

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2014
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W000000	<p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: January 8, 9, 10, 13, 14 and 16, 2014.</p> <p>Facility number: 012557 Provider number: 15G791 AIM number: 201017960A</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed January 23, 2014 by Dotty Walton, 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 record review and interview, the governing body failed for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #4), to exercise general operating direction in a manner to provide oversight to ensure an accurate accounting of clients' funds, their abuse and neglect policy was</p>	W000104	<p>W104 483.410(a)(1) GOVERNING BODY 1. In conjunction with addressing W140, 483.420(b)(1)(i), An accurate accounting system for all clients will be implemented. All staff at the home will be retrained on the procedure and importance of maintaining an always current, accurate count of</p>	02/15/2014

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>implemented and to ensure thorough investigations were conducted.</p> <p>Findings include:</p> <p>1. Please refer to W140: The facility failed to maintain an accurate accounting system for 4 of 4 clients who reside at the group home (clients #1, #2, #3 and #4), for whom the facility managed their personal funds accounts.</p> <p>2. Please refer to W149: The facility neglected for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #4), to implement written policy and procedures to prevent alleged abuse and neglect.</p> <p>3. Please refer to W154: The facility failed for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #4), to provide written evidence investigations were conducted.</p> <p>9-3-1(a)</p>		<p>each client's checking account and petty cash. Monthly and random audits of each client's checking account ledger and petty cash ledger will be completed by the House Manager and QDDP to ensure up-to-date and accurate accounting of all funds. Going forward, the House Managers, Program Director/QDDP's are responsible to complete monthly and random audits of each client's checking account ledger and petty cash ledger. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: House Manager and QDDP 2. In conjunction with addressing W149, 483.420(d)(1) STAFF TREATMENT OF CLIENTS, Dungarvin has a written policy and procedures in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). All staff at the home have been trained on policy B-2. The House Manager and QDDP have been trained on Policy B-2, including the expectation that any incident of client to client aggression and Self Injurious Behavior (SIB) be addressed immediately, including an investigation, in order to prevent further incidents, and the findings of all investigations of abuse and neglect must be</p>				

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			<p>reported to the facility administrator within 5 business days.</p> <p>The Area Director will review all incident reports and ensure that a summary of each investigation is submitted in a timely manner.</p> <p>System wide, all House Managers and Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. Will be completed by: 2/15/14 Persons Responsible: House Manager and QDDP 3. In conjunction with addressing W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS, The House Manager and QDDP will be re-trained in the investigative procedures of any allegations or complaints of abuse, mistreatment and neglect of the clients, including the expectations that all violations are thoroughly investigated, and an Investigation Summary completed as evidence that all alleged violations have been thoroughly investigated. The Area Director will monitor and supervise the House Manager and QDDP in the investigation of any allegations of abuse, mistreatment and neglect. All investigative findings will be submitted to BDDS as follow-up reports and copies will be maintained in the office for</p>		

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based upon record review and interview, the facility failed to maintain an accurate accounting system for 4 of 4 clients who reside at the group home (clients #1, #2, #3 and #4), for whom the facility managed their personal funds accounts.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted at the group home office on 1/10/14 at 7:30 A.M. A review of client #1, #2, #3 and #4's personal petty cash financial records was conducted.</p> <p>There was no financial ledger to indicate the facility kept track of how much money was available for client #1's use at the group home and to indicate the facility was retaining an individual financial record, reconciliations and</p>	W000140	<p>review. System wide, all House Managers and Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. Will be completed by: 2/15/14 Persons Responsible: House Manager and QDDP</p> <p>W140, 483.420(b)(1)(i) In conjunction with addressing W104 483.410(a)(1) GOVERNING BODY, An accurate accounting system for all clients will be implemented. All staff at the home will be retrained on the procedure and importance of maintaining an always current, accurate count of each client's checking account and petty cash. Monthly and random audits of each client's checking account ledger and petty cash ledger will be completed by the House Manager and QDDP to ensure up-to-date and accurate accounting of all funds. Going forward, the House Managers, Program Director/QDDP's are responsible to complete monthly and random audits of each client's checking account ledger and petty cash ledger. System wide, all House Managers and Program Director/QDDP's will review this</p>	02/15/2014			

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	<p>receipts of her personal funds for the months of 12/13 and 1/14. Client #1's check book did not have a financial ledger to indicate the facility kept track of how much money was available for her in her bank account. Her checkbook indicated a blank voided check #1126 with a yellow sticky note with \$157.91 written on it.</p> <p>Direct Support Professional (DSP) #4 counted a balance of \$7.60 in client #2's personal petty cash financial pouch. There was no financial ledger to indicate the facility kept track of how much money was available for client #2's use at the group home and to indicate the facility was retaining an individual financial record, reconciliations and receipts of his personal funds. Further review of the record indicated there was no financial ledger for the months of 12/13 and 1/14.</p> <p>There was no financial ledger to indicate the facility kept track of how much money was available for client #3's use at the group home and to indicate the facility was retaining an individual financial record, reconciliations and receipts of his personal funds. Further review of the record indicated there was no financial ledger for the months of 12/13 and 1/14.</p>		<p>standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: House Manager and QDDP</p>		

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	<p>DSP #4 counted a balance of \$40.00 in client #4's personal petty cash financial pouch. There was no financial ledger to indicate the facility kept track of how much money was available for client #4's use at the group home and to indicate the facility was retaining an individual financial record, reconciliations and receipts of his personal funds. Further review of the record indicated there was no financial ledger for the months of 12/13 and 1/14.</p> <p>An interview with the Area Director (AD) was conducted on 1/14/14 at 10:30 A.M. The AD indicated the facility managed clients #1, #2, #3 and #4's finances and further indicated the facility was to keep an accurate account of their finances at all times. The AD further indicated each client should have a financial ledger which should reflect the clients' expenditures and balances to ensure they kept an accurate accounting of their petty cash funds by staff at the group home.</p> <p>9-3-2(a)</p>				

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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 2 of 2 sampled clients and 2 additional client (clients #1, #2, #3 and #4), the facility neglected to implement written policy and procedures to prevent alleged abuse/neglect regarding client to client aggression and Self Injurious Behavior (SIB) and failed to provide evidence thorough investigations were conducted.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 1/13/14 at 5:30 P.M. Review of the records indicated:</p> <p>-BDDS report dated 1/5/13 involving clients #2 and #1 indicated: "[Client #2] was at the dining room table eating and a housemate was sitting at the table also. [Client #2] told her housemate to stop watching her. [Client #1] and [client #2] exchanged some heated words that staff couldn't understand, and [client #2] followed after [client #1], when [client #1] had been directed to another room. [Client #1] turned around and [client #2]</p>	W000149	<p>W149 483.420(d)(1) STAFF TREATMENT OF CLIENTS In conjunction with addressing W104 483.410(a)(1) GOVERNING BODY, Dungarvin has a written policy and procedures in place that prohibits mistreatment, neglect or abuse of the clients (Policy B-2). All staff at the home have been trained on policy B-2. The House Manager and QDDP have been trained on Policy B-2, including the expectation that any incident of client to client aggression and Self Injurious Behavior (SIB) be addressed immediately, including an investigation, in order to prevent further incidents, and the findings of all investigations of abuse and neglect must be reported to the facility administrator within 5 business days.</p> <p>The Area Director will review all incident reports and ensure that a summary of each investigation is submitted in a timely manner.</p> <p>System wide, all House Managers and Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. Will be</p>	02/15/2014	

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	<p>punched [client #1] in the face. [Client #1] threw a glass of ice water on [client #2] and staff was able to break them apart."</p> <p>-BDDS report dated 1/27/13 involving client #1 indicated: "[Client #1] appeared to be in a good mood during the first shift, at 4 pm her mood changed when her staff changed. [Client #1] called her foster mom and talk (sic) to her for a while and after hanging up [client #1] wanted to change he (sic) clothes. [Client #1] went to a tote that was put up for the winter (summer clothes are stored in the tote) where she got out a pair of basketball shorts. [Client #1] then went to the restroom and closed the door behind her. Staff tried to go in behind her [client #1] told staff, 'leave me the f--- alone.' When [client #1] went to her room staff followed her again. [Client #1] shut the door before staff could get in the room with her and locked it. Staff opened the door and went in and [client #1] had her hooded sweatshirt on and her hood over her head. [Client #1] laid on her bed. Staff tried to talk to [client #1], asking her if everything was ok. [Client #1] told staff to look at her neck. [Client #1] had draped the string from her basketball shorts around her neck." Further review of the record did not</p>		completed by: 2/15/14 Persons Responsible: House Manager and QDDP				

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	<p>indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 1/31/13 involving clients #1 and #2 indicated: "[Client #1] was in the CAF (living room) area watching a movie with her staff and housemates. Her housemate (client #2) got up to go to the kitchen and slapped [client #1] in the face."</p> <p>-BDDS report dated 2/1/13 involving clients #1 and #2 indicated: "Staff and [client #2] were in the caf and housemate with their staff were in the kitchen cooking. Staff got up to gather books from the office and [client #2] got up and threw the remote at her housemate. staff came (sic) from the office and asked [client #2] to go to her room to calm down. She refused and attempted to hit/scratch staff...."</p> <p>-BDDS report dated 3/8/13 involving client #1 indicated: "[Client #1] said she needed to use the bathroom, while in the bathroom (she was not on safety status at the time). (sic) While she was in the bathroom she used her right hand (finger nails) to scratch the skin on the right side of her face. Staff asked why she did that because she appeared fine moments before the incident. [Client #1] shrugged her shoulders and walked out</p>						

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	<p>and retrieved papers from her bedroom (pictures she drew of herself hanging and colored red) she threw them away and staff performed a 4th room sweep and did not find anything."</p> <p>-BDDS report dated 4/2/13 involving clients #2 and #1 indicated: "[Client #2] became upset because it was her chore to do dinner dishes, staff reminded her that everyone has to (sic) their chore. [Client #2] stated 'Not everyone has to do it!' staff (sic) explained that they did. [Client #2] then looked at her roommate (client #10 and called her roommate a b---. Staff reminded [client #2] that she should not talk to people like that and asked if she would like to go to her room. [Client #2] yelled out a few more profanities and told her housemate she was going to punch her in the face..."</p> <p>-BDDS report dated 4/30/13 indicated an incident involving clients #1 and #2. The report indicated client #2 hit client #1 and grabbed her by her shirt and ripped it.</p> <p>-BDDS report dated 5/18/13 indicated an incident involving client #1 having SIB behavior using her left hand to scratch her right arm causing 3 scratches on the forearm.</p>			

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	<p>-BDDS report dated 5/21/13 indicated an incident involving clients #1 and #4. Client #4 called client #1 a b---- and client #1 slapped client #4.</p> <p>-BDDS report dated 5/23/13 indicated an incident in which client #1 hit client #2 on her head.</p> <p>-BDDS report dated 6/22/13 indicated an incident in which client #1 had SIB causing a scratch to her face.</p> <p>-BDDS report dated 10/21/13 indicated an incident in which client #1 had SIB due to a housemate (client #4) making remarks about client #1's past history of her cutting herself. Client #1 scratched her own face and scratched both her arms and shoulder.</p> <p>-BDDS report dated 10/21/13 indicated an incident in which clients #1 and #4 were horseplaying with staff. Client #4 became upset and began having SIB, banging her head on floors and walls and throwing her body against the living room entertainment center.</p> <p>-BDDS report dated 10/25/13 indicated an incident in which client #1 had SIB causing a surface cut measuring 1/4 inch on her right forearm.</p>				

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	<p>-BDDS report dated 12/8/13 involving client #1 indicated: "On Sunday, 12/8/13 [client #1] received a calendar from her roommate as a gift without staffs (sic) knowledge. [Client #1] had been a (sic) good mood all day and showed no signs of being depressed.. [Client #1] was in her bedroom and took a staple out of the calendar and pierced her left thigh (sic) it (sic) until she pushed the staple halfway (1/16th of an inch) under her skin..."</p> <p>-BDDS report dated 12/13/13 indicated an incident in which client #2 scratched and bit client #3. Client #3 then hit client #2 with a closed fist in her right eye.</p> <p>-BDDS report dated 1/4/14 indicated an incident in which client #1 had SIB scratching her face and both arms.</p> <p>-BDDS report dated 1/7/14 indicated an incident in which client #1 had SIB scratching her left arm.</p> <p>A review of the facility's "Policy and Procedure Concerning Individual Abuse, Neglect, and Exploitation" policy, dated 10/9/12, was conducted on 1/14/14 at 7:30 P.M. Review of the policy indicated:</p>						

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	<p>"Neglect or abuse of any consumer is strictly prohibited in any [agency] service delivery location. Each individual shall be free from mental, verbal and physical abuse, neglect, and exploitation....Reporting should be documented immediately, along with a description of the suspected incident on an Incident Report form. The Supervisor, or Program Coordinator/Senior Director, or his/her delegate will conduct a thorough investigation of the reported incident. The investigation will include the following:</p> <ol style="list-style-type: none"> 1. Review of witnesses. 2. Any evidence or previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the charge. <p>...The facility investigation will be completed within five (5) business days, and a summary of results of the investigation will be forwarded to the administrator within five (5) business days of the incident....Abuse is defined as:</p> <p>...2. Non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct</p>				

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	<p>which produces or could reasonably be expected to produce mental or emotional distress which includes, but is not limited to:</p> <ol style="list-style-type: none"> a. Intentionally touching another person in a rude, insolent or angry manner. b. willful infliction of injury. c. unauthorized restraint or confinement resulting from physical or chemical intervention. d. rape. <p>3. Emotional/verbal abuse, including but not limited to communicating with words or actions in a person's presence with the intent to:</p> <ol style="list-style-type: none"> a. cause the individual to be placed in fear of retaliation. b. cause the individual to be placed in fear of confinement or restraint. c. cause the individual to experience emotional distress or humiliation d. cause others to view the individual with hatred, contempt, disgrace or ridicule. e. cause the individual to react in a negative manner. <p>4. Domestic abuse, including but not limited to:</p> <ol style="list-style-type: none"> a. physical violence. b. sexual abuse. 			
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W000154	<p>c. emotional/vebal abuse. d. intimidation. e. economic deprivation. f. threats of violence.</p> <p>Neglect is defined as:</p> <p>1. Failure to provide appropriate supervision, care, or training. 2. Failure to provide a safe, clean and sanitary environment...."</p> <p>An interview with the Area Director (AD) was conducted on 1/14/14 at 10:40 A.M. The AD indicated staff should follow the facility's abuse/neglect policy. The AD indicated the facility's abuse/neglect policy should be followed at all times.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 2 sampled clients and 2 additional client (clients #1, #2, #3 and</p>	W000154	W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS In conjunction with addressing W104 483.410(a)(1)	02/15/2014			

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	<p>#4), the facility failed to provide evidence thorough investigations of client to aggression and self injurious behavior/SIB (possible neglect) were conducted.</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 1/13/14 at 5:30 P.M. Review of the records indicated there were no investigations for the following incidents client to client abuse and possible staff neglect regarding client SIB:</p> <p>-BDDS report dated 1/5/13 involving clients #2 and #1 indicated: "[Client #2] was at the dining room table eating and a housemate was sitting at the table also. [Client #2] told her housemate to stop watching her. [Client #1] and [client #2] exchanged some heated words that staff couldn't understand, and [client #2] followed after [client #1], when [client #1] had been directed to another room. [Client #1] turned around and [client #2] punched [client #1] in the face. [Client #1] threw a glass of ice water on [client #2] and staff was able to break them apart."</p> <p>-BDDS report dated 1/27/13 involving</p>		<p>GOVERNING BODY, the House Manager and QDDP will be re-trained in the investigative procedures of any allegations or complaints of abuse, mistreatment and neglect of the clients, including the expectations that all violations are thoroughly investigated, and an Investigation Summary completed as evidence that all alleged violations have been thoroughly investigated. The Area Director will monitor and supervise the House Manager and QDDP in the investigation of any allegations of abuse, mistreatment and neglect. All investigative findings will be submitted to BDDS as follow-up reports and copies will be maintained in the office for review. System wide, all House Managers and Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. Will be completed by: 2/15/14 Persons Responsible: House Manager and QDDP</p>		

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	<p>client #1 indicated: "[Client #1] appeared to be in a good mood during the first shift, at 4 pm her mood changed when her staff changed. [Client #1] called her foster mom and talk (sic) to her for a while and after hanging up [client #1 wanted to change he (sic) clothes. [Client #1] went to a tote that was put up for the winter (summer clothes are stored in the tote) where she got out a pair of basketball shorts. [Client #1] then went to the restroom and closed the door behind her. Staff tried to go in behind her [client #1] told staff, 'leave me the f--- alone.' When [client #1] went to her room staff followed her again. [Client #1] shut the door before staff could get in the room with her and locked it. Staff opened the door and went in and [client #1] had her hooded sweatshirt on and her hood over her head. [Client #1] laid on her bed. Staff tried to talk to [client #1], asking her if everything was ok. [Client #1] told staff to look at her neck. [Client #1] had draped the string from her basketball shorts around her neck." Further review of the record did not indicate an investigation was conducted in regard to this incident.</p> <p>-BDDS report dated 1/31/13 involving clients #1 and #2 indicated: "[Client #1] was in the CAF (living room) area</p>			

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	<p>watching a movie with her staff and housemates. Her housemate (client #2) got up to go to the kitchen and slapped [client #1] in the face."</p> <p>-BDDS report dated 2/1/13 involving clients #1 and #2 indicated: "Staff and [client #2] were in the caf and housemate with their staff were in the kitchen cooking. Staff got up to gather books from the office and [client #2] got up and threw the remote at her housemate. staff came (sic) from the office and asked [client #2] to go to her room to calm down. She refused and attempted to hit/scratch staff..."</p> <p>-BDDS report dated 3/8/13 involving client #1 indicated: "[Client #1] said she needed to use the bathroom, while in the bathroom (she was not on safety status at the time). (sic) While she was in the bathroom she used her right hand (finger nails) to scratch the skin on the right side of her face. Staff asked why she did that because she appeared fine moments before the incident. [Client #1] shrugged her shoulders and walked out and retrieved papers from her bedroom (pictures she drew of herself hanging and colored red) she threw them away and staff performed a 4th room sweep and did not find anything."</p>			

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	<p>-BDDS report dated 4/30/13 indicated an incident involving clients #1 and #2. The report indicated client #2 hit client #1 and grabbed her by her shirt and ripped it.</p> <p>-BDDS report dated 5/18/13 indicated an incident involving client #1 having SIB behavior where she used her left hand to scratch her right arm causing 3 scratches on the forearm.</p> <p>-BDDS report dated 5/21/13 indicated an incident involving clients #1 and #4. Client #4 called client #1 a b---- and client #1 slapped client #4.</p> <p>-BDDS report dated 5/23/13 indicated an incident in which client #1 hit client #2 on her head.</p> <p>-BDDS report dated 6/22/13 indicated an incident in which client #1 had SIB causing a scratch to her face.</p> <p>-BDDS report dated 10/21/13 indicated an incident in which client #1 had SIB due to a housemate (client #4) making remarks about client #1's past history of her cutting herself. Client #1 scratched her own face and scratched both her arms and shoulder.</p> <p>-BDDS report dated 10/21/13 indicated</p>						

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	<p>an incident in which clients #1 and #4 were horseplaying with staff. Client #4 became upset and began having SIB, banging her head on floors and walls and throwing her body against the living room entertainment center.</p> <p>-BDDS report dated 10/25/13 indicated an incident in which client #1 had SIB causing a surface cut measuring 1/4 inch on her right forearm.</p> <p>-BDDS report dated 12/8/13 involving client #1 indicated: "On Sunday, 12/8/13 [client #1] received a calendar from her roommate as a gift without staffs knowledge. [Client #1] had been a (sic) good mood all day and showed no signs of being depressed.. [Client #1] was in her bedroom and took a staple out of the calendar and pierced her left thigh (sic) it (sic) until she pushed the staple halfway (1/16th of an inch) under her skin..."</p> <p>-BDDS report dated 12/13/13 indicated an incident in which client #2 scratched and bit client #3. Client #3 then hit client #2 with a closed fist in her right eye.</p> <p>-BDDS report dated 1/4/14 indicated an incident in which client #1 had SIB scratching her face and both arms.</p>						

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W000157	<p>-BDDS report dated 1/7/14 indicated an incident in which client #1 had SIB scratching her left arm.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/15/14 at 12:15 P.M. The QIDP stated "I'm not sure if the incidents were investigated or not."</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 2 of 2 sampled clients and 2 additional clients (clients #1, #2, #3 and #4), the facility failed to take sufficient/effective corrective measures to prevent repeated episodes of client to client aggression/abuse and Self Injurious Behavior (SIB).</p> <p>Findings include:</p> <p>A review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports was conducted on 1/13/14 at 5:30 P.M. Review of the records</p>	W000157	<p>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS The House Manager and QDDP will review this standard. Going forward, all incidents of client to client abuse and Self Injurious Behavior (SIB) will be reviewed by the House Manager, QDDP, and Area Director to ensure that aggressive corrective action is implemented immediately following each incident. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be</p>	02/15/2014			

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	<p>indicated:</p> <p>1. -BDDS report dated 1/5/13 involving clients #2 and #1 indicated: "[Client #2] was at the dining room table eating and a housemate was sitting at the table also. [Client #2] told her housemate to stop watching her. [Client #1] and [client #2] exchanged some heated words that staff couldn't understand, and [client #2] followed after [client #1], when [client #1] had been directed to another room. [Client #1] turned around and [client #2] punched [client #1] in the face. [Client #1] threw a glass of ice water on [client #2] and staff was able to break them apart."</p> <p>-BDDS report dated 1/31/13 involving clients #1 and #2 indicated: "[Client #1] was in the CAF (living room) area watching a movie with her staff and housemates. Her housemate (client #2) got up to go to the kitchen and slapped [client #1] in the face."</p> <p>-BDDS report dated 2/1/13 involving clients #1 and #2 indicated: "Staff and [client #2] were in the caf and housemate with their staff were in the kitchen cooking. Staff got up to gather books from the office and [client #2] got up and threw the remote at her housemate. staff came (sic) from the</p>		completed by: 2/15/14 Persons Responsible: House Manager and QDDP				

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	<p>office and asked [client #2] to go to her room to calm down. She refused and attempted to hit/scratch staff...."</p> <p>-BDDS report dated 4/2/13 involving client #2 and #1 indicated: "[Client #2] became upset because it was her chore to do dinner dishes, staff reminded her that everyone has to (sic) their chore. [Client #2] stated 'Not everyone has to do it!' staff (sic) explained that they did. [Client #2] then looked at her roommate (client #1) and called her roommate a b---. Staff reminded [client #2] that she should not talk to people like that and asked if she would like to go to her room. [Client #2] yelled out a few more profanities and told her housemate she was going to punch her in the face..."</p> <p>-BDDS report dated 4/30/13 indicated an incident involving clients #1 and #2. The report indicated client #2 hit client #1 and grabbed her by her shirt and ripped it.</p> <p>-BDDS report dated 5/21/13 indicated an incident involving clients #1 and #4. Client #4 called client #1 a b---- and client #1 slapped client #4.</p> <p>-BDDS report dated 5/23/13 indicated an incident in which client #1 hit client #2 on her head.</p>			

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	<p>-BDDS report dated 10/21/13 indicated an incident in which clients #1 and #4 were horseplaying with staff. Client #4 became upset and began having SIB, banging her head on floors and walls and throwing her body against the living room entertainment center.</p> <p>-BDDS report dated 12/13/13 indicated an incident in which client #2 scratched and bit client #3. Client #3 then hit client #2 with a closed fist in her right eye.</p> <p>Review of the reports indicated the facility neglected to implement effective/sufficient corrective action to prevent recurrence of client to client aggression/abuse.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/15/14 at 12:15 P.M. The QIDP indicated she was not sure if any measures were put into place to prevent recurrence.</p> <p>2. -BDDS report dated 1/27/13 involving client #1 indicated: "[Client #1] appeared to be in a good mood during the first shift, at 4 pm her mood changed when her staff changed. [Client #1] called her foster mom and talk (sic)</p>			

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	<p>to her for a while and after hanging up [client #1 wanted to change he (sic) clothes. [Client #1] went to a tote that was put up for the winter (summer clothes are stored in the tote) where she got out a pair of basketball shorts. [Client #1] then went to the restroom and closed the door behind her. Staff tried to go in behind her [client #1] told staff, "leave me the f--- alone." When [client #1] went to her room staff followed her again. [Client #1] shut the door before staff could get in the room with her and locked it. Staff opened the door and went in and [client #1] had her hooded sweatshirt on and her hood over her head. [Client #1] laid on her bed. Staff tried to talk to [client #1], asking her if everything was ok. [Client #1] told staff to look at her neck. [Client #1] had draped the string from her basketball shorts around her neck."</p> <p>-BDDS report dated 3/8/13 involving client #1 indicated: "[Client #1] said she needed to use the bathroom, while in the bathroom (she was not on safety status at the time). (sic) While she was in the bathroom she used her right hand (finger nails) to scratch the skin on the right side of her face. Staff asked why she did that because she appeared fine moments before the incident. [Client #1] shrugged her shoulders and walked out</p>			

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	<p>and retrieved papers from her bedroom (pictures of herself hanging and colored red) she threw them away and staff performed a 4th room sweep and did not find anything."</p> <p>-BDDS report dated 5/18/13 indicated an incident involving client #1 having SIB behavior using her left hand to scratch her right arm causing 3 scratches on the forearm.</p> <p>-BDDS report dated 6/22/13 indicated an incident in which client #1 had SIB causing a scratch to her face.</p> <p>-BDDS report dated 10/21/13 indicated an incident in which client #1 had SIB due to a housemate (client #4) making remarks about client #1's past history of her cutting herself. Client #1 scratched her own face and scratched both her arms and shoulder.</p> <p>-BDDS report dated 10/25/13 indicated an incident in which client #1 had SIB causing a surface cut measuring 1/4 inch on her right forearm.</p> <p>-BDDS report dated 12/8/13 involving client #1 indicated: "On Sunday, 12/8/13 [client #1] received a calendar from her roommate as a gift without staffs (sic) knowledge. [Client #1] had</p>				

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	<p>been a (sic) good mood all day and showed no signs of being depressed. [Client #1] was in her bedroom and took a staple out of the calendar and pierced her left thigh (sic) it (sic) until she pushed the staple halfway (1/16th of an inch) under her skin..."</p> <p>-BDDS report dated 1/4/14 indicated an incident in which client #1 had SIB scratching her face and both arms.</p> <p>-BDDS report dated 1/7/14 indicated an incident in which client #1 had SIB scratching her left arm.</p> <p>Review of the reports indicated the facility neglected to implement effective/sufficient corrective action to prevent recurrence of client #1's SIB.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/15/14 at 12:15 P.M. The QIDP indicated she was not sure if any measures were put into place to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview, for 2 of 2 sampled clients (clients #1 and #2), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to monitor client #1 and #2's objectives as no monthly summaries had been completed from 1/13 to 1/14. The QIDP failed to monitor client #1 in regard to assessments, and failed to address identified needs for clients #1 and #2. The QIDP failed to ensure facility staff implemented clients #1 and #2's training objectives as outlined in the clients' Individual Support Plan (ISP). The QIDP failed to keep an accurate accounting of clients' finances and failed to train staff.</p> <p>Findings include:</p> <p>1. A review of client #1's record was conducted on 1/13/14 at 11:55 A.M.. Review of client #1's most current Individual Support Plan (ISP) dated 6/18/13 indicated: "Will have leisure time 5 x (times) a week...Will count</p>	W000159	<p>W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL In conjunction with addressing W104, W140, W157, W149, W154, W189, W218, W220, and W249, the QDDP will be retrained by Area Director to ensure each client's active treatment program is consistently integrated, coordinated, and monitored. Training will include, but is not limited to, ensuring Monthly Summaries are completed including documentation of progress on objectives, all required assessments are completed and reviewed annually and as needed, ensure accurate accounting of all clients' finances, ensure identified needs of clients, to ensure all staff are trained on each client's ISP, Risk Plans, and Behavior Plans, and to ensure all training objectives are implemented by staff when formal/informal opportunities exist. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons</p>	02/15/2014			

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	<p>change and dollars... Will complete daily chores... Will have zero incidents of elopement... Will exercise once a day... Will state the name of her morning medications... Will use a knife correctly hand over hand... Will complete her laundry... Will gain an understanding of appropriate verbal communication... Will have zero incidents of elopement... Will read rotating with staff for 15 minutes... Will have 3 incidents or less of refusals... Will have 3 incidents or less of SIB (Self Injurious Behavior)... Will work with staff 3 times a week to learn her social security number... Will brush her teeth 2 x a day." Further review of the record did not indicate tracking of client #1's training objectives to indicate if she made progress and/or regressed in her training.</p> <p>A review of client #2's record was conducted on 1/13/14 at 1:30 P.M. Review of client #2's record indicated an ISP dated 6/18/13 which indicated: "Will participate in a weekly activity... Will follow the house chore chart... Will dress in clean appropriate clothing... Will use her V-tech learning device to enhance her communication skills... Will count change combinations... Will have less than 2 elopement incidents a month... Will state the name of her 8 A.M.</p>		Responsible: Area Director				

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	<p>medication...Will learn knife safety...Will complete her laundry...Will assist in cooking one meal per week...Will read out loud for 10 minutes with staff...Will brush her teeth 2 x daily." Further review of the record did not indicate tracking of client #2's training objectives to indicate if she made progress and/or regressed in her training.</p> <p>An interview with the QIDP was conducted at the facility's administrative office on 1/14/14 at 10:40 A.M. The QIDP indicated three was no documentation available to indicate client #1 and #2's objectives were monitored from 1/13 to 1/14. No documentation was submitted for review to indicate the QIDP monitored the clients' training objectives.</p> <p>1. Please refer to W140: The QIDP failed to maintain an accurate accounting system of clients' funds for 4 of 4 clients who reside at the group home (clients #1, #2, #3 and #4),</p> <p>2. Please refer to W189: The QIDP failed for 4 of 4 clients residing at the group (clients #1, #2, #3 and #4) to provide staff with initial and ongoing training on each clients' Individual Support Plans (ISP), Risk Plans and</p>						

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	<p>Behavior Support Plans (BSP).</p> <p>3. Please refer to W218: The QIDP failed for 1 of 2 sampled clients (client #2), to obtain a sensorimotor assessment.</p> <p>4. Please refer to W220. The QIDP failed for 1 of 2 sampled clients (client #2), to assess the client's communication skills on an annual basis.</p> <p>5. Please refer to W249. The QIDP failed to ensure facility staff implemented clients #1 and #2's training objectives when formal and/or informal opportunities existed.</p> <p>9-3-3(a)</p>				

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview the facility failed for 4 of 4 clients residing at the group (clients #1, #2, #3 and #4) to provide staff with initial and ongoing training on each clients' Individual Support Plans (ISP), Risk Plans and Behavior Support Plans (BSP).</p> <p>Findings include:</p> <p>A review of the group home staff and client list was conducted on 1/10/14 at 10:00 A.M. Review of the list indicated Direct Support Professionals (DSP) #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10 worked at the group home with clients #1, #2, #3 and #4.</p> <p>A request for all employee training records for all staff who worked at the group home with clients #1, #2, #3 and #4 was made on 1/8/14 at 6:15 P.M. On 1/10/14 at 2:15 P.M., a review of the group home staff personnel records did not indicate each staff were trained on clients #1, #2, #3 and #4's ISP, Risk Plans and BSP. When asked if there</p>	W000189	W 189 483.430(e)(1) STAFF TRAINING PROGRAMIn conjunction with addressing W104, W140, W157, W149, W154, W159, W218, W220, and W249, the QDDP will ensure all staff are initially trained, and are provided ongoing training to enable staff to perform their duties effectively, efficiently, and competently in implementing each client's ISP, Goals/Objectives, Risk Plans, and BSP. QDDP will keep a record of these trainings and provide copies to the Area Director and Human Resources department, to ensure all staff have been trained to work with all clients at which site they are scheduled. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: QDDP and House Manager	02/15/2014			

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	<p>was documentation available for review to indicate DSP #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10 were trained on clients #1, #2, #3 and #4's program needs and training programs, The Regional Director (RD) stated "If it's not in the records, then we don't have it." No documentation was available for review to indicate all staff who worked at the group home with clients #1, #2, #3 and #4 were trained on each client's program needs.</p> <p>A review of client #1's record was conducted on 1/13/14 at 11:55 A.M. Review of client #1's most current Individual Support Plan (ISP) dated 6/18/13 indicated: "Behavior issues (target/non target): [Client #1] has a behavior support plan to address target and non target behaviors. Target Behaviors: Physical Aggression, refusal, elopement, property destruction (sic) and self injurious behaviors." Further review of the record indicated client #1's diagnoses included, but were not limited to, oppositional defiance, constipation, seizures and hemorrhoids.</p> <p>A review of client #2's record was conducted on 1/13/14 at 1:30 P.M. Review of client #2's record indicated an ISP dated 6/18/13 which indicated: "Behavior Support Plan dated 4/19/13:</p>						

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	<p>Target and Non Target: [Client #2] has a Behavioral Support Plan in place; her behaviors consist of Physical aggression, verbal aggression, property destruction, elopement, self injurious behaviors, desire or threatening to harm others." Further review of the record indicated client #2's diagnoses included, but were not limited to, Impulse Control Disorder, Intermittent Explosive Disorder, Oppositional Defiant Phonological Disorder, Seizure, Enuresis (involuntary voiding of urine), Asthma, Possible Cerebral Palsy, Possible Muscular Dystrophy, Hyperlipidemia (high lipid levels), Constipation, Lactose Intolerance, GERD (Gastroesophageal reflux disease), Acne and Urinary Tract Infections.</p> <p>A review of client #3's record was conducted on 1/13/14 at 2:00 P.M. Review of client #3's most current ISP dated 10/1/13 indicated: "Date of BSP: 4/24/13: Targeted Behaviors: Verbal aggression, teasing/provoking, manipulation, threats of physical violence, physical aggression, refusals and not sharing." Further review of the record indicated client #3's diagnoses included, but were not limited to, Impulse Control Disorder, Intermittent Explosive Disorder, Antisocial</p>			

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	<p>Personality, Obesity, Hypothyroidism, Lactose Intolerance, Major Depressive, ADHD (attention deficit hyperactivity disorder), Generalized Anxiety, Receptive/Expressive Language deficits, Asthma, Desmenorrhrea, Sleep Disturbance and Constipation.</p> <p>A review of client #4's record was conducted on 1/13/14 at 3:00 P.M. Review of client #4's most current ISP dated 8/21/13 indicated: "Date of BSP: 4/1/13: Targeted Behaviors: Physical Aggression, verbal aggression, elopement, self injurious behaviors."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) and the Area Director (AD) was conducted at the facility's administrative office on 1/14/14 at 10:40 A.M. The QIDP indicated there was no documentation to indicate all mentioned staff receive initial and ongoing client specific training prior to working with clients #1, #2, #3 and #4. No documentation was submitted for review to indicate each staff received training on each clients, ISP training, behavioral and medical needs. The AD further indicated all staff should receive client specific training before working at the group home with clients #1, #2, #3 and #4.</p>				

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W000210	<p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 2 sampled clients (client #2), the facility failed to reassess client #2's communication needs.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/8/14 from 5:00 P.M. until 7:30 P.M. During the entire observation period, client #2 was unable to communicate her wants and needs in that the client could not be understood by her staff and housemates. Facility staff did not implement any communication training with the client and/or provide any assistive devices to assist client #2 to communicate her wants and needs.</p>	W000210	<p>W 210 483.440(c)(3) INDIVIDUAL PROGRAM PLAN In conjunction with addressing W104, W140, W157, W149, W154, W159, W189, W218, W220, and W249, the QDDP will be trained by Area Director to ensure that all clients' assessments have been completed and placed in each client's chart. Ongoing, within 30 days of admission, QDDP will ensure the IDT has performed accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Initially, QDDP will perform an audit of all client's files to ensure all assessments are complete, accurate, and filed in each client's chart. Thereafter, QDDP will complete an audit at least quarterly. QDDP will ensure each assessment is reviewed as needed and at least annually.</p>	02/15/2014
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	<p>An observation was conducted at the group home on 1/10/14 from 7:00 A.M. until 3:30 P.M. During the entire observation period, client #2 was unable to communicate her wants and needs in that the client could not be understood by her staff and housemates. Facility staff did not implement any communication training with the client and/or provide any assistive devices to assist client #2 to communicate her wants and needs.</p> <p>A review of client #2's record was conducted on 1/13/14 at 1:30 P.M. Client #2's most current speech assessment dated 9/7/11 indicated: "Plan of care: Patient/Family goals: Pt (patient) to be understood by roommates...Pt to increase intelligibility to 75% in known context...Pt to increase intelligibility to 70% in unknown context. Notes: Speech therapy 1 x (time) a week for 4 weeks."</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/15/14 at 12:15 P.M. The QIDP indicated client #2 had trouble being understood when she talked. When asked if client #2 had a recent speech/communication assessment, the QIDP stated "I don't think so."</p>		System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: Area Director and QDDP				

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W000225	<p>9-3-4(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review and interview, the facility failed to assess the vocational needs of 1 of 2 sampled clients (client #2).</p> <p>Finding include:</p> <p>A morning observation was conducted at the group home on 1/10/14 from 7:00 A.M. until 3:30 P.M. During the entire observation period, client #2 sat at the dining table or walked throughout her home. No alternative day service was observed to be provided.</p> <p>A review of client #2's record was conducted on 1/13/14 at 1:30 P.M. A review of the client's record failed to indicate client #2's vocational needs and abilities had been assessed.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 1/14/14 at 10:40 A.M. When asked if client #2 attended day services, the QIDP stated "No, she is the only one</p>	W000225	<p>W 225 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN In conjunction with addressing W210, the QDDP will be trained by Area Director to ensure that all clients' comprehensive functional assessments include, as applicable, vocational skills. Ongoing, within 30 days of admission, QDDP will ensure the IDTs have performed accurate CFAs or reassessments, as needed, to supplement the preliminary evaluation conducted prior to admission, including vocational skills. Initially, QDDP will perform an audit of all clients' files to ensure all CFA's are complete, accurate, contain vocational skills assessments, as applicable, and filed in each client's chart. Thereafter, QDDP will complete an audit at least quarterly. QDDP will ensure each CFA (Vocational Skills) is reviewed as needed and at least annually. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be</p>	02/15/2014

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W000249	<p>that doesn't go." When asked if client #2 had a vocational assessment completed, the QIDP stated "I'm not sure." The QIDP further indicated there was no documentation available for review to indicate client #2's vocational needs and abilities had been assessed.</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 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/8/14 from 5:00 P.M. until 7:40 P.M. During the entire observation period, client #1 stayed in</p>	W000249	<p>completed by: 2/15/14 Persons Responsible: Area Director and QDDP</p> <p>W 249 483.440(d)(1) PROGRAM IMPLEMENTATION In conjunction with addressing W104, W159, W189, W210, and W225 the QDDP will be trained by Area Director to ensure that all clients 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 client's IPP. Immediately and ongoing,</p>	02/15/2014			

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	<p>her room with no activity or interaction. Client #2 sat at the dining table playing Uno with Direct Support Professionals (DSP) #4. DSPs #1, #2 and #3 would walk through the facility and visually check on clients #1 and #2 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>An observation was conducted at the group home on 1/10/14 from 7:00 A.M. until 3:30 P.M. During the entire observation period, client #1 stayed in her room with no activity or interaction. Client #2 sat at the dining table. DSPs #1, #2 and #6 would walk through the facility and visually check on clients #1 and #2 but did not offer meaningful active treatment activities or implement client objectives.</p> <p>A review of client #1's record was conducted on 1/13/14 at 11:55 A.M. Review of client #1's most current Individual Support Plan (ISP) dated 6/18/13 indicated the following training objectives which could have been implemented: "Will have leisure time 5 x (times) a week...Will count change and dollars...Will complete daily chores...Will have zero incidents of elopement...Will exercise once a day...Will state the name of her morning medications...Will use a knife correctly</p>		<p>QDDP will complete weekly site visit observations to ensure all IPPs, consistent active treatment, and goals are being implemented by staff as written in their ISPs. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: Area Director and QDDP</p>				

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	<p>hand over hand...Will complete her laundry...Will gain an understanding of appropriate verbal communication...Will work with staff 3 times a week to learn her social security number...Will brush her teeth 2 x a day."</p> <p>A review of client #2's record was conducted on 1/13/14 at 1:30 P.M. Review of client #2's record indicated an ISP dated 6/18/13 which indicated the following training objectives which could have been implemented: "Will participate in a weekly activity...Will follow the house chore chart...Will dress in clean appropriate clothing...Will use her V-tech learning device to enhance her communication skills...Will count change combinations...Will state the name of her 8 A.M. medication...Will learn knife safety...Will complete her laundry...Will assist in cooking one meal per week...Will read out loud for 10 minutes with staff...Will brush her teeth 2 x daily."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 1/14/14 at 10:40 A.M. The QIDP stated client objectives should be implemented "at all times, all day." The QIDP further indicated clients #1 and #2 should have been provided with meaningful active treatment activities during the</p>			

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W000252	<p>observation periods.</p> <p>9-3-4(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview, the facility failed to provide evidence data was collected for training objectives for 2 of 2 sampled clients (clients #1 and #2). Findings include: A review of client #1's record was conducted on 1/13/14 at 11:55 A.M. Review of client #1's most current Individual Support Plan (ISP) dated 6/18/13 indicated: "Will have leisure time 5 x (times) a week...Will count change and dollars...Will complete daily chores...Will have zero incidents of elopement...Will exercise once a day...Will state the name of her morning</p>			W000252	<p>W 252 483.440(e)(1) PROGRAM DOCUMENTATION In conjunction with addressing W104, W159, W189, W210, W225, and W249 the QDDP will ensure that all clients' goals/objectives are documented as written/required in client's ISP. QDDP will complete Monthly Summaries, containing a summary of the data recorded relating to the progress of each clients' goal/objective, in measurable terms. Immediately and ongoing, QDDP will complete weekly site visit observations to ensure all IPPs, consistent active treatment, and goals are being implemented by staff as written in their ISPs. System wide, all House Managers and Program Director/QDDP's will review this</p>		02/15/2014

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	<p>medications...Will use a knife correctly hand over hand...Will complete her laundry...Will gain an understanding of appropriate verbal communication...Will have zero incidents of elopement...Will read rotating with staff for 15 minutes...Will work with staff 3 times a week to learn her social security number...Will brush her teeth 2 x a day." There was no documentation available for review of client #1's training objectives/behavior data.</p> <p>A review of client #2's record was conducted on 1/13/14 at 1:30 P.M. Review of client #2's record indicated an ISP dated 6/18/13 which indicated: "Will participate in a weekly activity...Will follow the house chore chart...Will dress in clean appropriate clothing...Will use her V-tech learning device to enhance her communication skills...Will count change combinations...Will have less than 2 elopement incidents a month...Will state the name of her 8 A.M. medication...Will learn knife safety...Will complete her laundry...Will assist in cooking one meal per week...Will read out loud for 10 minutes with staff...Will brush her teeth 2 x daily." There was no documentation available for review of client #2's training objectives/behavior data.</p>		<p>standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: QDDP</p>				

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W000259	<p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 1/14/14 at 10:40 A.M. The QIDP indicated clients' objectives were to be documented daily. The QIDP indicated due to changes in the group home she could not provide evidence to indicate data was completed.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, the facility failed to assure a Comprehensive Functional Assessment (CFA) was completed for 4 of 4 clients living in the group home (clients #1, #2, #3, and #4).</p> <p>Findings include: Client #1's record was reviewed on</p>	W000259	W 259 483.440(f)(2) PROGRAM MONITORING and CHANGE In conjunction with addressing W210 and W225 the QDDP will be trained by Area Director to ensure that at least annually, all clients' comprehensive functional assessments are reviewed, revised/updated as needed by the IDT for relevancy. QDDP will ensure these CFA's include, as applicable, vocational skills. Initially, QDDP will perform an	02/15/2014

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	<p>1/10/14 at 11:55 A.M. The review failed to indicate a CFA had been completed for client #1.</p> <p>Client #2's record was reviewed on 1/10/14 at 1:30 P.M. The review failed to indicate a CFA was completed for client #2.</p> <p>Client #3's record was reviewed on 1/10/14 at 2:00 P.M. The review failed to indicated a CFA was completed for client #3.</p> <p>Client #4's record was reviewed on 1/10/14 at 3:00 P.M. The review failed to indicate a CFA was conducted for client #4.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) and Area Director (AD) were interviewed on 1/14/14 at 10:40 A.M. The QIDP indicated the facility did not have documentation of CFAs being conducted for clients #1, #2, #3, and #4 since admittance. When asked when CFAs should be completed, the AD stated "CFAs should be completed annually."</p> <p>9-3-4(a)</p>		<p>audit of all clients' files to ensure all CFA's are complete, accurate, contain vocational skills assessments, as applicable, and filed in each client's chart.</p> <p>Thereafter, QDDP will complete an audit at least quarterly. QDDP will ensure each CFA (Vocational Skills) is reviewed as needed and at least annually. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: Area Director and QDDP</p>		

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W000261	<p>483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. Based on interview and record review the facility failed to have a family member and client member serve on the Human Rights Committee (HRC) for 4 of 4 clients (client #1, #2, #3 and #4) residing at the group home.</p> <p>Findings include:</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/10/14 at 1:00 P.M. When asked if the facility's HRC had a client representative and a family member/guardian, QIDP indicated the facility's HRC did not have a client representative and family member/guardian.</p> <p>A review of the facility's of the facility's Human Rights Committee (HRC) member list was conducted on 1/13/14</p>	W000261	W 261 483.440(f)(3) PROGRAM MONITORING and CHANGE Area Director will work with the Human Rights Committee (HRC) to find a client and a family member/guardian to serve as representatives on the HRC. In the event that a family member/guardian and/or client can no longer serve as a representative on the HRC, the Area Director will work with the other HRC members to find suitable replacements as soon as possible. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: Area Director and HRC	02/15/2014
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W000268	<p>at 5:30 P.M. A review of the facility's HRC member list did not indicate a family member and client member served on the facility's HRC.</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 2 of 2 sampled clients (clients #1 and #2), the facility failed to promote clients' independence, growth and dignity in regards to wearing appropriate clothing.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/8/14 from 5:00 P.M. until 7:40 P.M. During the entire observation period, client #2 walked around her home. As she walked around, her pants and underwear would fall exposing her buttocks. Client #1's pants legs were observed to be long, covering her feet. Client #1 was not prompted to and did not cuff her pant</p>	W000268	<p>W 268 483.450(a)(1)(i) CONDUCT TOWARD CLIENT In conjunction with addressing W104, W140, W157, W149, W154, W159, W189, W218, W220, and W249, the QDDP will ensure all staff are initially trained, and are provided ongoing training to enable staff to ensure all clients' independence, growth, and dignity is promoted by ensuring all clients have and wear appropriate and well fitting clothing. QDDP and House Manager will conduct weekly and random site visits and active treatment observations to ensure staff are ensuing all clients are wearing appropriate and well fitting clothing. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all</p>	02/15/2014	

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	<p>legs.</p> <p>An observation was conducted at the group home on 1/10/14 between 7:00 A.M. and 3:30 P.M. During the entire observation period, client #2 walked around her home. As she walked around, her pants and underwear would fall exposing her buttocks. Client #1's pant legs were observed to be long, covering her feet. Client #1 was not prompted to and did not cuff her pant legs.</p> <p>An interview with Direct Support professional (DSP) #3 was conducted on 1/8/14 at 6:00 P.M. DSP #3 stated "[Client #2's] pants keep falling down because she has lost a lot of weight and her clothes are too big."</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports was conducted on 1/10/14 at 5:30 P.M. Review of the reports indicated:</p> <p>-BDDS report dated 7/22/13 involving client #1: "Yesterday [client #1] was sitting outside with housemates and staff. [Client #1] got up and was walking towards the door and tripped over her pants' leg. All of [client #1's] pant legs are to (sic) long and staff does</p>		Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: QDDP and House Manager				

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W000331	<p>tell her to cuff her pant leg when she wears them. When [client #1] fell down she scraped right above her lip and her nose and chipped her front left tooth....Staff will continue to remind [client #1] to cuff her pant legs so she will not trip on them."</p> <p>An interview with the Qualified Intellectual Disabilities Professional was conducted on 1/15/14 at 12:15 P.M. When asked if clients should be provided with appropriately fitted clothing, the QIDP stated "Yes, they should."</p> <p>9-3-5(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 for 1 of 3 clients observed during the morning medication administration, (client #2), the facility's nursing services failed to reconcile doctor's orders with medication labels and Medication Administration Records (MAR).</p> <p>Findings include:</p> <p>An observation was conducted at the</p>	W000331	W 331 483.460(c) Nursing Services The nurse has reconciled client #2's doctor's order with medication label and MAR. Ongoing, the nurse will ensure all clients' doctors' orders are reconciled with medication labels and MARs every month and after any medication change/addition. Staff will be trained by QDDP to immediately report, per Policy/Procedure, any error in the reconciliation of medication labels and MARs. System wide, all House	02/15/2014
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	<p>group home on 1/10/14 from 7:00 A.M. until 3:30 P.M. At 8:17 A.M., Direct Support Professional (DSP) #2 administered client #2's prescribed medications. DSP #2 took out a disk inhaler and handed it to client #2, who inhaled 1 puff.</p> <p>Review of the medication label at 8:20 A.M., indicated: "Advair Diskus (asthma)...Inhale 1 puff by mouth twice daily...Rinse mouth thoroughly after each use." A review of the Medication Administration Record (MAR) dated January 1, 2014 to January 31, 2014 at 8:25 A.M. did not indicate "Rinse mouth thoroughly after each use." Client #2 did not and was not prompted to rinse her mouth after taking her inhaler.</p> <p>An interview with the nurse was conducted on 1/14/14 at 10:30 A.M. The nurse indicated she was responsible for reconciling the Physician Order (PO), MAR and medication label. The nurse further indicated she had not reconciled the label, MAR and PO for client #2's medication.</p> <p>9-3-6(a)</p>		Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: Nurse and QDDP		

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W000383	<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 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4), to ensure only authorized persons had access to the keys to the medication lock box and cabinet.</p> <p>Findings include:</p> <p>An observation was conducted at client #1, #2, #3 and #4's home on 1/10/14 from 7:00 A.M. until 3:30 P.M. During the entire observation Direct Support Professionals (DSPs) #1, #2, #5 and #6 walked in and out of the unlocked office. At 8:00 A.M., DSP #5 retrieved the group home medication closet keys out of a square pot sitting on the window ledge in the unlocked room located off the living room area and began administering client #2's prescribed medications. At 8:05 A.M., DSP #5 placed the medication keys in the square pot on the window ledge and left the room as clients #3 and #4 and DSPs #1 and #2 walked in and out of the office. At 8:15 A.M., DSP #2 entered into the room, picked the medication keys up from out of the square pot and began administering client #1's prescribed medications. At 8:25 A.M., DSP #2</p>	W000383	W 383 483.460(l)(2) DRUG STORAGE AND RECORDKEEPING In conjunction with addressing W189, QDDP and House Manager will train all staff to ensure the person responsible for administering medications must always maintain possession of the medication closet keys. These keys will be handed over, shift-to-shift, directly from one staff to the next responsible staff. Immediately and ongoing, QDDP will complete weekly site visit observations to ensure responsible staff are maintaining the keys at all times. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: QDDP and House Manager	02/15/2014			

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W000436	<p>placed the medication keys in the square pot and left the unlocked office.</p> <p>An interview with the Regional Director (RD) was conducted on 1/14/14 at 10:30 A.M. The RD 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 team as needed by the client. Based on observation, record review, and interview, for 4 of 4 clients who were prescribed eyeglasses (clients #1, #2, #3 and #4), the facility failed to encourage and teach the use of their prescribed eyeglasses.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 1/8/14 from 5:00</p>	W000436	W 436 483.470(g)(2) SPACE AND EQUIPMENT In conjunction with addressing W189, QDDP and House Manager will train all staff to ensure all clients are encouraged to use their adaptive equipment. Any client refusals to use their adaptive equipment will be documented by staff and data recorded by QDDP. In the event a client is regularly refusing, QDDP will develop a plan/goal to teach the client to use and make	02/15/2014

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	<p>P.M. until 7:40 P.M. During the entire observation period, clients #1, #2, #3 and #4 did not and were not prompted to wear their prescribed eyeglasses. Direct Support Professionals (DSPs) #1, #2, #3 and #4 did not prompt clients #1, #2, #3 and #4 to wear their eyeglasses.</p> <p>An observation was conducted at the group home on 1/10/14 between 7:00 A.M. and 3:30 P.M. Clients #1, #3 and #4 were observed the entire observation period not wearing eyeglasses. Direct Support Professionals (DSP) #1, #5 and #6 did not prompt clients #1, #3 and #4 to wear their eyeglasses.</p> <p>A review of client #1's record was conducted on 1/13/14 at 11:55 A.M.. A review of client #1's Individual Support Plan (ISP) dated 6/18/2013 indicated client #1 was prescribed eyeglasses. Client #1's "General Eye Exam" dated 10/16/13 indicated she was prescribed eyeglasses full time.</p> <p>A review of client #2's record was conducted on 1/13/14 at 1:30 P.M. A review of client #2's medical record indicated client #2 was prescribed eyeglasses.</p> <p>A review of client #3's record was conducted on 1/13/14 at 2:00 P.M. A</p>		<p>informed choices about the use of their adaptive equipment. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: QDDP and House Manager</p>		

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	<p>review of client #3's ISP dated 10/1/13 indicated she was prescribed eyeglasses.</p> <p>A review of client #4's record was conducted on 1/13/14 at 3:00 P.M. A review of client #4's ISP dated 8/21/13 indicated she was prescribed eyeglasses.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed at the facility's administrative office on 1/14/14 at 10:30 A.M. The QIDP indicated staff should be teaching clients to wear their eyeglasses at all times. The QIDP further indicated staff should have prompted clients #1, #2, #3 and #4 to wear their eyeglasses.</p> <p>9-3-7(a)</p>						
W000488	<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 1 of 2 sampled clients (client #2), served herself at mealtime.</p>	W000488	W 488 483.480(d)(4) DINING AREAS and SERVICE In conjunction with addressing W189, and W249, QDDP and House Manager will train all staff to ensure all clients are	02/15/2014			

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	<p>Findings include:</p> <p>An observation was conducted at the group on 1/10/14 from 7:00 A.M. until 3:30 P.M. At 10:10 A.M., Direct Support Professional (DSP) #1 prepared a plate of food and set it in front of client #2, who had been sitting at the table with no activity or interaction. The meal consisted of 2 over easy eggs, a slice of toast and 2 sausage patties. DSP #1 poured milk into client #2's cup. At 10:15 A.M., client #4 placed a plate with several eggs, a plate with toast and a plate with bacon on the table. Clients #1, #3 and #4 began serving themselves. At 10:20 A.M., clients #1, #2, #3 and #4 began eating their meal independently. Client #2 was not prompted to and did not serve herself.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/15/14 at 12:15 P.M. The QIDP stated "[Client #2] is capable of serving herself. Sometimes she may refuse, but staff should allow her the opportunity to serve herself." The QIDP further indicated clients should serve themselves at all meals times.</p> <p>9-3-8(a)</p>		<p>encouraged to eat in a manner consistent with their developmental level. Staff will encourage each client to serve themselves and teach and assist only as needed, and as identified in their ISP. Immediately and ongoing, QDDP and House Manager will complete weekly site visit observations to ensure all clients are encouraged to eat at their developmental level. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: QDDP and House Manager</p>		

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W009999	<p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p> <p>1. 460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p>	W009999	<p>W 9999 1. 460 IAC 9-3-2 Resident Protections Area Director will ensure three references are obtained for staff #12, 13, and 14. Immediately and ongoing, at least three references will be obtained for all new hires. This information will be available in their employee files and maintained by the Human Resources department System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: Area Director and HR 2. 460 IAC 9-3-3 Facility Staffing Area Director will ensure staff #12, 13, and 14 obtain evidence they are clear of TB. Immediately and ongoing, written evidence that a Mantoux TB skin test or chest x-ray will be obtained for all new hires. This information will be available in their employee files and maintained by the Human Resources department. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be</p>	02/15/2014			

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	<p>Based on record review and interview, for 3 of 3 staff (staff #12, #13 and #14) personnel files reviewed, the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p> <p>The facility's administrative records were reviewed on 1/10/14 at 2:41 P.M. Review of the personnel files for staff #12, #13 and #14 indicated three references were not obtained. The personnel files for staff #12, #13 and #14 did not include any references.</p> <p>The Regional Director (RD) was interviewed on 1/10/13 at 3:00 P.M. and indicated if there were no references in staff #12, #13 and #14's records, then they were not completed.</p> <p>An interview with the Area Director (AD) was conducted on 1/14/14 at 10:40 A.M. The AD indicated each employee should have three references completed prior to employment with the facility.</p> <p>9-3-2(c)(3)</p> <p>2. 460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job</p>		<p>completed by: 2/15/14 Persons Responsible: Area Director and HR 3. 460 IAC 9-3-4 Active Treatment Services Area Director will train QDDP to work with all clients' IDTs to attempt to find appropriate outside day programming for all individuals that do not currently have outside day programming. Until appropriate placement is found for these clients, QDDP will work with the team to develop meaningful, structured, vocational activities and goals/objectives based on their CFA and vocational skills assessment. Immediately and ongoing, QDDP will complete weekly site visit observations to ensure all structured day programming, active treatment, and goals are being implemented by staff as written in their ISPs. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Will be completed by: 2/15/14 Persons Responsible: Area Director and QDDP</p>				

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	<p>duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on interview and record review for 3 of 3 staff personnel records (staff #12, #13 and #14), the facility failed to ensure staff #12, #13 and #14 received annual Mantoux tests/screening.</p> <p>Findings include:</p> <p>The facility's employee records were reviewed on 1/10/14 at 2:41 P.M. Review of staff #12, #13 and #14's personnel files did not indicate each staff had a Mantoux test/screening completed.</p>			

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	<p>The Regional Director (RD) was interviewed on 1/10/13 at 3:00 P.M. and indicated if there were no Mantoux test/screening results in staff #12, #13 and #14's records, then they were not completed.</p> <p>An interview with the Area Director (AD) was conducted on 1/14/14 at 10:40 A.M. The AD indicated each employee should have Mantoux test/screenings completed prior to employment with the facility.</p> <p>9-3-3(e)</p> <p>3. 460 IAC 9-3-4 Active Treatment Services.</p> <p>(b) The provider shall obtain day services for each resident which: (1) meet the criteria and certification requirements established by the division of aging and rehabilitative services for all day service providers; (2) meet the resident's active treatment needs set forth in the resident's individual program plan as determined by the interdisciplinary team conference with preference for services in the least restrictive environment.</p> <p>This state rule was not met as evidenced</p>						

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	<p>by:</p> <p>Based on observation, record review and interview, the facility failed to meet the active treatment needs pertaining to day services programming for 1 of 2 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2 was observed at the group home on 1/10/14 from 7:00 A.M. until 3:30 P.M. During the entire observation, client #2 sat at the dining table or walked around the group home and talked with group home staff. No alternative day service was observed to be provided.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 1/9/14 at 6:00 P.M. When asked where client #2 attended day services, the QIDP stated "[Client #2] does not go to day services."</p> <p>A review of client #2's records were conducted on 1/13/14 at 1:30 P.M. A review of the client's record failed to indicate she attended day service.</p> <p>9-3-4(b)(1)(2)</p>						

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