STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G750	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	60680 LILAC RD SOUTH BEND, IN 46614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: June 24, 25, 26, and 27, 2014. Facility number: 011765 Provider number: 15G750 AIM number: 200908290 Surveyor: Tim Shebel, LSW. The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed July 2, 2014 by Dotty Walton, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure molding in the living room was repaired and windows in the facility were cleaned for 2 of 2 sampled clients (clients #1 and #2), and 2 additional clients (clients #3 and #4) who lived at the facility.	W000104	**W104 483.410(a)(1)** **GOVERNING BODY** The molding in the living room was repaired on 6/27/14 and the windows were cleaned sometime during the week of 6/29/14. The Program Director evaluated the cleanliness of the windows on 7/11/14. The Program Director noted that they were cleaned on the outside and	07/27/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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	Findings include: The group home where clients #1, #2, #3, and #4 resided was inspected during the 6/25/14 observation period from 2:54 P.M. until 5:33 P.M. Base molding at the entrance to the south living room was unsecured and angled outward into the entrance of the living room. Windows in the facility were smudged with a hazy residue. Direct care staff #3 was interviewed on 6/26/14 at 7:47 A.M. Direct care staff #3 stated, "The molding is a hazard. I've almost tripped on it myself." Direct care staff #3 further stated, "I'm not sure who is responsible for cleaning the windows." Program Director #1 was interviewed on 6/26/14 at 10:59 A.M. Program Director #1 stated, "Maintenance is to work on fixing the broken molding and staff (direct care staff) are to clean the windows." 9-3-1(a)		inside of each window, but there continues to be a haziness to the windows that appears to come from between the panes. In the event this haziness is not able to be cleaned by staff, a maintenance request will be submitted to clear up the haziness and/or repair the windows. For two weeks and then until compliance has been demonstrated, the Program Director will do site-visits at least three times per week to ensure the home is free of tripping hazards, any health and safety issues concerning the maintenance of the home have been properly addressed, and that the windows are clean. Thereafter, the Program Director will complete these checks at least weekly. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/27/14** **Persons Responsible: Area Director, Program Director, and Maintenance Coordinator**	
W000137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all			

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	clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview, the facility failed to assure direct care staff assisted or prompted 1 of 2 sampled clients (client #1) to wear pants that fit. Findings include: Client #1 was observed at the group home during the 6/25/14 observation period from 2:54 P.M. until 5:33 P.M. During the observation period, client #1 grabbed the sides of his pants and held them up as he walked around the facility. Direct care staff #3 was interviewed on 6/26/14 at 7:47 A.M. Direct care staff #3 stated, "[Client #1] has a thin waist and it's hard to find pants for him that fit." Program Director #1 was interviewed on 6/26/14 at 10:59 A.M. Program Director #1 stated, "Some of his [client #1's] pants are too big. Staff (direct care staff) have been given money to buy him (client #1) some new pants." 9-3-2(a)	W000137	**W137 483.420(a)(12) PROTECTION OF CLIENT RIGHTS** The Individual has purchased pants that fit to replace the pants that did not fit him well. Furthermore, staff will assist the Individual in going through all of their clothing and recommend they discard, or donate any clothing that does not fit appropriately, and replace with newer, well fitting clothing. Staff will assist the other Individuals in going through all of their clothing and recommend they discard, or donate any clothing that does not fit appropriately, and replace with newer, well fitting clothing. Program Director will retrain staff on ensuring all Individual's right to retain and use appropriate personal possessions and clothing, including teaching and/or prompting them to wear more appropriately fitting clothing items. For two weeks and then until compliance has been demonstrated, the Program Director will do site-visits at least three times per week to ensure all Individuals are wearing well fitting and clothing items in good repair. Thereafter, the Program Director will complete these checks at least weekly. System wide, all Program Directors,	07/27/2014

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			QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/27/14** **Persons Responsible: Area Director, Program Director, and Maintenance Coordinator**	
W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review, and interview, the facility failed to apply denture adhesive to the dentures of 1 of 2 sampled clients (client #1) as per physician's orders. Findings include: Client #1 was observed at the group home during the 6/25/14 observation period from 2:54 P.M. until 5:33 P.M. As client #1 would speak to direct care staff #1, #2, #3, and #4, his dentures floated around in his mouth making his speech unintelligible. During the evening meal, as client #1 ate, his mouth moved in a chewing motion as his dentures floated around in his mouth adhered to the pieces of food which were in his mouth.	W000368	**W368 483.460(k)(1) DRUG ADMINISTRATION** In conjunction with the Plan of Correction for W369 and W436, the Program Director will retrain staff on ensuring all drugs are administered in compliance with the physician's orders. Program Director will retrain staff on ensuring the Individual applies denture adhesive cream to their dentures, when needed and per the physician's orders. In the event the Individual refuses to use denture adhesive cream, staff will document the refusal on his MAR. For two weeks and then until compliance has been demonstrated, the Program Director will review his MAR on a daily basis and if a trend of regular refusals is noted, the Program Director will address this need with the Individual's IDT in order to create a training goal for the Individual and train staff on its	07/27/2014

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	Client #1's 6/14 Medication Administration Record was reviewed on 6/26/14 at 7:07 A.M. The review indicated client #1 was to receive the following: "Fixadent Adhesive Cream (denture adhesive), apply to dentures in AM (morning) & (and) prn (as needed)." Further review of the client's 6/14 Medication Administration Record indicated client #1 had not received denture adhesive on 6/25/14. Direct care staff #3 was interviewed on 6/26/14 at 7:47 A.M. Direct care staff #3 stated, "[Client #1] doesn't like to use the denture adhesive." Client #1's records were reviewed on 6/26/14 at 8:37 A.M. Review of the client's 6/13/14 physician's orders indicated the following: "Fixadent Adhesive cream, apply to dentures in the AM & prn." Program Director #1 was interviewed on 6/26/14 at 10:59 A.M. Program Director #1 stated, "Staff (direct care staff) are to prompt [client #1] to use the Fixadent throughout the day." 9-3-6(a)		implementation to address this need and trend of refusals. After this, the Program Director will do weekly documentation reviews. Program Director will also review all other Individuals' MARs to ensure they are receiving their medications as per physician's orders. If any regular trends of refusals are noted, the Program Director will address this need with the Individuals IDT in order to create a training goal for the Individual and train staff on its implementation to address this need and trend of refusals. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/27/14** **Persons Responsible: Program Director**	

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W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed to assure 1 of 23 administered medications were administered according to physician's orders for 1 of 2 sampled clients (client #2). Findings include: Client #2 was observed during the group home observation period on 6/26/14 from 6:30 A.M. until 8:10 A.M. At 7:36 A.M., client #2 began eating a bowl of cereal and a piece of toast. At 7:40 A.M., direct care staff #4 administered the following medication to client #2: Metformin 500 mg (milligram) tablet (oral insulin). At 7:42 A.M., client #2 returned to the dining room table and continued eating his breakfast. Client #2's record was reviewed on 6/26/14 at 9:22 A.M. Review of client #2's 6/13/14 physician's orders indicated the following order: "Metformin 500 mg tablet. Give 1 tablet orally 2 times a day	W000369	**W369 483.460(k)(2) DRUG ADMINISTRATION** In conjunction with the Plan of Correction for W368 and W436, the Program Director will retrain staff on ensuring all drugs are administered in compliance with the physician's orders, and without error. The responsible staff person for this particular medication error has received disciplinary action and retraining on Medication Administration Policy. Program Director will retrain all staff on Medication Administration Policy. For two weeks and then until compliance has been demonstrated, the Program Director will review all Individuals' MARs on a daily basis and the Medical Support DSP will audit all Individual's medications to ensure all medications are being administered per Policy/Procedure and physician's orders. After this, the Program Director will do weekly documentation reviews and the Medical Support DSP will audit all Individual's medications to ensure all medications are being administered per Policy/Procedure and physician's orders. Furthermore, the Nurse or	07/27/2014

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	{30 min (minutes) before meals}." Program Director #1 was interviewed on 6/26/14 at 10:59 A.M. Program Director #1 stated, "[Client #2's] Metformin should be given 30 minutes before meals." 9-3-6(a)		Program Director will complete three Medication Administration Observations on the responsible staff above, to ensure they are administering medications according to Policy/procedure. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/27/14** **Persons Responsible: Program Director, Nurse, Medical Support DSP**	
W000436	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. Based on observation, record review, and interview, the facility failed to encourage and teach 1 of 2 sampled clients who wore eyeglasses (client #1) to wear his prescribed eyeglasses. Findings include: Client #2 was observed during the 6/25/14 group home observation period from 2:54 P.M. until 5:33 P.M., and	W000436	**W436 483.470(g)(2) SPACE AND EQUIPMENT** In conjunction with the Plan of Correction for W368 and W369, the Program Director will retrain staff on ensuring all Individual's adaptive equipment is being utilized by the Individuals, and that in the event they are refusing to do so, staff are documenting these refusals. For two weeks and then until compliance has been demonstrated, the Program	07/27/2014

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	during the 6/26/14 group home observation period from 6:30 A.M. until 8:10 A.M. During the all observation periods, client #1 did not wear his eyeglasses nor did direct care staff #1, #2, #3, and #4 prompt or assist client #1 to wear his eyeglasses. Client #1's record was reviewed on 6/26/14 at 8:27 A.M. A review of the client's 10/17/13 vision exam indicated client #1 was to be wearing eyeglasses. Program Director #1 was interviewed on 6/26/14 at 10:59 A.M. Program Director #1 stated, "[Client #1] doesn't like to wear his eyeglasses but staff (direct care staff) should prompt him to wear them." 9-3-7(a)		Director will review all Individuals' MARs on a daily basis to ensure all Individuals are using their adaptive equipment as prescribed and/or recommended per their ISP/IDT. After this, the Program Director will do weekly documentation reviews to ensure all Individuals are using their adaptive equipment as prescribed and/or recommended per their ISP/IDT. If the Program Director notes any trend of regular refusal, the Program Director will address this need with the Individual's IDT in order to create a training goal for the Individual and train staff on its implementation to address this need and trend of refusals. Furthermore, for two weeks and then until compliance has been demonstrated, the Program Director will complete three Active Treatment Observations per week to ensure all Individuals are using their adaptive equipment as prescribed and/or recommended per their ISP/IDT. After compliance has been demonstrated, the program Director will complete weekly Observations to ensure compliance. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/27/14** **Persons Responsible: Program**	

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			Director	
W000473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview, the facility failed to assure lettuce salad and chicken/spaghetti Alfredo were served within 15 minutes after placing the foods on the dining room table and kitchen counter. Findings include: Clients #1, #2, #3, and #4 were observed at the group home on 6/25/14 from 2:54 P.M. until 5:30 P.M. At 4:06 P.M., direct care staff #1 prompted and assisted client #3 in preparing a lettuce salad with salad dressing. Client #3 placed the salad on the dining room table at 5:09 P.M. Direct care staff #2 assisted client #1 in preparing chicken/spaghetti Alfredo. Upon completion of the chicken/spaghetti Alfredo, direct care staff #1 left the dish in a covered pan on the kitchen counter at 5:11 P.M. The lettuce salad and chicken/spaghetti Alfredo remained on the dining room table and kitchen counter until it was served to clients #1, #2, #3, and #4 for dinner at 5:22 P.M. Program Director #1 was interviewed on 6/26/14 at 10:59 A.M. Program Director	W000473	**W473 483.480(b)(2)(ii) MEAL SERVICES** The Program Director will retrain staff on ensuring all food is served at the appropriate temperature. For two weeks and then until compliance has been demonstrated, the Program Director, Lead DSP, Nurse, Medical Support DSP, or other designated staff person will complete daily Active treatment Observations during meal time to ensure all food is served at the appropriate temperature. After compliance has been demonstrated, the Program Director will complete weekly Observations to ensure compliance. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/27/14** **Persons Responsible: Program Director, Lead DSP, Nurse, and Medical Support DSP**	07/27/2014

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	#1 stated, "The foods (lettuce salad and chicken/spaghetti Alfredo) should have been served at the appropriate temperature. " 9-3-8(a)			
W000484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed to assure 4 of 4 clients eating the evening meal (clients #1, #2, #3, and #4) had spoons. Findings include: Clients #1, #2, #3, and #4 were observed eating the evening meal during the 6/26/14 observation period from 2:54 P.M. until 5:33 P.M. The meal consisted of lettuce salad, chicken/spaghetti Alfredo, bread sticks, and fruit salad. Client #3 asked direct care staff #2 for a spoon. Direct care staff #2 stated, "Just use your fork." Client #3 continued eating his fruit salad with a fork.	W000484	**W436 483.470(g)(2) SPACE AND EQUIPMENT** In conjunction with the Plan of Correction for W368 and W369, the Program Director will retrain staff on ensuring all Individual's adaptive equipment is being utilized by the Individuals, and that in the event they are refusing to do so, staff are documenting these refusals. For two weeks and then until compliance has been demonstrated, the Program Director will review all Individuals' MARs on a daily basis to ensure all Individuals are using their adaptive equipment as prescribed and/or recommended per their ISP/IDT. After this, the Program Director will do weekly documentation reviews to ensure all Individuals are using their adaptive equipment as prescribed	07/27/2014

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	Program Director #1 was interviewed on 6/26/14 at 10:59 A.M. Program Director #1 stated, "All of the clients should of had a spoon." 9-3-8(a)		and/or recommended per their ISP/IDT. If the Program Director notes any trend of regular refusal, the Program Director will address this need with the Individual's IDT in order to create a training goal for the Individual and train staff on its implementation to address this need and trend of refusals. Furthermore, for two weeks and then until compliance has been demonstrated, the Program Director will complete three Active Treatment Observations per week to ensure all Individuals are using their adaptive equipment as prescribed and/or recommended per their ISP/IDT. After compliance has been demonstrated, the program Director will complete weekly Observations to ensure compliance. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/27/14** **Persons Responsible: Program Director**	