

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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
W 0000  Bldg. 00	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00185099.</p> <p>COMPLAINT #IN00185099: Substantiated. Federal and state deficiencies are cited at W149 and W304.</p> <p>Dates of Survey: January 19, 20, 21, and 22, 2016.</p> <p>Facility number: 001015 Provider number: 15G501 AIM number: 100245120</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 1/28/16 by #09182.</p>	W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general</p>			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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			
	<p>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 light cover in the kitchen was cleaned and free of dead insects which affected 4 of 4 sampled clients (clients A, B, C, and D), and 3 of 3 additional clients (clients E, F, and G).</p> <p>Findings include:</p> <p>The group home where clients A, B, C, D, E, F, and G resided was inspected during the 1/19/16 observation period from 3:23 P.M. until 5:45 P.M. At 3:52 P.M., as clients A, B, and C were in the kitchen preparing their lunches for the next day, the overhead light cover in the kitchen was noted to be covered with dead insects.</p> <p>Program Director #1 was interviewed on 1/21/16 at 12:21 P.M. Program Director #1 stated, "Staff (direct care staff) or maintenance should make sure the overhead light cover is cleaned."</p> <p>9-3-1(a)</p>	W 0104	<p>A maintenance request has been completed and the light fixture will be cleaned by 2/21/16. All light fixtures in the home will be checked at the time the maintenance is completed and any fixtures containing dead insects will be cleaned. For six weeks and then until compliance has been demonstrated, the Program Director will complete five 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>	02/21/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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			
W 0130  Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed to assure privacy when toileting for 1 of 4 sampled clients (client D) who required privacy.</p> <p>Findings include:</p> <p>Client #4 was observed at the group home on 1/19/16 from 3:23 P.M. until 5:45 P.M. At 3:44 P.M., direct care staff #1 pushed client D in her wheel chair to the bathroom and transferred the client onto the toilet. While toileting client D, Direct care staff #1 left the bathroom door ajar. Direct care staff #1 did not close the door for privacy as client D was sitting on the toilet.</p> <p>Program Director #1 was interviewed on 1/21/16 at 12:21 P.M. Program Director #1 stated, "He (direct care staff #1) should have closed the door for privacy while toileting [client D]."</p> <p>9-3-2(a)</p>	W 0130	<p>Direct Care Staff #1 received disciplinary action and retraining on ensuring Clients #1's privacy rights during treatment and personal care needs are maintained. In addition, all direct care staff at the home will receive training on client rights by 02/21/16 to ensure all client rights in the home are protected. Going forward, the Program Director/QIDP or designee will observe the facility five times per week for six weeks or until proficiency is demonstrated, to ensure that the client's rights to privacy are maintained. If the Program Director/QIDP observes that a staff member has not maintained the rights of a client, the Program Director will intervene and retrain the staff immediately. Documentation of these observations will be made on Active Treatment Observation forms. The five 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. System wide, all Program Director/QIDPs and</p>	02/21/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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
W 0149 Bldg. 00	<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, the facility neglected to implement their abuse/neglect policy for failure to provide appropriate care to prevent injury while in restraint for 1 of 4 sampled clients (client C) who received an injury during a restraint.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/19/16 at 10:07 A.M. The review of incident reports from 9/1/15 to 1/19/16 indicated the following physical restraint which resulted in an injury to client C. "Name [client #C], Date and Time of Incident: 10/18/15, 8:46 PM, [Client C] came home from an outing where she went with other individuals. [Client C] claims that while she was in the house staff grabbed her right arm and bruised her. She (client C) showed the bruise as evidence to the Program Director (Program Director #1). Since this was an allegation of abuse, staff was suspended</p>	W 0149	<p>Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/IDs.</p> <p>During the incident with Client C on 10/18/15, Client C attempted to punch a housemate and staff blocked her punch in a manner which was in accordance with agency training, however the force with which Client C threw the punch and the location in which Client C was standing at the time resulted in her wrist hitting a wall, causing it to become bruised. Later, during the same incident Client C grabbed on to staff while she was seated on the sofa and Client C then pulled on staff, which caused Client C to move forward and then off the couch and onto the floor, which resulted in a bruised tailbone. As a result of this incident Client C's behavior plan was revised to include one-on-one staffing in an effort to reduce and prevent future incidents of this nature. All staff were trained on the BSP revisions on 12/4/15. Since the revision to the BSP has taken effect Client C's physically aggressive behaviors have been reduced. All staff are trained upon hire,</p>	02/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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	
	<p>immediately pending investigations. [Client C] was taken to the urgent care clinic as she was also claiming that she was hurting on her tail bone. The X-ray (sic) were done and it showed that [client C] has injury of right wrist, initial encounter-contusion of Coccyx (tail bone), initial encounter-skin abrasion. No new medications ordered."</p> <p>A facility investigation, dated 10/21/15, was reviewed on 1/19/16 at 10:55 A.M. Review of the investigation indicated client C, upon interview, indicated the alleged staff was restraining her (client C) from hitting another client.</p> <p>Client C was interviewed on 1/19/16 at 4:17 P.M. Client C stated she remembered the incident and the alleged staff was "restraining me from hitting [client A]." Client C further stated she "fell off of the couch while staff had hold of my arm."</p> <p>Client C's record was reviewed on 1/20/16 at 9:07 A.M. Review of the client's 10/22/15 behavior plan indicated the plan addressed client C's physical aggression and the client was to be restrained if she was hitting or was attempting to hit another client.</p> <p>Program Director #1 was interviewed on</p>		<p>annually and on an as-needed basis on the policy and procedure concerning abuse, neglect, and exploitation. The Program Director/QIDP and all direct care staff at the home will be retrained on abuse, neglect and exploitation policy. For the next six weeks, or until proficiency is demonstrated, the Program Director/QIDP will conduct five weekly unannounced visits to the home on various shifts in order to ensure that staff are accurately implementing the behavior plan and/or Dungarvin's abuse/neglect policy. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not following the BSP and/or Dungarvin's abuse/neglect policy. The visits will be documented on an Active Treatment Observation form and the Area Director will review them on a weekly basis for quality assurance purposes. After six weeks the visits will taper off when proficiency has been determined. System wide, all Program Director/QIDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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	
W 0304  Bldg. 00	<p>1/21/16 at 12:21 P.M. Program Director #1 stated, "The investigation (investigation of the 10/18/15 incident involving client C) indicated she (client C) received the bruise as a result of a restraint."</p> <p>The facility's records were further reviewed on 1/21/16 at 2:10 P.M. The facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation," dated 2/27/14, indicated, in part, the following: "C. Neglect is defined as failure to provide appropriate care, supervision or training . . ."</p> <p>This federal tag relates to complaint #IN00185099.</p> <p>9-3-2(a)</p> <p>483.450(d)(5) PHYSICAL RESTRAINTS Restraints must be designed and used so as not to cause physical injury to the client. Based on record review and interview, the facility failed to assure 1 of 1</p>	W 0304	During the incident with Client C on 10/18/15, Client C attempted to punch a housemate and staff	02/21/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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	
	<p>additional client who was physically restrained (client C) was not injured in the restraint.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 1/19/16 at 10:07 A.M. The review of incident reports from 9/1/15 to 1/19/16 indicated the following physical restraint which resulted in an injury to client C. "Name [client C], Date and Time of Incident: 10/18/15, 8:46 PM, [Client C] came home from an outing where she went with other individuals. [Client C] claims that while she was in the house staff grabbed her right arm and bruised her. She (client C) showed the bruise as evidence to the Program Director (Program Director #1). Since this was an allegation of abuse, staff was suspended immediately pending investigations. [Client C] was taken to the urgent care clinic as she was also claiming that she was hurting on her tail bone. The X-ray (sic) were done and it showed that [client C] has injury of right wrist, initial encounter-contusion of Coccyx (tail bone), initial encounter-skin abrasion. No new medications ordered."</p> <p>A facility investigation, dated 10/21/15, was reviewed on 1/19/16 at 10:55 A.M. Review of the investigation indicated</p>		<p>blocked her punch in a manner which was in accordance with agency training, however the force with which Client C threw the punch and the location in which Client C was standing at the time resulted in her wrist hitting a wall, causing it to become bruised. Later, during the same incident Client C grabbed on to staff while she was seated on the sofa and Client C then pulled on staff, which caused Client C to move forward and then off the couch and onto the floor, which resulted in a bruised tailbone. Staff was not restraining her at the time that she fell from the sofa. As a result of this incident Client C's behavior plan was revised to include one-on-one staffing in an effort to reduce and prevent future incidents of this nature. All staff were trained on the BSP revisions on 12/4/15. Since the revision to the BSP has taken effect Client C's physically aggressive behaviors have been reduced. All staff are trained upon hire, annually and on an as-needed basis on the policy and procedure concerning abuse, neglect, and exploitation as well as on Dungarvin's crisis intervention and de-escalation techniques. In conjunction with the corrective action for W0149, the Program Director/QIDP and all direct care staff at the home will be retrained on Dunagrvin's abuse, neglect and exploitation policy as well as</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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	
	<p>client C, upon interview, indicated the alleged staff was restraining her (client C) from hitting another client.</p> <p>Client C was interviewed on 1/19/16 at 4:17 P.M. Client C stated she remembered the incident and the alleged staff was "restraining me from hitting [client A]." Client C further stated she "fell off of the couch while staff had hold of my arm."</p> <p>Client C's record was reviewed on 1/20/16 at 9:07 A.M. Review of the client's 10/22/15 behavior plan indicated the plan addressed client C's physical aggression and the client was to be restrained if she was hitting or was attempting to hit another client.</p> <p>Program Director #1 was interviewed on 1/21/16 at 12:21 P.M. Program Director #1 stated, "The investigation (investigation of the 10/18/15 incident involving client C) indicated she (client C) received the bruise as a result of a restraint."</p> <p>This federal tag relates to complaint #IN00185099.</p> <p>9-3-5(a)</p>		<p>how to safely implement Dungarvin's crisis intervention and de-escalation techniques by 2/21/16. For the next six weeks, or until competency is demonstrated, the Program Director/QIDP will conduct five weekly unannounced visits to the home on various shifts in order to ensure that staff are accurately implementing the behavior plan and/or Dungarvin's abuse/neglect policy and crisis intervention and de-escalation techniques. During the observations, the Program Director/QIDP will offer immediate feedback to the staff members in an effort to coach the staff that are not following the BSP and/or Dungarvin's abuse/neglect policy and crisis intervention and de-escalation techniques. The visits will be documented on an Active Treatment Observation form and the Area Director will review them on a weekly basis for quality assurance purposes. After six weeks the visits will taper off when proficiency has been determined. System wide, all Program Director/QIDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-ID's.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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	
W 0312  Bldg. 00	<p>483.450(e)(2) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to assure psychotropic drug usage was addressed in the Individual Program Plan of 1 of 2 sampled clients (client B) receiving psychotropic medication.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 1/20/16 at 8:33 A.M. The review of the client's 1/16 Medication Administration Record indicated the client was receiving Seroquel (anti-psychosis medication). Review of the client's 1/27/15 Individual Program Plan failed to indicate an active treatment component had been implemented which addressed client B's use of the Seroquel and the management of the client's associated symptomatic</p>	W 0312	The Behavior Plan for Client B/2 will be updated to include the client's use of Seroquel. In addition, the Behavior Intervention Programs for all individuals in the home will be reviewed by the QIDP by 2/21/16 to ensure that all current psychotropic medications and behavioral needs are addressed. Should any plan not address the behavioral needs of all persons served in the home the plan(s) will be revised and sent to guardian(s), IDTs, and the HRC for the required approvals. The current QIDP will be retrained on the expectation that all psychotropic drug usage and behavioral needs will be addressed in the Individual Program Plan through the Behavior Intervention Program. System wide, all Program Director / QIDPs have reviewed	02/21/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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			
W 0455 Bldg. 00	<p>behaviors.</p> <p>Program Director #1 was interviewed on 1/21/16 at 12:21 P.M. Program Director #1 stated, "[Client B's] Seroquel needs to be added to his Behavior Plan."</p> <p>9-3-5(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, the facility failed to assure 1 of 4 sampled clients (client A) washed her hands prior to handling food items.</p> <p>Findings include:</p> <p>Client A was observed during the group home observation period on 1/19/16 from 3:23 P.M. until 5:45 P.M. At 4:00 P.M., direct care staff #2 prompted client A to come to the kitchen and pack her lunch for the next day. Client A used her walker to maneuver to the kitchen where direct care staff #2 prompted the client to make a lunch meat sandwich. Direct care</p>	W 0455	<p>this standard and will ensure that this concern is being addressed at all Dungarvin ICF-IDs.</p> <p>All staff will be retrained by 2/21/16 on the expectation that they exercise proper infection control standards and universal precautions as well as prompting and assisting each client to wash their hands prior to meal preparation, dining, and/or setting the table. The individuals at the home will have opportunities for learning by staff prompting them to wash their hands and providing assistance with hand washing in a manner consistent with their developmental level. The Program Director/QIDP will conduct five observations per week for the next six weeks or until competency is demonstrated to monitor that each individual is</p>	02/21/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G501	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  01/22/2016
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2816 YORK 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	
	<p>staff #2 did not prompt or assist client A to wash her hands prior to handling the food items for her lunch.</p> <p>Program Director #1 was interviewed on 1/21/16 at 12:21 P.M. Program Director #1 stated, "Staff (direct care staff #2) should have assured (client A) washed her hands prior to handling food items."</p> <p>9-3-7(a)</p>		<p>being prompted and assisted with hand washing in a manner consistent with her developmental level and the formal hand washing goals are implemented as required. The Program Director/QIDP will also observe staff during these five weekly visits to ensure that staff are washing their hands prior to meal times and meal preparation. Staff who fail to implement appropriate infection control measures will be retrained and will receive disciplinary action. The five weekly observations will taper to once weekly observations once staff have demonstrated full competence and compliance with this standard of care. System wide, all Program Director/QIDPs will review this standard and will ensure that this concern is being addressed at all Dungarvin ICF-ID's.</p>		