

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G452	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/30/2014
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 52812 HIGHLAND DR SOUTH BEND, IN 46635
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: June 24, 25, 26 and June 30, 2014.</p> <p>Facility number: 000966 Provider number: 15G452 AIM number: 100234470</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/15/14 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.</p> <p>Based on observation, record review, and interview for 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7,</p>	W000104	All staff at the home have been re-trained on the agency policy on smoking. A designated smoking area for employees is established a safe distance from the home	07/30/2014

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>and #8), the governing body failed to exercise general policy and operating direction over the facility to ensure implementation of the facility smoking policy.</p> <p>Based on observation and interview for 8 of 8 clients living at the group home (#1, #2, #3, #4, #5, #6, #7, and #8), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility was maintained in good repair.</p> <p>Findings include:</p> <p>On 6/24/14 between 4:43 PM and 6:52 PM, group home observations were conducted. At 4:43 PM, the garage door was open and Client #5 was sitting, not smoking, on one of two lawn chairs in the garage which was attached to group home by a door into the kitchen. The lawn chairs were less than 8 feet away from the entrance door to the kitchen. In between the lawn chairs was an ash tray cup. At 6:50 PM, the ash tray cup was not in view but there were 3 cigarette butts under one of the lawn chairs.</p> <p>On 6/25/14 between 6:30 AM and 8:25 AM, group home observations were conducted. At 8:05 AM, cigarette ashes were observed beneath a lawn chair in the</p>		<p>with a designated receptacle for disposing of the butts. Dungarvin has contracted the necessary staff to complete the painting and trim work needed throughout the home. The supplies are purchased and the work is scheduled for 7/28 and 7/29. All of the windows and window sills have been cleaned throughout the home. A schedule of window cleaning has been developed which identifies the responsible parties and acceptable timelines. We reviewed these findings and as they affected all individuals in the Highland facility already, we did not review for additional individuals. Going forward, the Lead DSP, Maintenance Coordinator, Program Director, and Area Director will all be responsible to check these areas of compliance. All DSPs, under the direction of the Lead DSP, will report needed routine maintenance needs to the Maintenance Director. The Program Director will complete weekly walk-thru checks of the home and the Maintenance Director is at the home at least monthly. The Area Director is at the home as another layer of safeguard at a minimum once per quarter. All of the employees in these key positions are being re-trained on the expectations that these concerns will be reported and acted on in a timely fashion.</p>	

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	<p>garage. At 8:05 AM, during an interview, the House Manager indicated staff are to smoke at a designated area in the back yard with an approved ash tray.</p> <p>On 6/26/14 at 12:08 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the facility did have a policy addressing smoking implemented to protect clients living in the group home (Clients #1, #2, #3, #4, #5, #6, #7, and #8). The QIDP stated staff were to be "8 to 10 feet" from an entrance. The QIDP indicated none of the clients in the home smoked.</p> <p>On 6/24/14 at 1:25 PM, the facility "Employee Professionalism" dated 4/24/14 was reviewed and indicated "B. Employees must NOT: 10. Smoke at any Dungarvin location (i.e., home of person served, office, etc.) including eight feet within the entrance to such location, as required by state law."</p> <p>2) On 6/24/14 between 4:43 PM and 6:52 PM and on 6/25/14 between 6:30 AM and 8:25 AM, group home observations were conducted. The dining room walls in the kitchen area had scuff marks throughout and around the dining room table predominantly under the chair rail. There was a square patch around the</p>			

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W000214	<p>corner of the soffit (outer lip of ceiling above counters) primed but not painted in the kitchen. The windows near the dining table were opened and dead flies were laying in the bottom window ledge. The maintenance issues had the potential to affect all clients residing in the group home (Clients #1, #2, #3, #4, #5, #6, #7 and #8).</p> <p>On 6/26/14 at 1:25 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated staff should have been cleaning the windows. The QIDP indicated the kitchen and dining area could use fresh paint.</p> <p>9-3-1(a)</p> <p>483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p>			

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	<p>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.</p> <p>Based on observation, record review, and interview, the facility failed to complete a comprehensive behavior assessment for 1 of 4 clients (Client #4) based on identified need.</p> <p>Findings include:</p> <p>On 6/24/14 between 4:43 PM and 6:52 PM, group home observations were conducted. The clients had eaten dinner early because they had a scheduled event. Between 4:43 PM and 5:55 PM, Client #4 remained at the kitchen sink and did dishes. Client #4 had a belt buckled tightly around his waist above his jeans. On 6/24/14 at 5:55 PM during an interview, Client #4 stated he "won't eat" some of the food his housemanager gives to him. Client #4 stated "if she makes me eat it" then indicated he would skip several days of meals. Client #4 stated he "needed to get it out" of his system. Client #4 indicated he would go to the restroom in the facility owned day program in the morning and run in place in the stall. Client #4 indicated he wanted to exercise off his breakfast meal. Client #4 spoke rapidly and talked extensively about items such as movies,</p>	W000214	<p>For client #4, we have reviewed all of our internal assessments to ensure they are updated and reflect his current needs. We have revised our Dungarvin Behavior Support Plan and are training all staff on this plan. At the same time, we have determined that he would benefit from the review of a behavior consultant company to ensure that a more clinical review of his concerns is completed. We have submitted the application to the behavior consultant company and they have agreed to take him on in August. This company had previously provided a consult to develop his current plan, so they have a solid, previous assessment to compare his current status to. In addition, the nurse has revised his dining support plan to include greater training for the staff about meal replacement options to offer to client #4. The plan also specifies the frequency of obtaining client #4's weight, and the threshold for contacting the nurse and/or the physician for additional recommendations. We have reviewed this finding for all individuals supported at the Highland group home to ensure that each individual requiring a comprehensive behavior assessment has this completed</p>	07/30/2014

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	<p>series, bands and production companies. Client #4 was knowledgeable and analytical about these interests and it was important to him to complete each collection. Client #4 indicated he doesn't always watch or even open all movies that he buys because he just wants to collect the whole series. Client #4 stated he "doesn't want the pills" when he was discussing his antidepressant medications.</p> <p>On 6/25/14 at 8:05 AM during an interview, the Housemanager (HM) indicated Client #4 had lived at home most of his life and was particular about which brands of food he would eat. The HM stated if staff cooked the food without Client #4 "seeing", he "usually would eat just fine." The HM stated Client #4 has "hoarding" issues due to his OCD (obsessive compulsive disorder).</p> <p>On 6/26/14 at 11:22 AM, record review indicated Client #4 diagnoses included, but were not limited to, mild intellectual disabilities and probable OCD (obsessive compulsive disorder). Record review indicated Client #4's ISP (Individual Support Plan) dated 6/5/14 included a BSP (Behavior Support Plan) dated 6/13/14. Client #4's BSP indicated his target behaviors were hoarding behaviors, and non-compliance (defined as "refusal</p>		<p>so that their program plans provide all needed supports. It is the responsibility of the Program Director/QIDP to identify the assessed needs of each client in the development of the individual program plan. All Program Director/QIDPs have been retrained on the importance of completing a comprehensive behavior assessment for any individual with that identified need. The completion of updated assessments is audited through quarterly master file reviews, also to be completed by the QIDP.</p>	

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	<p>to follow staff direction as related to time spent on computer usage and Internet access or refusal to self-care.") Client #4's BSP indicated "[Client #4] displays obsessive compulsive behaviors and his conversations will mainly center on movies with young boys, DVDs and magazines, Google (Internet search engine) and You-tube (Internet video site). [Client #4] wants to spend almost all his money on buying DVDs and magazines featuring movie stars when they were young boys. These behaviors are being addressed through counseling sessions." Client #4's BSP indicated he "may choose not to open his new DVDs, choose not to put on new shoes or new pairs of socks or clothing. He prefers to keep these in his closet as new."</p> <p>On 6/26/14 at 12:08 PM during an interview, the QIDP (Qualified Intellectual Disability Professional) indicated Client #4's counselor comes to assist him and Client #4 to clean out his room due to his hoarding tendencies. The QIDP stated Client #4 "likes to run in place" at work and staff are to redirect him back to work. The QIDP indicated Client #4's behavior to run in place at the day program has not been addressed in his ISP (Individual Support Plan)/BSP (Behavior Support Plan). The QIDP indicated Client #4 was particular about</p>			

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W000331	<p>eating because of the brands. The QIDP indicated Client #4 had not had a comprehensive behavior evaluation. The QIDP indicated a comprehensive behavior evaluation would be beneficial to Client #4 to better understand and address Client #4's identified behavior needs.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility nurse failed to ensure doctor's recommendations were followed in regards to eyelid scrub for 1 of 4 sampled clients (#3).</p> <p>Based on record review and interview, the facility nurse failed to ensure a dining plan was developed for 1 of 4 sampled clients (#4).</p> <p>Findings include:</p> <p>1) On 6/26/14 at 11:05 AM, record review indicated Client #3 had an eye doctor appointment on 2/1/13 which indicated Client #3 had blepharitis</p>	W000331	<p>For client #3, the eye scrub treatment has been added to the MAR as ordered. All staff are being trained on the MAR entry and related expectations. For client #4, the nurse developed a dining plan to address the medical end of his extremely particular eating habits. The plan includes a target caloric intake for snacks, lists food items that client #4 particularly enjoys, outlines a frequency for weighing client #4 and the weight threshold at which we need to notify the nurse and/or physician for further action. We are also contracting with an outside behavior support company for client #4 to ensure that a full evaluation of his behavioral support needs has been completed. All staff are</p>	07/30/2014

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	<p>(occurs when tiny oil glands near the base of the eyelashes malfunction leading to irritated, red, and itchy eyes) on both eyes. The physician note indicated "recommend lid scrubs 2x (two times) day."</p> <p>Record review of Client #3's MAR (medication administration record) dated 6/1/14 indicated no order or nursing consideration for the treatment of lid scrubs.</p> <p>On 6/27/14 at 1:09 PM, the QIDP (Qualified Intellectual Disability Professional) indicated in an email (electronic mail) there was no documentation to indicate the eye doctor's recommendation for lid scrubs two times daily was ever on Client #3's MAR (medication administration record). The QIDP indicated the eye doctor's recommendation should have been followed up by the nurse.</p> <p>2) On 6/24/14 between 4:43 PM and 6:52 PM, group home observations were conducted. The clients had eaten dinner early because they had a scheduled event. Between 4:43 PM and 5:55 PM, Client #4 remained at the kitchen sink and did dishes. Client #4 had a belt buckled tightly around his waist above his jeans. On 6/24/14 at 5:55 PM during an</p>		<p>being trained on the revised dining plan. We have reviewed these findings and systemically ensured that they do not affect the other individuals residing at the Highland group home. We audited the consultation forms and assessments for all individuals at the home to ensure that all needed risk plans are in place and that all recommended treatments and orders are in place. Going forward, we have revised the meeting agenda to be used by the Nurse and Med Support DSP during weekly reviews at the home. The revised form is uploaded with this Plan of Correction. For the next few months the Program Director/QIDP is expected to attend this weekly meeting to ensure a full team review of all concerns each week. Each week, all appointments and consultation forms will be reviewed to ensure that all new orders and recommendations have been implemented. Each week, one full file audit will also be conducted to ensure that nothing has slipped through and that a global look is taken at the overall needs for health support plans for each individual. All of the Med support DSPs, nurses, Lead DSPs, and Program Director/QIDPs were in-serviced on the expectations regarding this meeting and given the new form to use. Each week, this agenda, once completed, is</p>		

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	<p>interview, Client #4 stated he "won't eat" some of the food his housemanager gives to him. Client #4 stated "if she makes me eat it" then indicated he would skip several days of meals. Client #4 stated he "needed to get it out" of his system. Client #4 indicated he would go to the restroom in the facility owned day program in the morning and run in place in the stall. Client #4 indicated he wanted to exercise off his breakfast meal.</p> <p>On 6/25/14 at 8:05 AM during an interview, the Housemanager (HM) indicated Client #4 had lived at home most of his life and was particular about which brands of food he would eat. The HM stated if staff cooked the food without Client #4 "seeing", he "usually would eat just fine."</p> <p>On 6/26/14 at 11:22 AM, record review indicated Client #4 diagnoses included, but were not limited to, mild intellectual disabilities and probable OCD (obsessive compulsive disorder). Record review indicated Client #4's ISP (Individual Support Plan) dated 6/5/14 had no dining plan to indicate to staff which brands and types of foods Client #4 would eat, how to substitute items of nutritive value, and how best to prepare meals in Client #4's presence.</p>		to be forwarded to the Director of Nursing Services and the Area Director for further review and quality assurance.				

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W000436	<p>On 6/26/14 at 12:08 PM, the QIDP (Qualified Intellectual Disabilities Professional) stated Client #4 was "particular about brands, about brands he grew up on." The QIDP indicated Client #4 did not have a dining plan. The QIDP indicated Client #4 could benefit from a dining plan.</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 team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed to maintain adaptive equipment in regards to wrist splints for 1 of 4 sampled clients (#4).</p> <p>Based on observation, record review, and interview, the facility failed to encourage</p>	W000436	<p>For client #4, we were able to locate his wrist splint. It is available to him to wear as he chooses. He currently has refused to wear the splint. We have obtained an order from his primary care physician for a new evaluation to determine if this splint is still indicated for him. We will implement all new recommendations as soon as</p>	07/30/2014

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	<p>use of adaptive equipment in regards to wearing eye glasses for 1 of 4 sampled clients (#3).</p> <p>Findings include:</p> <p>1) On 6/24/14 between 4:43 PM and 6:52 PM and on 6/25/14 between 6:30 AM and 8:25 AM, group home observations were conducted. Throughout the observation, Client #4 did not wear wrist splints.</p> <p>On 6/26/14 at 10:36 AM, record review indicated Client #4's diagnoses included, but were not limited to, mild intellectual disabilities. Record review indicated Client #4 had a recommendation from an OTR (Occupational Therapist Registered) on 6/11/11 to "have [Client #4] wear wrist splint as needed or as he desires."</p> <p>On 6/27/14 at 1:09 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated through email (electronic mail) that the Housemanager (HM) indicated "[Client #4] used to wear a wrist splint to work a couple years ago, but she hasn't seen him wear it in a while. That it was [Client #4]'s choice when he needed to wear it, as written on order." No further documentation was available to indicate Client #4 still had a wrist</p>		<p>they are received. The QIDP has developed a program plan to encourage client #3 to wear his glasses as ordered by his eye doctor. All facility staff are being trained on this new program. We have reviewed this issue for all individuals residing at the Highland group home to ensure that all indicated adaptive equipment is present at the home, that the needed orders are on file, that the adaptive equipment is in good working order, and that appropriate learning programs are in place to encourage appropriate use of the adaptive equipment. It is a responsibility of the management team of the home - including the Med Support DSP, the Lead DSP, the Program Director/QIDP, and the facility Nurse to ensure that all adaptive equipment is available at the home, maintained in good repair, and that appropriate learning programs are in place to encourage appropriate use of the adaptive equipment. Going forward, we have revised the meeting agenda to be used by the Nurse and Med Support DSP during weekly reviews at the home. The revised form is uploaded with this Plan of Correction. For the next few months the Program Director/QIDP is expected to attend this weekly meeting to ensure a full team review of all concerns each week. After that, the Program Director will attend</p>				

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	<p>splint in his possession.</p> <p>2) On 6/24/14 between 4:43 PM and 6:52 PM and on 6/25/14 between 6:30 AM and 8:25 AM, group home observations were conducted. Throughout the observation, Client #3 did not wear his eye glasses. On 6/24/14 between 5:20 PM and 5:45 PM, Client #3 played a game on a cellphone and had to hold it close to his face to see the screen. Staff did not prompt or encourage Client #3 to wear his glasses.</p> <p>On 6/26/14 at 11:05 AM, record review indicated Client #3's diagnoses included, but were not limited to, intellectual disabilities and legal blindness. Record review indicated Client #3 had an ISP (Individual Support Plan) dated 10/29/13. Client 3's ISP did not include a formal goal to wear his glasses.</p> <p>On 6/25/14 at 8:05 AM during an interview, the Housemanager (HM) indicated Client #3 had a prescription for glasses and still had glasses at the home. The HM indicated Client #3 did not like to wear his glasses.</p> <p>On 6/26/14 at 12:08 PM during an interview, the QIDP (Qualified Intellectual Disabilities Professional) stated Client #3 "refuses to wear glasses."</p>		<p>at least every other week. Each week, all appointments and consultation forms will be reviewed to ensure that all new orders and recommendations have been implemented, including adaptive equipment needs. Each week, one full file audit will also be conducted to ensure that nothing has slipped through and that a global look is taken at the overall needs for adaptive equipment for each individual. All of the Med support DSPs, nurses, Lead DSPs, and Program Director/QIDPs were in-serviced on the expectations regarding this meeting and given the new form to use. Each week, this agenda, once completed, is to be forwarded to the Director of Nursing Services and the Area Director for further review and quality assurance.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G452	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/30/2014
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	The QIDP stated Client #3 did not have a "formal goal to encourage him" to wear his glasses. The QIDP indicated Client #3 would benefit from staff encouraging him to wear his glasses.  9-3-7(a)			