

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G573	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2016
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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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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: March 8, 9, 10, 11, and 14, 2016.</p> <p>Facility number: 001087 Provider number: 15G573 AIM number: 100239960</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/18/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to assure the facility was clean and in good repair for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 of 4 additional clients (clients #5, #6, #7, and #8).</p>	W 0104	<p>A maintenance request has been completed and the walls in the hallway will be painted and protective paneling will be installed if necessary to protect the walls from damage due to wheelchair use in the home. The hall heat diffuser will be replaced and the hole in the flooring repaired.</p> <p>For six weeks and then until</p>	04/13/2016

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

TITLE

(X6) DATE

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

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W 0263 Bldg. 00	<p>Findings include:</p> <p>The facility where clients #1, #2, #3, #4, #5, #6, #7, and #8 lived was inspected during the 3/9/16 observation period from 5:48 A.M. until 7:45 A.M. The walls in the hallway of the facility were scraped and missing paint in areas. The hallway heat diffuser was crushed and there was a hole in the floor near the back door of the facility. All of these areas were utilized by clients #1, #2, #3, #4, #5, #6, #7, and #8.</p> <p>Program Director #1 was interviewed on 3/10/16 at 8:33 A.M. Program Director #1 stated, "We were planning on getting these areas repaired although we don't have a work order in yet to have them repaired."</p> <p>9-3-1(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal</p>				<p>compliance has been demonstrated, the Program Director complete three time weekly site visits to ensure the home is free of hazards and/or any health and safety issues concerning the maintenance of the home and furniture therein. Thereafter, the Program Director will complete these checks at least weekly. System wide, all Program Director/QIDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>		

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	<p>guardian. Based on record review and interview, the facility failed to obtain written consent from 1 of 4 sampled clients (client #3) prior to implementing a restrictive Behavior Plan.</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 3/9/16 at 7:59 A.M. The review indicated client #3 was adjudicated incompetent and had the services of her parents as guardians. Further review of client #3's record indicated the client had a restrictive behavior plan, dated 2/11/16, which included physical interventions, and also addressed the management of client #3's behaviors of skin picking and self injurious behaviors. Additional review of the client's behavior plan failed to indicate the client's guardians had provided the facility with written consent for the plan's implementation.</p> <p>Program Director #1 was interviewed on 3/10/16 at 8:33 A.M. Program Director #1 stated, "We (the facility) sent the plan (behavior plan) to [Client #3's] guardians but we have not received it back from them yet."</p> <p>9-3-4(a)</p>	W 0263	<p>The Program Director/QIDP will beretrained on assuring that emancipated persons served or guardiansapprove Behavior Intervention Plans that are restrictive in nature,prior to implementing the plan. The Program Director / QIDP will ensure that a signature for approval of implementation of Client 3's plan is obtained by her guardians by 4/13/16 Quarterly, Program Director / QIDP will conduct audits of the clientfiles. This audit will include assuring that approvals by the PersonServed or their Guardian is obtained for any restrictive Behavior Plans. These audits will be reviewed by the Area Director for follow up assurance. System wide, all Program Director/QDDP's will review this standard and the needto assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>	04/13/2016	

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W 0336 Bldg. 00	<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. Based on record review and interview, the facility failed to assure nursing assessments were conducted at least quarterly (every 90 days) for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 3/10/16 at 6:15 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 3/10/16 indicated quarterly nursing assessments were completed on 10/14/15, 7/5/15, and 4/3/15. The review failed to indicate the client's nursing assessments were completed at least quarterly (every 90 days).</p> <p>Client #2's records were reviewed on 3/10/16 at 7:29 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 3/10/16 indicated quarterly nursing assessments were</p>	W 0336	<p>We have reviewed this concern for all 7 individuals residing at the facility. The previous facility nurse was on a leave of absence beginning December 2015 and left employment in March 2016. Other nurses employed by Dungarvin are filling in and have completed quarterly health assessments to ensure that the nursing quarterlies for all individuals in the home have been updated and are current. The Program Director / QIDP, and the facility nurse have been retrained on the expectation that a full year of nursing quarterlies are expected to be filed in the medical file at any given time and will be completed at least quarterly for every client in the home. 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/IDs.</p>	04/13/2016

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	<p>completed on 10/15/15, 7/6/15, and 4/3/15. The review failed to indicate the client's nursing assessments were completed at least quarterly (every 90 days).</p> <p>Client #3's records were reviewed on 3/10/16 at 7:59 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 3/10/16 indicated quarterly nursing assessments were completed on 10/15/15, 7/6/15, and 4/3/15. The review failed to indicate the client's nursing assessments were completed at least quarterly (every 90 days).</p> <p>Client #4's records were reviewed on 3/10/16 at 7:00 A.M. A review of the client's quarterly nursing assessments from 1/1/15 to 3/10/16 indicated quarterly nursing assessments were completed on 10/15/15, 7/6/15, and 4/3/15. The review failed to indicate the client's nursing assessments were completed at least quarterly (every 90 days).</p> <p>Program Director #1 was interviewed on 3/10/15 at 8:33 A.M. Program Director #1 stated, "Our (the facility's) nurse is on sick leave and there might be some assessments (quarterly nursing assessments) that have not been</p>				

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W 0382 Bldg. 00	<p>completed at this time."</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 of 4 additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed during the group home observation period on 3/9/16 from 5:48 A.M. until 7:45 A.M. At 5:54 A.M., direct care staff #2 was preparing medications to administer to client #7. Direct care staff #2 had client #7's medications on the medication room table when he left the medication room to locate client #7. The open medications</p>	W 0382	<p>Staff #2 received immediate disciplinary action and retraining on the standard that medications will be locked at all times except when being prepared for administration. All staff in the home will receive training on this expectation by 4/13/16. For six weeks and then until compliance has been demonstrated, the Program Director complete three site visits per week to ensure that medications are kept locked at all times except when being prepared for administration. If the Program Director/QIDP observes that a staff member has failed to keep medications secure, the Program Director will intervene and retrain the staff immediately. Documentation of these observations will be made on Active Treatment Observation forms. The five</p>	04/13/2016

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	<p>were left on the table making them accessible to clients #1, #2, #3, #4, #5, #6, #7, and #8. At 6:03 A.M., direct care staff #2 wheeled client #7 to the family room after administering the client's medications. Direct care staff #2 had client #7's medications on the medication room table when he left the medication room. The open medications were left on the table making them accessible to clients #1, #2, #3, #4, #5, #6, and #8.</p> <p>Program Director #1 was interviewed on 3/10/16 at 8:33 A.M. Program Director #1 stated, "Medications are to be locked when they aren't being administered."</p> <p>9-3-6(a)</p>				<p>observations will taper to one observation per week for quality assurance, once the Program Director/QIDP is satisfied that the staff have demonstrated full competency of the standard. The observation sheets will be turned in to the Area Director for review on a weekly basis. 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/IDs.</p>		