review of the record failed to indicate client #6 had a wheelchair assessment completed.</p> <p>A review of client #8's record was conducted on 4/4/14 at 1:00 P.M.. Review of client #8's ISP dated 11/21/13 indicated he used a wheelchair for mobility at all times.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/4/14 at 2:00 P.M.. The PD/QIDP indicated client #4 sits improperly, leaned to the left, while in his wheelchair requiring repairs to the wheelchair frequently. The PD/QIDP indicated due to his size it is hard to keep him positioned upright because he leans to the left. When asked if an assessment had been completed to address his improper positioning while seated in his wheelchair, the PD/QIDP indicated she thought so but could not provide documentation to indicate an assessment had been completed. The PD/QIDP indicated staff should use footrests on</p>			

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W000440	<p>client #6's wheelchair when wheeling him in and out of the group home to prevent his feet from dragging on the ground. The PD/QIDP further indicated staff should prompt and teach clients on maintaining proper posture while seated in their wheelchairs. The PD/QIDP indicated client #8's personal wheelchair currently needed repairs and was using a loaner chair. When asked how long it would be before client #8 received his wheelchair for use, the PD/QIDP indicated she did not know.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview, the facility failed to conduct evacuation drills during the overnight/asleep shift (11:00 P.M. to 7:00 A.M.) during the first quarter (January 1st through March 31st) of 2013 which affected 8 of 8 clients living in the facility (clients #1, #2, #3,</p>	W000440	We have systematically reviewed this concern for all 8 individuals residing at the facility. All facility staff have been re-trained on the expectation regarding frequency of evacuation drills on each shift. These drills are being clearly assigned to staff on various shifts by the Lead DSP. The Program Director/QIDP is responsible to	05/23/2014

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W000460	<p>#4, #5, #6, #7 and #8.)</p> <p>Findings include:</p> <p>The facility's records were reviewed on 4/1/14 at 3:00 P.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3, #4, #5, #6, #7 and #8 on the overnight/asleep shift during the first quarter of 2013.</p> <p>The Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was interviewed on 4/4/14 at 2:00 P.M.. The PD indicated evacuation drills are to be conducted during each quarter for each shift.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on record review and interview, for 1 additional client (client #6), the facility failed to assure the staff provided food in accordance with client's diet order.</p> <p>Findings include:</p>	W000460	<p>monitor that these drills are occurring as assigned during weekly site visits. The Program Director/QIDP will be responsible to address any staff member who fails to perform this aspect of their job duties with retraining and disciplinary action. System wide, all Program Director/QIDPs will review this standard and the need to ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p> <p>At the time of this incident, the staff member responsible for packing the lunch for client #6 was suspended during an investigation of possible neglect. The investigation concluded that this was not an instance of neglect, but an instance of human error. The dining plan for client #6 was immediately revised to include a detailed de-boning</p>	05/23/2014			

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	<p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 4/1/14 at 1:45 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 10/15/13 at the outside day program involving client #6 indicated: " [Client #6] brings his lunch to day program each day, prepared for him by residential staff. When staff was getting ready to give [client #6] his main course, which was a chicken salad sandwich puree, they stirred it so the puree would have a uniform consistency and they noted a 2" (inch) chicken bone in the puree. They removed it and checked for any additional bones. Finding none, they gave [client #6] his lunch to eat. Considering that [client #6] feeds himself this could have been a potential choking hazard."</p> <p>A review of client #6's record was conducted on 4/4/14 at 12:30 P.M.. Review of client #6's "Health Care Plan for Choking/Aspiration" dated 10/2/13 indicated: "[Client #6] will only consume food prepared as ordered: a. Pureed.;b. Thin liquids."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was</p>		<p>protocol for any meats or fish products that we may prepare for him. All staff at the home were retrained on this revised protocol. The home has also started purchasing all boneless meat products for client #6 whenever possible. We have systematically reviewed this concern for all 8 individuals residing at the facility. A similar de-boning protocol has been put in place for any individual in the home with a similar modified diet, and a template de-boning protocol was provided to all Program Director/QIDPs state-wide to ensure that a similar incident never occurs in any Dungarvin facility. System wide, all Program Director/QIDPs and facility nurses will review this standard and the need to ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>		

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W000488	<p>conducted on 4/4/14 at 2:00 P.M.. The PD/QIDP indicated staff should have followed client #6's prescribed diet.</p> <p>9-3-8(a)</p> <p>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 and interview, the facility failed to assure 7 of 8 clients residing at the group home (clients #1, #2, #4, #5, #6, #7 and #8) were involved meal preparation.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group on 4/1/14 from 7:15 A.M. until 8:40 A.M.. At 7:30 A.M., Direct Support Professional (DSP) #2 began packing clients #1, #2, #4, #5, #6, #7 and #8's lunch bags. Clients #1, #2, #5 and #8 sat in the living room with no interaction and no activity. Clients #4 and #6 sat in the day room with no interaction and no activity. Client #7 walked back and forth from the hallway to the living room with no interaction and no activity. Clients #1, #2, #4, #5, #6, #7 and #8 did not assist in packing their</p>	W000488	<p>We have systematically reviewed this concern for all 8 individuals residing at the facility. All staff at the site will have been retrained on the expectation of providing family style dining during meal times. This includes encouraging the individuals to assist with all parts of the meal preparation. Random observations will be conducted by the Program Director or designee to ensure that each staff is implementing this expectation. Immediate feedback will be given to the staff during those observations. This will be documented on an Active Treatment Observation form. A copy of those forms will be given to the Area Director for review and follow up. System wide, all Program Director/QMRP's will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.</p>	05/23/2014

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W009999	<p>lunches and were not prompted to pack their lunches.</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/4/14 at 2:00 P.M.. The PD/QIDP indicated clients were capable of packing their lunches and further indicated they should be assisting in packing their lunches at all times.</p> <p>9-3-8(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. (16. A medication error or medical treatment error. 18. Use of any PRN medication related to an individual's</p>	W009999	<p>We have systematically reviewed this concern for all 8 individuals residing at the facility. Dungarvin has a policy and procedure in place which addresses the reporting of incidents (policy A-7). All major incidents are to be reported by DSPs to a supervisor immediately. The supervisor is then to ensure that the incident is reported to BDDS, BQIS, APS, legal guardians or other required regulatory bodies within 24 hours. All staff at the home have been re-trained on this policy and the expectations regarding incident reporting. System wide, all Program Director/QIDPs will review this standard and ensure</p>	05/23/2014

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	<p>behavior.)</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 3 of 3 incidents, involving of 1 of 4 sampled clients and 1 additional client (clients #3 and #7), to report to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted on 4/1/14 at 1:45 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 6/5/13...date of knowledge 6/13/13 involving client #7 indicated: "Upon conducting medication review on 6/13/13, of [client #7]'s medications, it was found that [client #7] possibly missed his 8 A.M. dosage of Risperidone (bipolar) on 6/5/13. [Client #7] did receive all of his other regularly scheduled medications for this time frame and date. Staff did not initial the MAR (Medication Administration Record) and was unable to remember this medication specifically. [Client #7]'s bubble packs were also reviewed to see if</p>		that this concern is being addressed at all Dunganvin ICF-MR's.				

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	<p>it could be determined whether or not he received this medication. There is a possibility that [client #7] received his medication from an old bubble pack, but any previously used bubble packs have since been pulled from the medication area. Since it is unclear whether or not [client #7] received this medication, it is being treated as a missed medication."</p> <p>-BDDS report dated 4/18/13 indicated an incident of Self Injurious Behavior (SIB) involving client #3 indicated: "[Client #3] was exhibiting SIB of hitting himself on the face off and on for a period of about an hour and was unable to be redirected. Staff called the Program Director on-call and nurse. The nurse advised staff to give him his prn (as needed) med of Alprazolam 1 mg (milligram) (anxiety). He was given this med at 8:20 A.M.. [Client #3] was able to calm down after getting this medication and he later went to Day Program without further incident."</p> <p>BDDS report dated 12/31/13...Date of Knowledge: 1/2/14 involving client #3 indicated: "[Client #3] was continuously hitting himself over 15 minutes and was unable to be redirected by staff upon his arrival home from day program. There was no predetermining factors that staff was aware of that caused [client] to</p>			

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	<p>become self injurious. Staff continued to attempt to redirect [client #3]. Staff contacted [Facility name] nurse to request for administration of [client #3]'s PRN medication. Staff received authorization to administer. [Client #3] was calm and returned to regular activity within a half hour. Staff failed to notify Program Director regarding PRN administration as written in [client #3]'s PRN protocol after staff received nurse's approval. Program Director was unaware of PRN administration until 1/2/13 (sic) upon reviewing documentation."</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 4/2/14 at 8:00 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 4/4/14 at 1:30 P.M.. The PD/QIDP indicated all incidents are to be immediately reported to the administrator</p>			

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	<p>and within 24 hours to BDDS. The PD/QIDP indicated staff should have contacted the PD/QIDP immediately, the PD/QIDP would have notified the administrator and then reported the incidents to BDDS. The QIDP indicated because the PD/QIDP was not immediately notified, the administrator was not immediately notified and BDDS was not notified within 24 hours.</p> <p>9-3-1(b)</p>				