

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2015
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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W 000  Bldg. 00	<p>This visit was a full annual recertification and state licensure survey which resulted in Immediate Jeopardy.</p> <p>Dates of Survey: March 16, 17, 18, 19, 20, 23, 24 and 25, 2015.</p> <p>Facility number: 011602 Provider number: 15G748 AIM number: 200903760</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 42 CFR, part 483, subpart I, and 460 IAC 9.</p> <p>Quality review completed March 26, by Dotty Walton, QIDP.</p>	W 000		
W 100  Bldg. 00	<p>440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is</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.

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	<p>to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions;</p> <p>(2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and</p> <p>(3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440.</p> <p>Based on observation, record review and interview for 2 of 2 sampled clients (clients #1 and #2) and two additional clients, (#3 and #4), the Intermediate Care Facility failed to provide active treatment services for which the facility received payment.</p> <p>Findings include:</p> <p>The facility (Intermediate Care Facility/ICF), failed to ensure clients #1, #2, #3 and #4 received a continuous and aggressive active treatment program which addressed their rights to be free of abuse/neglect, to receive behavioral supports and address their training needs. The ICF failed to ensure active treatment and behavioral programs were implemented for client #1. The ICF failed to ensure staff implemented formal and informal training programs when opportunities existed and failed to develop individualized Active Treatment Schedules (ATS) for clients #1, #2, #3, and #4..</p>	W 100	<p><b>W 100 440.150(e) ICF SERVICES OTHER THAN IN INSTITUTIONS</b></p> <p>In conjunction with the Plan of Corrections for W102, W104, W122, W149, W157, W195, W196, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this standard. Client #1 will not be returning to the facility due to their aggression towards others, and a more appropriate placement will be secured for Client #1 at another facility. The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT</p>	04/07/2015

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W 102  Bldg. 00	<p>Please refer to W195 for the Intermediate Care Facility's failure to meet the Condition of Participation: Active Treatment Services.</p> <p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the Governing Body failed</p>	W 102	<p>to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>To ensure these programs are implemented at each opportunity and staff are adhering to each Individuals' ATS, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations <b>at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15 Persons Responsible: QDDP</b></p>	04/07/2015	

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	<p>to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (#1 and #2), and 2 additional clients (#3 and #4). The Governing Body neglected to prevent neglect and/or abuse by not developing and/or implementing systematic policies and protocols in regard to client #1's escalated violent physical aggression.</p> <p>Findings include:</p> <p>1. Please refer to W122. The governing body failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #3). The facility neglected to implement its written policy and procedures to prevent abuse and/or neglect of clients. The facility neglected to put in place measures to prevent potential harm and/or recurrence in regard to client #1's violent physical aggression towards clients #2 and #3.</p> <p>2. Please refer to W195. The Governing Body failed to meet the Condition of Participation: Active Treatment Services for 2 of 2 sampled clients (clients #1 and #2) and two additional clients, (#3 and #4). The Governing Body failed to ensure each client received a continuous, aggressive active treatment program. The facility failed to ensure staff</p>		<p><b>W 102 483.410 GOVERNING BODY AND MANAGEMENT</b></p> <p>In conjunction with the Plan of Corrections for W100, W104, W122, W149, W157, W195, W196, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this CONDITION.</p> <p>1. On 3/22/15, Client #1 was removed from the facility will not be returning to the facility due to their aggression towards others; BDDS will secure a more appropriate placement for Client #1 at another facility. This will prevent abuse in the future of clients #2, 3, and 4 from Client #1.</p> <p>2. The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will</p>				

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	<p>implemented formal and informal training programs when opportunities existed and failed to develop individualized Active Treatment Schedules (ATS).</p> <p>3. Please refer to W104. The governing body neglected to exercise general policy and operating direction over the facility for 2 of 2 sampled clients and 2 additional client (clients #1, #2) and (#3 and #4), to put measures in place to prevent abuse and neglect in regard to client #1's escalated physical aggression and failed to ensure continuous active treatment was implemented. The facility's governing body neglected to ensure clients' living spaces were kept in a sanitary condition.</p> <p>9-3-1(a)</p>		<p>coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>3. On 3/22/15, Client #1 was removed from the facility will not be returning to the facility due to their aggression towards others; BDDS will secure a more appropriate placement for Client #1 at another facility. This will prevent abuse in the future of clients #2, 3, and 4 from Client #1.</p> <p>The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment</p>		

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			<p>Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules. Staff will be re-trained to ensure all living areas of the facility are maintained to be sanitary at all times.</p> <p>To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations <b>at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p>	

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W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 2 sampled clients(#1 and #2), and 2 additional clients (#3 and #4), the facility's governing body neglected to put measures in place to prevent abuse and neglect in regard to client #1's escalated physical aggression. The facility's governing body neglected to ensure clients' living spaces were kept in a sanitary condition.</p> <p>Findings include:</p> <p>1. A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M. where clients #1, #2, #3, and #4 resided. Upon entering the group home and walking past the bathroom located near clients #1 and #2's bedrooms, there was a strong odor. At 7:35 A.M., upon entering the bathroom, there was a pair of black shorts with fecal matter laying on the floor in front of the</p>	W 104	<p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p> <p><b>W 104 483.410(a)(1) GOVERNING BODY</b></p> <p>In conjunction with the Plan of Corrections for W100, W102, W122, W149, W157, W195, W196, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p> <p>On 3/22/15, Client #1 was removed from the facility will not be returning to the facility due to their aggression towards others; BDDS will secure a more appropriate placement for Client #1 at another facility. This will prevent abuse in the future of clients #2, 3, and 4 from Client #1.</p>	04/07/2015	

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	<p>toilet and fecal matter was smeared all over the floor. The fecal matter was cleaned by DSP (Direct Support Professional) #7 at 9:35 A.M..</p> <p>An evening observation was conducted at the group home on 3/18/15 from 4:30 P.M. to 5:30 P.M.. At 5:05 P.M., client #2 asked this surveyor to enter his room to see his new chair. Upon entering client #2's room, there was a strong odor. There was no linen on the bed and no soiled linen in the bedroom.</p> <p>An interview with DSP #8 was conducted on 3/18/15 at 5:15 P.M.. DSP #8 indicated client #2 urinates in his bed every night and further indicated staff at the group home have tried getting the urine smell out of client #2's bedroom, but they have had no success at doing so.</p> <p>An interview with the GHM was conducted on 3/25/15 at 4:10 P.M.. The GHM indicated the facility washes client #2's clothes everyday and indicated the facility replaced his bed two weeks ago and mops the bedroom with bleach everyday. The GHM indicated client #2's bedroom should not smell of urine. The GHM indicated the staff should try to prompt clients to clean up when they have a toileting accident or should ensure the accident is cleaned up quickly.</p>		<p>The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>Staff will be re-trained to ensure all living areas of the facility are maintained to be sanitary at all times.</p> <p>Below is the Allegation of Removal of Immediate Jeopardy that occurred on Monday, 3/23/15 for the above facility:</p> <p>-</p>		

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	<p>2. Please refer to W149. The facility's Governing Body neglected to implement its written policy and procedure to prevent neglect and/or abuse for 2 of 2 sampled clients (#1 and #2), and 1 additional client (#3), the facility neglected to implement its written policy and procedure to prevent neglect and/or abuse of clients. The facility neglected to ensure that clients #2 and #3 were not being physically abused by client #1 and were able to reside in their home without fear. The facility neglected to ensure additional supports were put in place to assist staff to protect clients while residing in their home. The facility neglected to seek alternate placement for client #1 due to the client's increase in violent behavior.</p> <p>3. Please refer to W157. The Governing Body of the facility failed to take sufficient/effective corrective measures in regard to preventing/addressing client #1's documented increase in physical aggression for 2 of 4 sampled clients (#1 and #2) and 1 additional client (#3).</p> <p>4. Please refer to W195. The Governing Body failed to meet the Condition of Participation: Active Treatment Services for 2 of 2 sampled clients (clients #1 and #2) and two additional clients, (#3 and</p>		<p>I. On 3/23/15, [Client #1] was admitted to Methodist Hospital ICU due to elevated temp, elevated white blood-cell count, and elevated pulse. Due to circumstances surrounding Immediate Jeopardy[Client #1's] IDT, Facility, and Agency agreed that <u>[Client #1] will not return to the home</u>, and will be provided supports by the Agency in an alternative setting until permanent, appropriate placement is secured for [Client #1] by BDDS.</p> <p>II. 3/27/15, [Client #1] was discharged from Methodist hospital inpatient psych unit. In order to ensure [Client #1] and the community's safety, the Agency arranged for 2 staff to support him 24/7 in his alternative setting.</p> <p>III. The current staff to Individual ratio will remain until his IDT determines that his safety can be assured with 1-on-1 staffing.</p> <p>IV. [Client #1] is visiting regularly with his sister and POA, [.....], who lives in the Lafayette area. He visited with her on Saturday, 3/28/15 from 2pm to 5pm, and on Sunday, 2/29/15 from 11:30a to 4:00pm. On both occasions, [.....] picked him up and took him to her</p>		

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	<p>#4). The Governing Body failed to ensure each client received a continuous, aggressive active treatment program. The facility failed to ensure staff implemented formal and informal training programs when opportunities existed and failed to develop individualized Active Treatment Schedules (ATS).</p> <p>9-3-1(a)</p>		<p>home for the visits.</p> <p>V. At this time, [Client #1] is displaying appropriate behavior and is not exhibiting verbal or physical aggression.</p> <p>VI. [Client #1] will be placed in a permanent, appropriate living setting by BDDS at the earliest possible opportunity; he has not been to the above facility since 3/23/15 and <u>will not</u> return to the above facility in the future.</p> <p>VII. All Individuals who live at the above facility have been monitored regularly each day per the submitted, "Plan for removal of Immediate Jeopardy." By all accounts, these Individuals and current staff at the site have stated they are comfortable and feel secure and safe in their home now that [Client #1] is not there, have been participating in active treatment, have exhibited multiple signs that they feel safe and secure, and all observations support that they are comfortable in their environment.</p> <p>VIII. Observations at the home by a member of the local supervisory</p>		

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			<p>team will continue each day, for two weeks, to ensure the Individuals and staff remain comfortable in the home. Ongoing, supervisory visits will be completed at least weekly, and as needed, by each member of the oversight staff (House Manager, QDDP, Nurse, and Behaviorist). All supervisory visits will be reported to the Area Director. The Area Director will visit the home weekly for one month, then at least every quarter thereafter, to ensure all Individuals and staff remain comfortable and secure in the home. Staff will be encouraged to promptly notify the local supervisory team of any concerns regarding the Individuals' health and safety, and the local supervisory team will promptly notify the Area Director, to ensure any issues are promptly addressed.</p> <p>In the future, all allegations of Abuse and/or Neglect will be treated according to Agency Policy and Procedure. To ensure this Policy and Procedure is adhered to, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations at least weekly and at random.</p>	

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W 122	483.420 CLIENT PROTECTIONS		<p>To ensure these programs and corrective actions are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations <b>at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>		

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Bldg. 00	<p>The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #3). The facility neglected to implement its written policy and procedures to prevent abuse and/or neglect of clients. The facility neglected to put in place measures to prevent potential harm and/or recurrence in regard to client #1's violent physical aggression towards clients #2 and #3. This noncompliance resulted in an Immediate Jeopardy/IJ in regard to a lack of protective measures to address client #1's violent physical aggression. The Immediate Jeopardy was identified on 3/17/15 at 5:08 P.M.. The Area Director and the Group Home Manager were notified of the Immediate Jeopardy on 3/17/15 at 5:15 PM. The Immediate Jeopardy began on 3/6/15. The facility submitted a plan for removal of the Immediate Jeopardy on 3/18/15 at 3:00 P.M.. The facility's plan of action/removal indicated the following:</p> <p>I. 3/18/15 Emergency IDT (Inter Disciplinary Team) Meeting Regarding [client #1]:</p> <p>A. Behavioral and supervision/monitoring protocol for</p>	W 122	<p><b>W 122 483.420 CLIENT PROTECTIONS</b></p> <p>In conjunction with the Plan of Corrections for W100, W102, W104, W149, W157, W195, W196, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this CONDITION, that the facility must implement its written policy and procedures to prevent abuse and/or neglect of clients. The House Manager, QDDP, Nurse, Behaviorist, and AD will be retrained on the Agency policy concerning Abuse/Neglect and/or Exploitation of Individuals Served.</p> <p>On 3/22/15, Client #1 was transported to Methodist Hospital for evaluation and treatment. Below is the Allegation of Removal of Immediate Jeopardy that occurred on Monday, 3/23/15 for the above facility:</p> <p>-</p> <p>I. On 3/23/15, [Client #1] was admitted to Methodist Hospital ICU due to elevated temp, elevated white blood-cell count, and</p>		04/07/2015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015	
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	<p>[client #1] has been revised to include the following:</p> <ul style="list-style-type: none"> <li>i. 1-on-1 supervisions at all times with designated staff person.</li> <li>ii. Designated staff person will ensure [client #1] is at least 5 feet away from all of his housemates at all times, and be in between [client #1] and any of his housemates in his vicinity, in order to ensure they are able to intervene and prevent any contact between [client #2] and his housemates, ensuring their health and safety.</li> <li>iii. Designated staff will follow his Behavior Plan and utilize HRC (Human Rights Committee) approved, authorized DCI (crisis intervention) physical restraints as necessary, using least restrictive method necessary, to ensure [client #1] is 5 feet away at all times from housemates.</li> <li>iv. Designated staff person will keep [client #1] in consistent line-of sight during all waking hours.</li> <li>v. Staff will be instructed to ensure another staff person relieves them, and takes over their 1-on-1 duties in the event they need to use the bathroom, take a break, etc., in order to ensure consistent implementation of this protocol.</li> <li>vi. Staff will be instructed to keep IDT informed promptly of any significant changes, incidents, aggression, or difficulty implementing his</li> </ul>		<p>elevated pulse. Due to circumstances surrounding Immediate Jeopardy[Client #1's] IDT, Facility, and Agency agreed that <u>[Client #1] will not return to the home</u>, and will be provided supports by the Agency in an alternative setting until permanent, appropriate placement is secured for [Client #1] by BDDS.</p> <p>II. 3/27/15, [Client #1] was discharged from Methodist hospital inpatient psych unit. In order to ensure [Client #1] and the community's safety, the Agency arranged for 2 staff to support him 24/7 in his alternative setting.</p> <p>III. The current staff to Individual ratio will remain until his IDT determines that his safety can be assured with 1-on-1 staffing.</p> <p>IV. [Client #1] is visiting regularly with his sister and POA, [.....], who lives in the Lafayette area. He visited with her on Saturday, 3/28/15 from 2pm to 5pm, and on Sunday, 2/29/15 from 11:30a to 4:00pm. On both occasions, [.....] picked him up and took him to her home for the visits.</p>				

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	<p>BSP or Protocol.</p> <p>vii. All staff will be trained on site on these revisions before working in the home.</p> <p>viii. These revisions will be implemented immediately.</p> <p>B. [BDDS (Bureau of Developmental Disabilities Services) Generalist] will send out I.J. letters to guardians and individuals at the home.</p> <p>C. [Nurse name] contacted [Psychiatrist name] to see if she can get him (client #1) admitted inpatient for psychiatric stabilization.</p> <p>D. IDT will attempt to find [client #1] an inpatient psychiatric placement for evaluation and stabilization.</p> <p>E. IDT and BDDS will pursue a long term, more appropriate placement for [client #1].</p> <p>F. BDDS will submit an S.O.S. (sic) (State Operated Facility) referral. In order for it to be submitted, IDT will provide BDDS requested narrative and documentation, including behavioral changes, medical changes, medication changes, hospitalizations, and overall status over past six months. This will be provided to BDDS on 3/18/15.</p> <p>II. Staff training (Will begin 3/18/15, ongoing, until all staff are trained on revisions).</p>		<p>V. At this time, [Client #1] is displaying appropriate behavior and is not exhibiting verbal or physical aggression.</p> <p>VI. [Client #1] will be placed in a permanent, appropriate living setting by BDDS at the earliest possible opportunity; he has not been to the above facility since 3/23/15 and <u>will not</u> return to the above facility in the future.</p> <p>VII. All Individuals who live at the above facility have been monitored regularly each day per the submitted, "Plan for removal of Immediate Jeopardy." By all accounts, these Individuals and current staff at the site have stated they are comfortable and feel secure and safe in their home now that [Client #1] is not there, have been participating in active treatment, have exhibited multiple signs that they feel safe and secure, and all observations support that they are comfortable in their environment.</p> <p>VIII. Observations at the home by a member of the local supervisory team will continue each day, for two weeks, to ensure the Individuals and staff remain comfortable in the home. Ongoing, supervisory visits</p>				

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	<p>III. QDDP (Qualified Developmental Disabilities Professional), House Manager, Nurse, and Behaviorist</p> <p>A. QDDP, House Manager, Nurse, and Behaviorist will immediately begin monitoring the effectiveness of the revisions and staff competence in ensuring the revisions in [client #1]'s protocol. The QDDP, House Manager, Nurse, or Behaviorist will be in the home each day through out the week, at various times including shift changes and random overnight checks. A schedule has been developed illustrating who will be monitoring the home above (see attached supervision schedule).</p> <p>B. Monitoring and supervision will continue until all staff have demonstrated competency in this protocol and the IDT determines the protocol had been effective in ensuring the health and safety of all individuals in the home. When this has been determined, the IDT will revise the monitoring schedule as necessary to ensure daily, random observations in order to continue the continuity and effectiveness of the protocol.</p> <p>C. QDDP, House Manager, Nurse, and Behaviorist will submit daily updates on their observations to the Area Director.</p> <p>D. QDDP, House Manager, Nurse, and Behaviorist will promptly communicate any issues, concerns, or</p>		<p>will be completed at least weekly, and as needed, by each member of the oversight staff (House Manager, QDDP, Nurse, and Behaviorist). All supervisory visits will be reported to the Area Director. The Area Director will visit the home weekly for one month, then at least every quarter thereafter, to ensure all Individuals and staff remain comfortable and secure in the home. Staff will be encouraged to promptly notify the local supervisory team of any concerns regarding the Individuals' health and safety, and the local supervisory team will promptly notify the Area Director, to ensure any issues are promptly addressed.</p> <p>In the future, all allegations of Abuse and/or Neglect will be treated according to Agency Policy and Procedure To ensure this Policy and Procedure is adhered to, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations <b>at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least</b></p>		

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	<p>observed ineffectiveness of protocol to Area Director.</p> <p>E. While monitoring the home, the QDDP, House Manager, Nurse, and Behaviorist will offer counseling to [client #1]'s housemates in order to reassure them and address any concerns or fears they may have, including offering to arrange professional counseling as needed/requested.</p> <p>F. While monitoring the home, the QDDP, House Manager, Nurse, and Behaviorist will provide ongoing support and reassurance to all staff working in the home.</p> <p>IV. QDDP</p> <p>A. QDDP will arrange an IDT meeting for all of [client #1]'s housemates, to address the recent increase in aggression and fear they have been experiencing in the home. Each IDT will work to develop a plan to foster the individual in being comfortable in their own home and reassured of their health and safety.</p> <p>V. Area Director</p> <p>A. An Area Director (AD) will perform daily visits to the home to ensure this Plan is adhered to as written and to provide support and counseling to staff and [client #1]'s housemates in order to reassure their health and safety. These</p>		<p><b>quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>	

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	<p>visits will continue until all staff and housemates are comfortable and confident of their health and safety, in the home.</p> <p>B. The AD will review the daily notes/reports provided by QDDP, House Manager, Nurse, and Behaviorist, and promptly assist in addressing any concerns, issues, etc.</p> <p>C. The AD will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served."</p> <p>The facility's Immediate Jeopardy continued because the facility needed to ensure adequate placement for client #1 where his needs could be met; and to ensure adequate staff were scheduled to work with client #1 to provide 1-to-1 supervision at the group home for his safety and that of his peers. The facility also needed to continue monitoring/supervising facility staff, over a period of time, to ensure the plan of removal was followed/implemented to supervise client #1 to prevent his violent physical aggression towards clients #2 and #3, and to reduce the clients' potential for harm.</p>						

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	<p>Review of a letter from client #1's psychiatrist dated 3/19/15 was reviewed on 3/19/15 at 5:00 P.M.. Review of the letter indicated:</p> <p>"To Whom it May Concern:</p> <p>[Client #1] is currently a patient under my care. He is diagnosed with Chronic Paranoid Schizophrenia, and an intellectual disability. For over a year we have seen a decline in [client #1]'s baseline, with increased psychosis and associated irritability and aggression. Multiple medication changes have shown minimal to no benefit. In the last several months he has had two acute inpatient psychiatric hospitalizations at [Hospital #12]. Despite working closely with is team of doctors on the inpatient unit, we have ultimately not seen improvement in [client #1]'s psychosis and he continues to be aggressive in his group home to staff and his roommates on a daily basis. He has recently been aggressive in his primary care physician's office and in the local emergency department. Consequently, he is currently at risk of losing his primary care physician due to aggressive behaviors.</p> <p>[Client #1] suffers from a chronic and severe psychiatric illness, and is not simply making 'bad choices.'</p>			

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	<p>Unfortunately, despite evidence based psychiatric care, intensive behavioral plans, and acute hospitalizations, his symptoms are not improving. It is clear that he is failing in his current level of services in his group home. Repeated acute hospitalizations have been unsuccessful at returning his symptoms to a level that can be managed at his current home. His psychosis and aggression continue to put himself and others at risk. Furthermore, the behaviors exhibited by other roommates (loud vocalizations, yelling) likely exacerbate [client #1]'s chronic symptoms, and present significant challenges for staff to manage everyone safely in the same home.</p> <p>It is my recommendation that [client #1] requires a higher level of long term care, which may include placement at a state hospital facility. [Client #1] does have a history of admission to a state hospital, which is better equipped to manage these severe and chronic symptoms."</p> <p>A review of the facility's Bureau of Developmental Disabilities (BDDS) reports dated 3/18/15 to 3/21/15 was conducted on 3/22/15 at 10:30 A.M.. Review of the reports indicated:</p> <p>-BDDS report dated 3/18/15 involving</p>			

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	<p>client #1 indicated: "During an Annual recertification survey by the [state agency name] on Tuesday 3/17/15, an Immediate Jeopardy (IJ) was placed on [client #1]'s home due to his increased physical aggression towards others and the identified fear of him exhibited by his housemates, noted by the surveyor. On 3/18/15, [client #1]'s IDT contacted his psychiatrist regarding [client #1]'s current status and his psychiatrist stated that [Hospital #1] does not have any beds and that he should be taken to an ER (Emergency Room) to be evaluated and treated. [Client #1] was taken to [Hospital #2] and arrived around 3 P.M.. [Client #1] attempted to hit staff several times in the van on the way to the hospital. While walking into the hospital, [client #1] was attempting to kick and hit staff. [Client #1] then was put in a wheel chair. The nurse attempted to put a hospital bracelet on him and he swatted their (sic). [Facility] staff then put the bracelet on [client #1]. Once in the room, the nurse took down notes. The nurse stated that she would get a social worker to comet (sic) see [client #1]. Shea (sic) also stated, 'It's going to be hard to admit him due to being MR (Mental Retardation); if he just had schizophrenia then they would have a better chance.' After approximately 30 minutes the nurse came in and stated that</p>			

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	<p>there was nothing they could do. Staff stated to her that neither the doctor not the social worker had been in the room and that we were in IJ and fear for the safety of the individuals and staff in the home. I also told her that (the) BDDS and (the) State were involved. The nurse then said she would get a social worker. After approximately 20 minutes, the nurse returned and stated that the social worker left and they had to call another. I explained that we are in IJ and that I fear for the individuals and staff in the home and that BDDS and state are involved. She then stated that her boss said there was nothing they could do because he was MR. I asked if she had any suggestions and she said sorry, she does not. While talking to the Social Worker, [client #1] was starting to get agitated and yell and swat at staff. I then asked if they could give him something to calm him down. The Social Worker said she would talk to the nurse and get something. Approximately 30 minutes later the nurse came in and give (sic) the shot. [Client #1] did attempt to hit the nurse. The nurse held his arm down and administered the shot...."</p> <p>-BDDS report dated 3/19/15 involving client #1 indicated: "On 3/18/15, facility was informed that due to the Immediate Jeopardy, [client #1] could not be in the</p>			

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	<p>home. [Client #1] was given a PRN (as needed) Thorazine 25 mg (milligram) per protocol and taken to [Hospital #3] in [City #1] in an attempt to get him needed inpatient psychiatric stabilization until alternative, more appropriate placement can be found for [client #1]. [Client #1] was at [Hospital #3] ER from 1:30 P.M. -approximately 11:30 P.M. as they attempted to find him an inpatient placement. [Hospital #3] could not take him at this time because they had other very violent schizophrenics at the time. They have seclusion areas that are being used constantly and therefore no room to help [client #1]. They were able to get [client #1] accepted at [Hospital #2] in [City #2]. [Client #1] was prepped to leave and he punched the ambulance driver. They had to wait for a nurse to come administer PRN for the drive to [City #2]. During this waiting period [Hospital #4] called back and recanted because they ran [client #1]'s [Insurance] and he used all of his inpatient days and they have not replenished yet. They explained this would be the case at any private facility. The social worker attempted to contact [Hospital #5] and they refused based on his intellectual disability. [Hospital #6] also declined due to intellectual disability. [Hospital #7] in [City #3] is full. The social worker followed up and stated to go back</p>			

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	<p>to [Hospital #3] since he had already been admitted there twice and is receiving medications provided from their team. She also recommended [Hospital #8] in [City #4]. At 8:30 P.M. we got a new social worker at [Hospital #1] and she explained that we could not bring [client #1] back to the group home because he is endangering the others. She asked what we were going to do and we explained staying with him at a hotel overnight. I explained we are taking him to an outpatient facility at 9 A.M. tomorrow and that we appreciated their assistance in keeping everyone safe....On the morning of 3/20/15, [client #1] was taken to [Hospital #9] in [City #5], an outpatient facility, but who said they have therapists on staff that can and will do emergency assessments. Per their director, if [client #1] meets their criteria they will contact 'gatekeepers' and do everything they can to find [client #1] placement for stabilization. [Hospital #9] was very helpful in trying to find [client #1] a placement, but none were successful...."</p> <p>-BDDS report dated 3/22/15 involving client #1 indicated: "It's 1 A.M. on Saturday morning and I wanted to give an update on [client #1]. With a lot of hard work and nothing to really show for it, [client #1] was not admitted anywhere</p>				

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	<p>and returned to the home this afternoon. Around 5 P.M. he was relaxing in common area and got up and chased after staff for several minutes. He calmed down shortly after and had his meds passed. [Client #1] sat awake in the common area all afternoon. When I arrived around 9:45 P.M. [client #1] was engaging in some new erratic behaviors. He was giggling uncontrollably. When prompted or redirected he wouldn't acknowledge staff. At 10:15 (P.M.) he got up and chased towards staff, Stomping (sic), yelling, throwing arms in the air. He was yelling things that were inaudible. He returned to his chair continuing the odd outbursts. I was present and contacted IDT about PRN since he was not calming down and peers were attempting to sleep. They were in agreement and PRN administered around 10:20 P.M.. Follow up an hour later and he was exactly the same. Giggling, jumping out of chair, yelling at staff. It's currently 1 A.M. and he is continuing the same pattern. As long as I have known [client #1] the paranoia is always outward, talking to others, acknowledging things that are not there, telling voices to leave him alone. Now he is screaming out almost like someone is harming him, swatting, jumping away from things that aren't there, his demeanor has changed significantly as</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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	<p>well. He appears like he is sad and may cry. I'm concerned b/c (because) he is so up and down and there's no way to comprehend his sounds so you cannot assist him in anything....I got there about 7:20 A.M. and [client #1] was in bed, he closed his door. Staff cracked the door so they could see him. At 8:30 A.M. he began screaming from his room and only lasted a few seconds. At 8:45 A.M. staff administered 8 A.M. medications with success. He then laid back in the bed. Occasionally he would scream from his bed. At approximately 9:30 A.M. he sat up in bed and took the pillow from behind him and started hitting it then began screaming lasting approximately 15-20 seconds, then put the pillow back in under his head. I asked several times if he needed anything and if he was okay and he did (sic) answer any of my questions. Staff fixed him breakfast and went into his room and he got up, went to the table and took a bite of toast. When he was finished with that he got up walked towards his room and then leaned over at a 90 degree angle and ran at full speed into his room. He grabbed his blanket and started yelling. He then got into bed for a couple of minutes and got up and threw himself onto the floor. He laid there for approximately 3-5 minutes. Then got up came into the dining room area and laid on the floor. Staff asked</p>				

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	<p>multiple times if he wanted help getting up and if he was okay and he would not answer. He then got up and walked into his room and back out and laid on the floor outside his room. He sat up and laid back down approximately 8 times and he would scream and cry out. He repeated this behavior all morning. At 11:15 A.M. we were successful in giving his PRN Chlorpromazine 25 mg (schizophrenia). Since then he has continued the screaming and coming in and out of his room. At 11:40 A.M. he is in a recliner sitting. Several times throughout the morning it appeared as though he was holding his fist with the other hand trying to prevent him from hitting himself. He also appeared to be screaming out in pain and pulling away from people who were not there. His gait was very shaky and he was noted to have severe tremors and twitching throughout his whole body. We called 911 to have him transported to the ER for evaluation due to new symptoms of psychosis. At approximately 11:45 A.M. a police officer and ambulance came and spoke with [client #1]. EMTs (Emergency Medical Technicians) updated on situation and stated they would transport him to [Hospital] for an evaluation. [Client #1] walked out to the ambulance with no aggression noted. Staff to follow him to ER. I also spoke</p>			

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	<p>with [client #4] this morning. I asked him how he felt about his roommate returning and he said 'not so good.' Then he asked 'when is [client #1] leaving?' I told him we were doing our best to get [client #1] into a more appropriate placement. He said 'OK. I offered to have him speak with someone if he had any other questions or concerns regarding the situation, and he declined....-Nurse: [QDDP], staff and I followed the ambulance to hospital. Once we arrived [client #1] was calm. [Client #1] was a little agitated but manageable til (until)3:30 P.M.. He started to yell and scream then rolled off the bed onto the floor screaming 'Take cover.' The nurse came and assisted. He was crying in fetal position say (sic) 'they are going to get me.' He continued to lay on the floor for approximately 45 minutes to an hour. Then he looked at staff and acted like nothing happened asking to get back in bed. The doctor stopped in and was calling several places but they were either full or didn't take care of MR patients. [Client #1] started to get a little more agitation (sic) so he was given a shot of 10 mg (milligrams) Geodon (antipsychotic). We did not request this, the nurse knew [client #1] from the last visit and stated that we can't wait till (until) sic [client #1] is too agitated like last time and it took so much medication</p>			

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	<p>to calm him down. [Sister] called the room and staff spoke with her. She said she feels that [client #1] should not return to the home in the condition he is in. [Client #1] continued to yell and scream randomly to things that were not there. The doctor came in and stated that he talked to [Psychiatrist], and she prescribed Zyprexa 10 mg 1 time daily routine). While in the ER [client #1] did get an x-ray completed and a urine sample. All tests were normal. Before leaving the doctor gave [client #1] 10 mg Zyprexa. Staff transported [client #1] home. There were no issues coming home. It is 11 P.m. now and [client #1] has been sitting in the recliner in the common area since arriving home at 10 P.M.. He has yelled a couple of times 'you are dead;', 'you will be destroyed,' 'that is all.'...Sunday 3/22/15 4:42 A.M.: It's about 4:30 A.M. on Sunday morning. [Client #1] returned home for (sic) the ER still agitated on and off most of the evening. He would be sitting in his chair then jump up and scream out at the staff. He threatened the staff numerous times. He was in his room from about 11:15 P.M. on (sic) [Client #1] was in his room but not asleep. He continued to kick his bed and have outbursts. The worst outburst was around 2:15 A.M.. He screamed and yelled and threatened everyone for about 5 minutes. Staff</p>			

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	<p>asked me for PRN approval considering he continued to be agitated, yelling, and not sleeping. PRN was approved. However, [client #1] was so agitated he refused the medicine, so it was not passed. [Client #1] was quiet for about the next hour then again at 3:30 A.M. was very upset and awake. I was able to go in and [client #1] spoke to me in a few sentences for the first time in over two weeks. [Client #1] told me he was thirsty. He drank a glass (8 ounces of water). Then he began kicking and screaming again. I asked [client #1] to take PRN medication Chlorpromazine-25 mg, and he took it for me around 4:30 A.M.. [Client #1] stated he was hungry, he asked me for pizza and hot dogs. I didn't have either but offered him left overs in the fridge, he opted for an oatmeal pie as a snack and even thanked staff for it. [Client #1] then had another 8 ounce glass of water. At this moment 4:35 A.M., [client #1] is wide awake, having slept maybe an hour total this evening. There are currently 3 staff to 3 individuals here plus myself. The staff have been tremendous in working with [client #1] and attempting to help him. Until 4 A.M. he refused any interaction with staff....Behaviorist: Sunday 3/22/15 7:11 A.M.: Hello again. I left around 5 A.M. and [client #1] was agitated but manageable. I got a call around 5:45</p>			

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	<p>A.M. he was awake and screaming. By shift change at 6 A.M. he was out of bed and the screaming was so loud the staff coming in heard him from the end of the driveway. He is constantly yelling, jumping out of his chair, chasing staff, and throwing himself to the floor. He keeps telling the staff he's going to put them to death and kill them. His PRN (chlorpromazine 25 mg) at 4:30 A.M. was ineffective. In fact, he is much more agitated and aggressive. Since he was sent home with Zyprexa I instructed the staff to call the nurse....Behaviorist 3/22/15 10:57 A.M.: Arrived at group home at 8 A.M.. Could hear [client #1] yelling as I approached the door. [Client #1] was sitting in his recliner in the front common area. [Client #4] and [client #3] remain in their rooms. Staff documentation indicates [client #1] has slept very little, if at all through the night. Reviewed current protocol with staff. Due to [client #1]'s state of agitation, housemates' meds were passed in their respective rooms. Staff report that [client #1] had been yelling about bugs and trying to brush bugs off, stomp bugs and shoot bugs using his hands as a gun and making shooting sounds. He has bm (bowel movement) in his pants, but staff are unable to approach him. At 8:50 [client #1] calmed enough to pass his 8 A.M. meds. He continues to cycle</p>			

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	<p>through quiet and yelling periods approximately every 5 to 7 minutes. During the yelling periods, [client #1] tremors increase significantly and blood vessels appear on his forehead and neck. At 9:50 (A.M.) we asked and received permission from [Nurse] to administer a prn. [Client #1] calmed enough at 10:12 (A.M.) to take the prn. [Physician] stated last night that it doesn't do us any good to try to find placement for him. It is a waste of our time and a waste of his time. He suggested taking him to [Hospital #12] next time. [Client #1] is not safe to transport and ambulance won't take him to [City name] and [Psychiatrist] asked us not to take him to [Hospital #12]. So, our staff try to offer him meds, food etc in the 5 minutes or less of calmness, the housemates are staying in their rooms. All staff continue to follow [client #1]'s HRC (Human Rights Committee)approved BSP (Behavior Support Plan), obtain approval for all PRNs, and continue to follow the Plan for Removal of IJ. Team continues to agree [client #1] is a danger to himself and others, and is in dire need of psychiatric treatment for acute, new, unusual, and ongoing psychotic symptoms. APS (Adult Protection Services) was notified via telephone and being sent all updates via email and reports. Team is currently attempting to</p>			

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	<p>arrange to transport [client #1] to [Hospital #12] since this hospital has treated [client #1] via inpatient stays in the past, are familiar with him, and this was suggested by [Physician] and a Social Worker." The follow up report indicated: "Over the past 5 days, [client #1] has been to four different hospital emergency rooms and [Treatment Center] in an attempt to get him treatment for severe, worsening, and unusual psychotic symptoms. Today 3/3/15 (sic) at approximately 2:00 A.M., [client #1] was admitted to [Hospital] ICU (Intensive Care Unit) due to elevated white blood cell count, fever, and elevated pulse. The outcome of the outpatient appointment was that [Outpatient facility] stated there was nothing else they could do for [client #1] and he was asked to leave and returned to his home. Eventually on 3/23/15, [client #1] was admitted to [Hospital] ICU for observation and treatment. No hospitals would admit [client #1] for inpatient psychiatric services due to being full or due to [client #1]'s diagnosis of Mild MR. His psychiatrist attempted to find [client #1] inpatient care, but was unable to do so. All staff have been trained on the plans in place. Staff will continue to follow the plans, the IDT will continue to monitor his care, follow up as needed and update all parties."</p>			

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	<p>An interview with the AD was conducted on 3/23/15 at 8:28 A.M.. The AD indicated client #1's psychotic symptoms had gotten worse over the weekend. The AD indicated client #1 was currently admitted at the hospital's ICU for testing. The AD indicated he was not sure when client #1 would be discharged and when he is discharged where he would go.</p> <p>An interview with the GHM was conducted on 3/24/15 at 2:30 P.M.. The GHM indicated client #1 was out of ICU and in a regular room. The GHM indicated client #1 may be discharged any day and further indicated the facility was not sure where they would be able to get client #1 admitted to because no one would admit him.</p> <p>Findings include:</p> <p>1. Please refer to W149: The facility neglected for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #3), to implement its written policy and procedure to prevent neglect and/or abuse of clients. The facility neglected to ensure clients #2 and #3 were not being physically abused by client #1 and were able to reside in their home without fear. The facility neglected to ensure additional supports were put in</p>						

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	<p>place to assist staff to protect clients while residing in their home. The facility neglected to obtain alternate placement for client #1 due to the client's increase in violent behavior.</p> <p>2. Please refer to W157. The facility failed to take sufficient/effective corrective measures in regard to preventing/addressing client #1's documented increase in physical aggression for 2 of 4 sampled clients (#1 and #2) and 1 additional client (#3).</p> <p>9-3-2(a)</p>			

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W 149 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 observation, interview and record review for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #3), the facility neglected to implement its written policy and procedure to prevent neglect and/or abuse of clients. The facility neglected to ensure that clients #2 and #3 were not being physically abused by client #1 and were able to reside in their home without fear. The facility neglected to ensure additional supports were put in place to assist staff to protect clients while residing in their home. The facility neglected to seek alternate placement for client #1 due to the client's increase in violent behavior.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/16/15 from 8:00</p>	W 149	<p><b>W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS</b></p> <p>In conjunction with the Plan of Corrections for W100, W102, W104, W122, W157, W195, W196, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard, that the facility must implement its written policy and procedures to prevent abuse and/or neglect of clients. The House Manager, QDDP, Nurse, Behaviorist, and AD will be retrained on the Agency policy concerning Abuse/Neglect and/or Exploitation of Individuals Served.</p>	04/07/2015

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	<p>P.M. until 9:30 P.M.. Upon entering the group home, Direct Support Professional (DSP) #1 immediately approached this surveyor and indicated to follow her into the staff office. Upon entering the office, DSP #1 stated "Stay out of [client #1]'s sight. He is very violent and will attack you at any time. He targets everyone." Client #1 then slowly walked into the office and sat in a chair facing surveyor and began staring at surveyor. DSPs #1, #2 and #3 immediately stood in front of surveyor blocking client #1's sight. Client #1 then walked out of the office and sat on a couch located in front of client #2's bedroom door, which was closed. DSPs #1, #2 and #3 walked into the living room area and watched client #1 from a distance. At 8:15 P.M., client #1 began yelling and screaming. DSPs #1, #2 and #3 tried to calm him by talking to him and asking him what was wrong. At 8:30 P.M., client #1 slowly walked into the staff office again, sat in a chair for 2 minutes, stared at DSPs #1, #2, #3 and surveyor, got up, walked into the living room, sat on the couch located in front of client #2's bedroom and stared down at the ground. Clients #2, #3 and #4 stayed in their bedrooms with the doors shut during the entire observation period.</p> <p>An interview with DSPs #1, #2 and #3</p>		<p>On 3/22/15, Client #1 was transported to Methodist Hospital for evaluation and treatment. Below is the Allegation of Removal of Immediate Jeopardy that occurred on Monday, 3/23/15 for the above facility:</p> <p>-</p> <p>I. On 3/23/15, [Client #1] was admitted to Methodist Hospital ICU due to elevated temp, elevated white blood-cell count, and elevated pulse. Due to circumstances surrounding Immediate Jeopardy[Client #1's] IDT, Facility, and Agency agreed that [Client #1] <u>will not return to the home</u>, and will be provided supports by the Agency in an alternative setting until permanent, appropriate placement is secured for [Client #1] by BDDS.</p> <p>II. 3/27/15, [Client #1] was discharged from Methodist hospital inpatient psych unit. In order to ensure [Client #1] and the community's safety, the Agency arranged for 2 staff to support him 24/7 in his alternative setting.</p> <p>III. The current staff to Individual ratio will remain until his IDT determines that his safety can be assured with 1-on-1 staffing.</p>		

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	<p>was conducted on 3/16/15 at 8:45 P.M.. DSP #1 indicated client #1 has always had physical and verbal aggression but indicated his physical and verbal aggression has increased within the last 6 months. DSPs #1, #2 and #3 indicated all staff who work at the group home and clients #2 and #3 "are scared of client #1" because of his escalation in physical aggression. DSPs #1, #2 and #3 indicated "client #1 is very quick and strong" and "beats up" staff when they attempt to protect clients #2 and #3 from being aggressed upon. DSP #1 indicated staff and clients #2 and #3 have locked themselves in the bedrooms or staff office to protect themselves from being physically aggressed upon. DSP #1 indicated clients #2 and #3 have to sleep with their doors locked because client #1 walks around the group home all night and will attack the clients while they are asleep. DSP #1 stated client #1 "targets" clients #2 and #3 and targets all staff. DSP #1 indicated client #1 punched her in the face and broke her nose about 6 months ago.</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. Upon entering the group home, clients #1, #2, #3 and #4 were in their bedrooms. Clients #2, #3 and #4's bedroom doors were shut and</p>		<p>IV. [Client #1] is visiting regularly with his sister and POA, [.....], who lives in the Lafayette area. He visited with her on Saturday, 3/28/15 from 2pm to 5pm, and on Sunday, 2/29/15 from 11:30a to 4:00pm. On both occasions, [.....] picked him up and took him to her home for the visits.</p> <p>V. At this time, [Client #1] is displaying appropriate behavior and is not exhibiting verbal or physical aggression.</p> <p>VI. [Client #1] will be placed in a permanent, appropriate living setting by BDDS at the earliest possible opportunity; he has not been to the above facility since 3/23/15 and <u>will not</u> return to the above facility in the future.</p> <p>VII. All Individuals who live at the above facility have been monitored regularly each day per the submitted, "Plan for removal of Immediate Jeopardy." By all accounts, these Individuals and current staff at the site have stated they are comfortable and feel secure and safe in their home now that</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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	<p>client #1's bedroom door was open. At 8:00 A.M., client #1 slowly walked into the staff office and stood in the middle of the room. DSPs #4 and #6 stood in front of surveyor blocking client #1's line of sight. DSP #5 stood by the door that led to the outside of the home, with the door partially open, as if she were going to exit the office. Client #1 turned around, exited the office and sat on the couch located near client #2's bedroom. DSPs #4, #5 and #6 stated it was "weird" for client #1 to sit on that couch, because he "always" sits in his recliner. DSP #6 stated client #1 must be waiting for client #2 to exit his room, and may be "targeting" client #2. At 8:45 A.M., client #2 exited his bedroom, DSPs #4 and #6 immediately stood in front of client #2, blocking him from client #1's line of sight. Client #2 was observed to lean down, attempting to hide behind DSPs #4 and #6. When client #1 looked down to the ground, DSPs #4 and #6 prompted client #2 to the office. Client #2 ran from the living room into the office and DSP #6 quickly followed behind. At 9:00 A.M., client #2 went back into his bedroom and shut the door. At 10:20 A.M., client #2 entered the kitchen and began preparing his breakfast. Client #3 began making a pitcher of tea. At 10:35 A.M., Client #2 sat at the dining table and began eating</p>		<p>[Client #1] is not there, have been participating in active treatment, have exhibited multiple signs that they feel safe and secure, and all observations support that they are comfortable in their environment.</p> <p>VIII. Observations at the home by a member of the local supervisory team will continue each day, for two weeks, to ensure the Individuals and staff remain comfortable in the home. Ongoing, supervisory visits will be completed at least weekly, and as needed, by each member of the oversight staff (House Manager, QDDP, Nurse, and Behaviorist). All supervisory visits will be reported to the Area Director. The Area Director will visit the home weekly for one month, then at least every quarter thereafter, to ensure all Individuals and staff remain comfortable and secure in the home. Staff will be encouraged to promptly notify the local supervisory team of any concerns regarding the Individuals' health and safety, and the local supervisory team will promptly notify the Area Director, to ensure any issues are promptly addressed.</p> <p>In the future, all allegations of Abuse and/or Neglect will be treated according to Agency Policy and Procedure. To ensure this Policy</p>		

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>his breakfast. At 10:30 A.M., client #1 slowly walked into the dining area. Clients #2 and #3 immediately got up from the dining table and entered their bedrooms and shut the doors. Clients #2 and #3 stayed in their bedrooms the remainder of the observation period.</p> <p>An interview with DSPs #4 and #6 was conducted on 3/17/15 at 7:36 A.M.. DSPs #4 and #6 indicated client #1 had just lay down in his bed around 7:15 A.M.. DSPs #4 and #6 indicated client #1 was up all night walking the group home and "attacking" staff. DSP #4 indicated he was called in early this morning to assist the overnight staff due to client #1's physical aggression throughout the night and to ensure the safety of clients #2 and #3, who DSPs #4 and #6 stated client #1 "targets." DSPs #4 and #6 indicated client #1 sat outside of the bathroom located on the other end of the home near client #3's bedroom. DSPs #4 and #6 indicated client #1 sat outside the bathroom because he thought client #3 was still in the bathroom, but staff had escorted client #3 "safely" to his bedroom when client #1 walked over to the other side of the home. DSP #6 indicated client #1 entered client #3's bedroom, during the early morning, but client #3 had been escorted to the staff office so he</p>		<p>and Procedure is adhered to, the AD will be immediately notified of any allegation of abuse and/or neglect. AD will ensure Team implements immediate safety measures and each IDT works to ensure the Health and Safety of all Individuals. A member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations at <b>least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>	

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	<p>could eat his breakfast "safely."</p> <p>A review of the facility's records was conducted on 3/17/15 at 12:20 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes, Emails and investigation record indicated:</p> <p>-Email Dated 3/17/15 from Nurse: "I wanted to update everyone on [client #1]'s night last night. He was up the majority of the night chasing staff around the house. While they were attempting to do some cleaning (sic). I received a few phone calls regarding him. I spoke with [Staff name] and we discussed given (sic) his PRN (as needed) the med approval was given but the med was not due to his continued physical aggression towards staff. (per nurse this meant he refused this PRN). They called [GHM (Group Home Manager)] at 3 A.M. and she approved another staff member to come in and assist. During the night [client #1] went outside the front and attempted to enter staff's vehicle while being naked from the waste (sic) down. Staff attempted to redirect him back in the house with no success. He did return to house after multiple prompts from staff. Staff also reports that during the night they locked</p>				

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>the office door due to [client #1] pacing and he repeatedly tried to open the door, nearly breaking the handle. While [client #3] was showering [client #1] was waiting outside the bathroom door. Staff reports that [client #1] did leave the area and [client #3] was able to leave and go to his room safely. [Client #3] wanted breakfast and staff felt for him to eat safely he should eat in the office due to [client #1] pacing the house and his continued aggression so they took him out the front door, around the house and to the office so that he could eat in there. While [client #3] was eating [client #1] entered [client #3]'s room, staff was monitoring him at all times and he quickly exited the room. Night shift was unable to get him to take his 6 A.M. but once [DSP #4] arrived and began to give his 8 A.M. meds I gave approval for him to give the 6 A.M. meds as well, and [client #1] did take them without any difficulties...."</p> <p>-Email dated 3/16/15 from nurse: "Good Morning. I wanted to email everyone with an update on [client #1]. We have had an interesting weekend. Over the weekend he was still refusing to eat, get out of bed and we went from urinating everywhere to not urinating at all. We had no choice but to have him evaluated by the ER (Emergency Room). So on</p>			

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	<p>Sunday at approximately 1 P.M. he was taken to the ER. Once he arrived at the ER and got out of the van he tried to punch staff. Staff assisted him to the hospital lobby, he attempted to hit staff 3 times before making it there. A PATIENT at the hospital was trying to assist in getting a wheelchair for [client #1] and he attempted to hit him. He actually did make contact with said PATIENT while the hospital staff was trying to put on his hospital bracelet. Staff was trying to intervene without success. [Client #1] was taken back to the room, he did allow the nurse to take his blood pressure but then tried to hit the doctor. He did hit the doctor and he was unable to complete his examination. The doctor said he would not be treating [client #1] but he would see what the nurse could do. The nurses tried to assist him in getting an EKG (electrocardiogram-testing for heart) and he hit the nurse. The doctor then order (sic) a shot to try to calm him down. He appeared to be calm and got out of bed...staff tried to assist him back to bed and he swung at staff and walked out of his room into the hallway. Then he began walking the hallway with his pants falling down and his privates showing to everyone. He was asked multiple times by staff, nurses, hospital staff to return to his room. He refused and began hitting</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>the nurse. Two nurses attempted to restrain him but he hit them and got away. He saw a patient being pushed in a bed and tried to hit them and was restrained again by those two nurses. They got him back to his room and the doctor ordered another shot and they called security. Security restrained him while he was given the shot. Once the medication began to work the nurses were able to do what they needed to and no further aggression was shown during the rest of the hospital visit. The doctor reported to staff that the tests showed there is no medical reason why he is not eating or urinating. And he was discharged home with no changes in medications. When he arrived home he did eat 100% of his meal, then went to bed. At the hospital he was given Haldol and Ativan injections. I know that we need to make a follow up appointment with [Physician name] but he told staff if he comes to his office aggressive again he will no longer serve him. So I am not sure at this point when it would be safe to take him for his follow up. No appointment scheduled at this time. This morning I received a phone call from [DSP #4] who is trying to get [client #1] ready for his psych appoint with [Psychiatrist name] and he has hit staff multiple times this morning. He hit staff during med pass and knocked meds out</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>of their hands, spit meds out. Has attempted to hit staff 4 times and made contact twice. [DSP #4] was able to get him into the van to go to his appointment. These are the things he is saying, 'I shouldn't eat that, it might kill me.' 'I don't want those anymore.' 'I'm going to kill you and I am going to put you to death.' On Saturday he did sit at the dinner table with no clothes on from the waste (sic) down. He then went into the living room at (sic) sat on the couch with no clothes on. Staff tried to get clothes on him but he refused. His sister [Sister name] who is also his POA (Power of Attorney) has been updated on everything. So any help here?"</p> <p>-Email dated 3/16/15 from the nurse: "Good afternoon, I wanted to send another update on [client #1]. He was seen by (psych) [Psychiatrist name] today and has a med change. His Chlorpromazine 12.5 mg (schizophrenia) was increased back to 25 mg. Her progress note says: 1. Persistent aggressive behavior-hitting staff and medical personnel...2. Chlorpromazine 25 mg 1 tab by mouth every day at bedtime...3. Call with questions/concerns-please call by weeks end with update...4. If not eating or drinking (especially drinking) needs to be assessed in emergency department for</p>			

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	<p>dehydration...Once he returned to the home he was incontinent of bowel and refused to allow staff to clean him up. He also proceeded to sit on his recliner with bm all over himself and became physically aggression (sic) to any and all staff who tried to clean him up. Staff called [Behaviorist name] who went to the house to see if she could help."</p> <p>-Email dated 3/16/15 from the Behaviorist: "[Client #1] allowed myself and additional staff, for the lack of a better word, sponge bathe him. Refusing to move. He will not walk to the restroom and will not go near shower. I handed him a wet towel and he cleaned a small section of himself but he had a bowel movement from his hands to his feet and all over a chair. I was able to completely wipe him down and physically assisted him in getting clean clothes on. We are bleaching the entire (sic) now. [Client #1] did not say one word to me the entire time I was there, when he usually greets me right away and makes small conversation about what's for dinner, lunch or the weather. He wouldn't make eye contact. The only time he showed a response was when I would tap a limb and ask him to pick it up so I could wipe it down. He smiled at me a few times. This is a very drastic change even in the last 2 weeks. [Client</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>#1] is drooling from the mouth and has excessive tapping of his feet/arms."</p> <p>-TLog (Electronic Daily Progress notations by DSP staff) dated 3/15/15 involving client #1: "Saturday [client #1] was in bed all morning. He refused to get up to eat breakfast and spit his medications out at med pass. He urinated on the floor one time and did not urinate the rest of the day. He got up for lunch but refused to put pants or underwear on. He sat at the table with only a shirt on refusing to wear pants at all. He ate a couple bites of corn and drank a sip of water then sat on the couch in common area front still refusing to wear pants or underwear. He sat there pantless for a couple hours then returned to his bedroom and put pants on. He laid down all afternoon. He swung at staff and told them to get out each time staff checked on him. [Client #1] refused to get up and eat dinner. When staff prompted him to eat [client #1] told staff, 'I shouldn't eat that, it might kill me.' He did not get up and did not use the restroom until 10 P.M.. He had a bm (bowel movement) on third shift and urinated once at 5 A.M.. He refused breakfast Sunday morning and laid in bed instead. He did take his medications but refused to get up for lunch. He went to the hospital and drank an entire Pepsi on the way and had</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>multiple physical behaviors once he arrived. He tried hitting staff, patients, made contact with the doctor and several nurses. [Client #1] was given a shot of Geodon 20 mg (milligram), This seemed to work at first then he became very upset and went into hallway to leave and began to attack hospital staff when they asked him to return to his bed. After attacking several more hospital staff including security guard, [client #1] was restrained to the bed and given a shot of Haldol 5 mg and a shot of Ativan 2 mg as instructed by the doctor...."</p> <p>-Email dated 3/13/15 from nurse: "Good afternoon, I wanted to let everyone know and get anyone's suggestions on what to do with him (client #1). He is continuing to refuse to come out of his room. He is still extremely incontinent of urine. Today he has refused meals. He only ate a couple slices of pizza yesterday and a bit of yogurt. He is refusing to get out of bed and refusing to come out of his room. Any suggestions?...I am assuming this is what is going on. Its (sic) just not his usual and I what (sic) to be sure and be on top of it with him because there is not very often there is a middle with him. He is either like this or he is smacking everyone. O2 (oxygen) sat is within normal limits. We will just monitor him through the weekend and reevaluate on</p>			

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	<p>Monday."</p> <p>-GER dated 3/6/15 involving clients #1 and #3: "1 peer got out of his chair and walked passed (sic) [client #1] over arm's length away. As peer passed near [client #1], he leaned over and slapped peer's arm (client #3) hard enough for slap to be heard and to make peer cry in pain. 1 staff member stayed in common area with [client #1] while the other staff got the peers to be seated at the table then walked back to the room. [Client #1] got up and ran after staff with his fist drawn. Staff was able to put (sic) get on the other side of the couch. [Client #1] walked back to his chair and sat down...."</p> <p>-GER dated 3/6/15 involving clients #1 and #2: "Peers were sitting at the table quietly (without speaking) waiting for dinner when [client #1] got up out of his chair and ran into the dining room and began trying to choke [client #2]. [Client #1] did not gave (sic) any warning, no words that he was coming. [Client #1] simply came out of his chair towards peer. As [client #1] was being separated from peer [client #1] began scratching and punching him in the head and pulling [client #2]'s hair causing peer to have facial bleeding and headache."</p> <p>-Email dated 3/6/15 from behaviorist:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
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	"...After doctor came into room, Doctor asked staff for his medication list. Staff informed him that medications were decreased and he now has a PRN for aggression. The QDDP (Qualified Developmental Disabilities Professional) talked to the doctor about possibly getting him tested for dementia. The doctor stated he could see the decline in [client #1] in the last few months. He stated he would refer [client #1] to a neurologist for testing. The staff also reported he had complained of eye pain and about the fall he took in the parking lot. The doctor visually scanned him due to physical aggression. He also talked about what the psychiatrist and [Hospital name] thought about his placement with us and him returning back to the home. Staff reported that [Psychiatrist] was trying to help us find appropriate placement for [client #1] due to him endangering others in the home. [Client #1] then turned without saying a word and punched behaviorist in the left arm. Behaviorist moved considerably farther away from [client #1]. The Doctor asked what would happen if he attempted to take [client #1] back to the psychiatric facility? Staff reported they probably would deny him since he has already been there 2 times in 3 months. [Client #1] continued to clam (sic) and then randomly attempted to hit Behavior						

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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(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>Specialist. She blocked those hits and prompted [client #1] to return to his seat. Two minutes later [client #1] hit Behavior Specialist again. For a period of ten minutes [client #1] hit Behavior Specialist 5 times, and he attempted to kick both staff. Afterwards [client #1] was sitting in chair, before standing up and starting to hit staff and Behavior Specialist, before saying im (sic) ready to go and leaving. As behaviorist (sic) specialist was leaving, [Physician name] asked what would happen if he called the police right now. Behavior Clinician stated that was not the place for him and they wouldn't take him. Then she exited the room with the lead following [client #1]. QDDP stayed behind gathering paperwork and talking to the doctor about other options for [client #1]. [Client #1] walked out of room door and started walking down the hallway with staff right there with him. After walking out the front door Behavior Specialist and staff prompted [client #1] to wait before crossing the road, but [client #1] ignored staff and started walking across the street. There was a police officer driving down street but stopped when he saw him walking. [Client #1] then continued walking towards the van. [Client #1] got inside the van and fastened his seat belt."</p> <p>-Email dated 3/6/15 from nurse: "...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2015
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	<p>[Behavior Specialist name] said that [Physician name] questioned during the visit why we don't call the police. [Behavior Specialist] informed him that jail was not the place for him and they wouldn't take him. So they discussed with the doctor about the possibility of dementia and medical issues for the aggression. [Physician name] said he was going to call and speak with his neurologist and see what they can come up for [client #1]. After the visit [DSP #4] called and reported that [Physician name]'s office called and stated that they spoke with the neurologist and they determined that the issues with [client #1] is (sic) Developmental Disability issues not a medical issue and that he needs to be placed in a different facility like [State Hospital name] or somewhere like that. But as far as medical it is determined that its (sic) not the issue. So my question to the team is where do we go from here?"</p> <p>-GER dated 3/5/15 involving clients #1 and #2: "[Client #1], his peers and staff were sitting in the dining room eating a family style lunch. [Client #1] said to staff member setting (sic) across from him that he was having a bad day and the staff member said that he was having a good day. [Client #1] went back to eating his food and his peers were eating</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>their food and staff members were talking low and staff member updated the staff member about the person in the hospital. [Client #1] became upset and through (sic) his spoon at one of his peers (client #2) and made contact that was diagonally across from him and dish with food and drink between peer and staff member...."</p> <p>-Email dated 2/17/15 from nurse: "Good morning. I wanted to send another update on [client #1]. I called yesterday and spoke with the social worker. She said there has not been any change with [client #1] at this point. Still has been very physically aggressive. No discharge date as of yet. No med changes since he has been in [Hospital name]. There was a med change in his clozaril shortly before going to the hospital. Still having to use security when needing vital signs and doing blood draws. [Social Worker] said there has (sic) been talks about doing ECT. Electroconvulsive therapy (ECT) is a procedure in which electric currents are passed through the brain chemistry that can quickly reverse symptoms of certain mental illnesses. They have talked with [Sister name] and she is declining this treatment at this time. Again I am going to ask the team for any suggestions they have in regards to [client #1]. His physical aggression in the home is getting worse. [Behaviorist]</p>			

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	<p>and I have talked and he is not receptive in regarding to using coping skills. We have to think about the safety for everyone involved: [Client #1], other individuals in the home and staff. Thank you and have a great day."</p> <p>-Email dated 2/17/15 from GHM: "Im (sic) in hopes that being in the hospital this time will help with his aggression, but I feel that we are fighting a disease that is just going to keep getting worse. I feel that we need to find him a more suitable placement now before someone gets hurt."</p> <p>-Email dated 2/13/15 from nurse: "I just wanted to send an update on [client #1]. He has been at [Hospital name] since Wednesday. I called the hospital and spoke with [Hospital Nurse]. She said there has been no change in his behavior. No med changes noted. Vital signs stable. They still have to call security to help them when they want to draw blood or do vitals. He is dressing himself at this time and using the restroom without assistance. He was being physically aggressive on Wednesday but it is mild today. I want to put it (sic) this out to the team and I look forward to your suggestions...We need to come up with a way to do more documentation in regards to his physical aggression. [Staff name]</p>			

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	<p>mentioned doing more IR's (sic) (Internal Reports), so would it be possible for us to so an IR at the end of a bad day with times and descriptions of all the physical aggressions, so that she has more documentation and that will assist us in getting him transferred to somewhere more suitable for him? My other concern is that we are fighting a disease progression. [Behaviorist] has tried several coping strategies with no success. The 'voices' tell him to hit people. How are we going to get anywhere positive or productive with a disease progressively getting worse?"</p> <p>-Email dated 1/19/15 from Behaviorist: "Hello Everyone, I was contacted along with [Nurse name] and [GHM name] several times over the weekend about [client #1]'s physical and verbal aggression. There were 20+ BSP (Behavior Support Plan) notes written between Friday and this morning. The staff is aware and following the BSP, I gave several other recommendations for then (sic) to follow as well as to try to change [client #1]'s environment, give him time away, preparing positive things around tasks he avoids or dislikes, even trying to eat separately. [Nurse name] and I talked first thing this morning because we are all concerned. Since returning from his psychiatric stay he is</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>consistently incontinent, which has not been the case for almost 2 years. [Client #1] is refusing things he normally participates in, and continues to avoid showers and changing clothes. This is concerning because now he is covered in body fluids and when staff prompt him to shower or change clothes he becomes aggressive. On top of that most of notes stated all of the other individual's (sic) in the home spent most of the weekend in their rooms because they could see how upset [client #1] was. The few times they came out and sat quietly [client #1] would verbally or physically attack them. He continues to throw items at almost every meal time and endangering the others. I am concerned because there are typically no antecedents to behavior. [Client #1] is sitting quietly in his chair, then jumping up and throwing furniture, punching it around and cornering staff. Staff is having a difficult time ensuring the others' safety because they cannot make the other individuals' (sic) stay in their room or separate them at mealtimes. He had over 10 physical aggressions in 60 hours and even more verbal. I am at a loss in figuring out not only how to keep him safe, but the other individuals' (sic) in the home. His new medication regimen does not seem to be working any better, if anything he's more aggressive, and now incontinent as well. [Nurse</p>			

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	<p>name] notified the psychiatrist via email with all the logs from the weekend, and he actually had a visit with her in person this morning. The staff just informed me that [Psychiatrist] would be contacting myself and [Nurse name] today and then think about readmitting him. Just wanted to keep everyone updated. Thank you."</p> <p>-Email dated 12/20/14 from nurse: "Good afternoon. I just spoke with [Hospital staff] and it looks like [client #1] will be discharged on Monday. He is coming out of his room more and engaging in conversations more. He hasn't made physical contact with anyone in a couple days. Today they were assisting him with a bath and he tried to swat the nurse. She told him NO and he stopped. He told her they (sic) voices made him do (sic) and asked her to help them (sic) make them stop. He is still on the clearly and it is now 400 mg at his (sic) and 100 mg every am. She said he allowed them to draw blood. I am sure hoping he does when he is in our care. I will call her again Monday with discharge."</p> <p>-Email dated 12/17/14 from nurse: "Good afternoon. I wanted to get everyone's input on [client #1]. Currently his discharge is on hold until they decide what they are going to do with him</p>			

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	<p>because he is refusing the blood draws for the clozaril. My fear is that they may discharge him without giving us proper notification. So I wanted to get everyone's input...if he is still aggressive in the home when he returns what steps are we going to put in place to keep his roommates and staff safe? I would greatly appreciate all suggestions because he is so unpredictable. I spoke with [Area Director (AD)] today and we wanted to make sure we had something in place and all staff was (sic) trained on it before he returns home. Thank you for your help."</p> <p>-Email dated 12/16/14 from the nurse: "Received a call from [client #1]'s sister and she has some concerns and states that not much has changed since his arrival at the hospital. She has been there to see him and he is still having physical aggression. He told her that he doesn't belong there. And she states she knows but explained to him that he is there to help with the medication changes. She just feels like him being there hasn't changed a thing. She asked to speak with the doctor but they told her that she has to call and set up a conference call, that he/she wouldn't meet with her while she was there. I have called and left [Psychiatrist name] a voicemail and I am waiting on a return call."</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>-Email dated 12/16/14 from nurse: "Just wanted to let everyone know I received a call from [psychiatrist]'s nurse and [Psychiatrist] is aware that not much has changed with him as far as physical aggression goes. She knows that he is supposed to be discharged to us tomorrow. He will be having a follow up with [Psychiatrist] on Friday. They will call with a time. I will keep everyone posted. Thank you."</p> <p>-GER dated 10/23/14 involving clients #1 and #3: "[Client #1] was eating lunch with staff and peers in the dining room. [Client #1] had finished his sandwich and asked staff for another sandwich. Staff prompted [client #1] to eat his yogurt and peaches before getting another sandwich. [Client #1] stood up from his seat yelling 'You can't talk to me like that'. [Client #1] then picked up the empty chair beside him and swung it towards staff and then began hitting his peer with the chair. Striking his peer in the shoulder with the chair. The dining room chair broke."</p> <p>-GER dated 10/23/14 involving client #3: "[Client #3] was in the dining room eating lunch with staff and peers. [Client #3] has a red mark on the back of his left shoulder approximately the size of a softball. [Client #3] is complaining of</p>			

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	<p>pain in his shoulder." Further review of the report indicated the injury was from client #1 hitting client #3 with the dining room chair.</p> <p>A review of client #1's record was conducted on 3/17/15 at 4:00 P.M.. Review of his Behavioral data indicated:</p> <p>"March 2014- 5 incidents of physical aggression and 5 incidents of verbal aggression April 2014-12 incidents of physical aggression and 6 incidents of verbal aggression May 2014-8 incidents of physical aggression and 8 incidents of verbal aggression June 2014-8 incidents of physical aggression and 4 incidents of verbal aggression July 2014-6 incidents of physical aggression and 4 incidents of verbal aggression August 2014-10 incidents of physical aggression and 5 incidents of verbal aggression September 2014-13 incidents of physical aggression and 3 incidents of verbal aggression October 2014-18 incidents of physical aggression and 7 incidents of verbal aggression November 20</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/25/2015
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---	---

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	<p>14-10 incidents of physical aggression and 7 incidents of verbal aggression December 2014-4 incidents of physical aggression and 2 incidents of verbal aggression January 2015-28 incidents of physical aggression and 14 incidents of verbal aggression February 2015-13 incidents of physical aggression and 2 incidents of verbal aggression March 2015-18 incidents of physical aggression so far this month."</p> <p>A review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14 was conducted at the facility's administrative office on 3/17/15 at 2:00 P.M. and indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement</p>			

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---	---

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	<p>resulting from physical or chemical intervention....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...Neglect is defined as failure to provide appropriate care, supervision, or training, failure to provide food and medical services as needed, failure to provide a safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)....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"> <li>1. Review of witnesses.</li> <li>2. Any evidence or previous abuse or neglect.</li> <li>3. All other evidence to determine the veracity and seriousness of the charge."</li> </ol>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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	<p>An interview with the facility's Behaviorist and GHM was conducted on 3/17/15 at 2:00 P.M.. The Behaviorist indicated client #1 has had a recent increase in behaviors over the last 6 months. The Behaviorist and GHM indicated the staff who work at the group home and clients #2 and #3 "are scared of client #1" due to his "explosive" physical aggression. The GHM indicated client #1 also threatens clients and staff. The GHM indicated alternate placement for client #1 has not been considered because his sister who is his POA does not want him to move anywhere.</p> <p>A review of the facility's Bureau of Developmental Disabilities (BDDS) reports dated 3/18/15 to 3/21/15 was conducted on 3/22/15 at 10:30 A.M.. Review of the reports indicated:</p> <p>-BDDS report dated 3/18/15 involving client #1 indicated: "During an Annual recertification survey by the [state agency name] on Tuesday 3/17/15, an Immediate Jeopardy (IJ) was placed on [client #1]'s home due to his increased physical aggression towards others and the identified fear of him exhibited by his housemates, noted by the surveyor. On 3/18/15, [client #1]'s IDT contacted his psychiatrist regarding [client #1]'s current status and his psychiatrist stated that</p>				

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	<p>[Hospital #1] does not have any beds and that he should be taken to an ER (Emergency Room) to be evaluated and treated. [Client #1] was taken to [Hospital #2] and arrived around 3 P.M.. [Client #1] attempted to hit staff several times in the van on the way to the hospital. While walking into the hospital, [client #1] was attempting to kick and hit staff. [Client #1] then was put in a wheel chair. The nurse attempted to put a hospital bracelet on him and he swatted their (sic). [Facility] staff then put the bracelet on [client #1]. Once in the room, the nurse took down notes. The nurse stated that she would get a social worker to comet (sic) see [client #1]. Shea (sic) also stated, 'It's going to be hard to admit him due to being MR (Mental Retardation); if he just had schizophrenia then they would have a better chance.' After approximately 30 minutes the nurse came in and stated that there was nothing they could do. Staff stated to her that neither the doctor not the social worker had been in the room and that we were in IJ and fear for the safety of the individuals and staff in the home. I also told her that (the) BDDS and (the) State were involved. The nurse then said she would get a social worker. After approximately 20 minutes, the nurse returned and stated that the social worker left and they had to call another. I</p>			

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	<p>explained that we are in IJ and that I fear for the individuals and staff in the home and that BDDS and state are involved. She then stated that her boss said there was nothing they could do because he was MR. I asked if she had any suggestions and she said sorry, she does not. While talking to the Social Worker, [client #1] was starting to get agitated and yell and swat at staff. I then asked if they could give him something to calm him down. The Social Worker said she would talk to the nurse and get something. Approximately 30 minutes later the nurse came in and give (sic) the shot. [Client #1] did attempt to hit the nurse. The nurse held his arm down and administered the shot...."</p> <p>-BDDS report dated 3/19/15 involving client #1 indicated: "On 3/18/15, facility was informed that due to the Immediate Jeopardy, [client #1] could not be in the home. [Client #1] was given a PRN (as needed) Thorazine 25 mg (milligram) per protocol and taken to [Hospital #3] in [City #1] in an attempt to get him needed inpatient psychiatric stabilization until alternative, more appropriate placement can be found for [client #1]. [Client #1] was at [Hospital #3] ER from 1:30 P.M. -approximately 11:30 P.M. as they attempted to find him an inpatient placement. [Hospital #3] could not take</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
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	<p>him at this time because they had other very violent schizophrenics at the time. They have seclusion areas that are being used constantly and therefore no room to help [client #1]. They were able to get [client #1] accepted at [Hospital #2] in [City #2]. [Client #1] was prepped to leave and he punched the ambulance driver. They had to wait for a nurse to come administer PRN for the drive to [City #2]. During this waiting period [Hospital #4] called back and recanted because they ran [client #1]'s [Insurance] and he used all of his inpatient days and they have not replenished yet. They explained this would be the case at any private facility. The social worker attempted to contact [Hospital #5] and they refused based on his intellectual disability. [Hospital #6] also declined due to intellectual disability. [Hospital #7] in [City #3] is full. The social worker followed up and stated to go back to [Hospital #3] since he had already been admitted there twice and is receiving medications provided from their team. She also recommended [Hospital #8] in [City #4]. At 8:30 P.M. we got a new social worker at [Hospital #1] and she explained that we could not bring [client #1] back to the group home because he is endangering the others. She asked what we were going to do and we explained staying with him at a hotel overnight. I</p>						

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	<p>explained we are taking him to an outpatient facility at 9 A.M. tomorrow and that we appreciated their assistance in keeping everyone safe....On the morning of 3/20/15, [client #1] was taken to [Hospital #9] in [City #5], an outpatient facility, but who said they have therapists on staff that can and will do emergency assessments. Per their director, if [client #1] meets their criteria they will contact 'gatekeepers' and do everything they can to find [client #1] placement for stabilization. [Hospital #9] was very helpful in trying to find [client #1] a placement, but none were successful...."</p> <p>-BDDS report dated 3/22/15 involving client #1 indicated: "It's 1 A.M. on Saturday morning and I wanted to give an update on [client #1]. With a lot of hard work and nothing to really show for it, [client #1] was not admitted anywhere and returned to the home this afternoon. Around 5 P.M. he was relaxing in common area and got up and chased after staff for several minutes. He calmed down shortly after and had his meds passed. [Client #1] sat awake in the common area all afternoon. When I arrived around 9:45 P.M. [client #1] was engaging in some new erratic behaviors. He was giggling uncontrollably. When prompted or redirected he wouldn't acknowledge staff. At 10:15 (P.M.) he</p>			
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	got up and chased towards staff, Stomping (sic), yelling, throwing arms in the air. He was yelling things that were inaudible. He returned to his chair continuing the odd outbursts. I was present and contacted IDT about PRN since he was not calming down and peers were attempting to sleep. They were in agreement and PRN administered around 10:20 P.M.. Follow up an hour later and he was exactly the same. Giggling, jumping out of chair, yelling at staff. It's currently 1 A.M. and he is continuing the same pattern. As long as I have known [client #1] the paranoia is always outward, talking to others, acknowledging things that are not there, telling voices to leave him alone. Now he is screaming out almost like someone is harming him, swatting, jumping away from things that aren't there, his demeanor has changed significantly as well. He appears like he is sad and may cry. I'm concerned b/c (because) he is so up and down and there's no way to comprehend his sounds so you cannot assist him in anything....I got there about 7:20 A.M. and [client #1] was in bed, he closed his door. Staff cracked the door so they could see him. At 8:30 A.M. he began screaming from his room and only lasted a few seconds. At 8:45 A.M. staff administered 8 A.M. medications with success. He then laid back in the bed.				

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	Occasionally he would scream from his bed. At approximately 9:30 A.M. he sat up in bed and took the pillow from behind him and started hitting it then began screaming lasting approximately 15-20 seconds, then put the pillow back in under his head. I asked several times if he needed anything and if he was okay and he did (sic) answer any of my questions. Staff fixed him breakfast and went into his room and he got up, went to the table and took a bite of toast. When he was finished with that he got up walked towards his room and then leaned over at a 90 degree angle and ran at full speed into his room. He grabbed his blanket and started yelling. He then got into bed for a couple of minutes and got up and threw himself onto the floor. He laid there for approximately 3-5 minutes. Then got up came into the dining room area and laid on the floor. Staff asked multiple times if he wanted help getting up and if he was okay and he would not answer. He then got up and walked into his room and back out and laid on the floor outside his room. He sat up and laid back down approximately 8 times and he would scream and cry out. He repeated this behavior all morning. At 11:15 A.M. we were successful in giving his PRN Chlorpromazine 25 mg (schizophrenia). Since then he has continued the screaming and coming in			

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	and out of his room. At 11:40 A.M. he is in a recliner sitting. Several times throughout the morning it appeared as though he was holding his fist with the other hand trying to prevent him from hitting himself. He also appeared to be screaming out in pain and pulling away from people who were not there. His gait was very shaky and he was noted to have severe tremors and twitching throughout his whole body. We called 911 to have him transported to the ER for evaluation due to new symptoms of psychosis. At approximately 11:45 A.M. a police officer and ambulance came and spoke with [client #1]. EMTs (Emergency Medical Technicians) updated on situation and stated they would transport him to [Hospital] for an evaluation. [Client #1] walked out to the ambulance with no aggression noted. Staff to follow him to ER. I also spoke with [client #4] this morning. I asked him how he felt about his roommate returning and he said 'not so good.' Then he asked 'when is [client #1] leaving?' I told him we were doing our best to get [client #1] into a more appropriate placement. He said 'OK. I offered to have him speak with someone if he had any other questions or concerns regarding the situation, and he declined....-Nurse: [QDDP], staff and I followed the ambulance to hospital. Once we arrived			

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	[client #1] was calm. [Client #1] was a little agitated but manageable til (until)3:30 P.M.. He started to yell and scream then rolled off the bed onto the floor screaming 'Take cover.' The nurse came and assisted. He was crying in fetal position say (sic) 'they are going to get me.' He continued to lay on the floor for approximately 45 minutes to an hour. Then he looked at staff and acted like nothing happened asking to get back in bed. The doctor stopped in and was calling several places but they were either full or didn't take care of MR patients. [Client #1] started to get a little more agitation (sic) so he was given a shot of 10 mg (milligrams) Geodon (antipsychotic). We did not request this, the nurse knew [client #1] from the last visit and stated that we can't wait till (until) sic [client #1] is too agitated like last time and it took so much medication to calm him down. [Sister] called the room and staff spoke with her. She said she feels that [client #1] should not return to the home in the condition he is in. [Client #1] continued to yell and scream randomly to things that were not there. The doctor came in and stated that he talked to [Psychiatrist], and she prescribed Zyprexa 10 mg 1 time daily routine). While in the ER [client #1] did get an x-ray completed and a urine sample. All tests were normal.			

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	<p>Before leaving the doctor gave [client #1] 10 mg Zyprexa. Staff transported [client #1] home There were no issues coming home. It is 11 P.m. now and [client #1] has been sitting in the recliner in the common area since arriving home at 10 P.M.. He has yelled a couple of times 'you are dead;, 'you will be destroyed,' 'that is all.'...Sunday 3/22/15 4:42 A.M.: It's about 4:30 A.M. on Sunday morning. [Client #1] returned home for (sic) the ER still agitated on and off most of the evening. He would be sitting in his chair then jump up and scream out at the staff. He threatened the staff numerous times. He was in his room from about 11:15 P.M. on (sic) [Client #1] was in his room but not asleep. He continued to kick his bed and have outbursts. The worst outburst was around 2:15 A.M.. He screamed and yelled and threatened everyone for about 5 minutes. Staff asked me for PRN approval considering he continued to be agitated, yelling, and not sleeping. PRN was approved. However, [client #1] was so agitated he refused the medicine, so it was not passed. [Client #1] was quiet for about the next hour then again at 3:30 A.M. was very upset and awake. I was able to go in and [client #1] spoke to me in a few sentences for the first time in over two weeks. [Client #1] told me he was thirsty. He drank a glass (8 ounces of</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>water). Then he began kicking and screaming again. I asked [client #1] to take PRN medication Chlorpromazine-25 mg, and he took it for me around 4:30 A.M.. [Client #1] stated he was hungry, he asked me for pizza and hot dogs. I didn't have either but offered him left overs in the fridge, he opted for an oatmeal pie as a snack and even thanked staff for it. [Client #1] then had another 8 ounce glass of water. At this moment 4:35 A.M., [client #1] is wide awake, having slept maybe an hour total this evening. There are currently 3 staff to 3 individuals here plus myself. The staff have been tremendous in working with [client #1] and attempting to help him. Until 4 A.M. he refused any interaction with staff...Behaviorist: Sunday 3/22/15 7:11 A.M.: Hello again. I left around 5 A.M. and [client #1] was agitated but manageable. I got a call around 5:45 A.M. he was awake and screaming. By shift change at 6 A.M. he was out of bed and the screaming was so loud the staff coming in heard him from the end of the driveway. He is constantly yelling, jumping out of his chair, chasing staff, and throwing himself to the floor. He keeps telling the staff he's going to put them to death and kill them. His PRN (chlorpromazine 25 mg) at 4:30 A.M. was ineffective. In fact, he is much more agitated and aggressive. Since he was</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>sent home with Zyprexa I instructed the staff to call the nurse....Behaviorist 3/22/15 10:57 A.M.: Arrived at group home at 8 A.M. Could hear [client #1] yelling as I approached the door. [Client #1] was sitting in his recliner in the front common area. [Client #4] and [client #3] remain in their rooms. Staff documentation indicates [client #1] has slept very little, if at all through the night. Reviewed current protocol with staff. Due to [client #1]'s state of agitation, housemates' meds were passed in their respective rooms. Staff report that [client #1] had been yelling about bugs and trying to brush bugs off, stomp bugs and shoot bugs using his hands as a gun and making shooting sounds. He has bm (bowel movement) in his pants, but staff are unable to approach him. At 8:50 [client #1] calmed enough to pass his 8 A.M. meds. He continues to cycle through quiet and yelling periods approximately every 5 to 7 minutes. During the yelling periods, [client #1] tremors increase significantly and blood vessels appear on his forehead and neck. At 9:50 (A.M.) we asked and received permission from [Nurse] to administer a prn. [Client #1] calmed enough at 10:12 (A.M.) to take the prn. [Physician] stated last night that it doesn't do us any good to try to find placement for him. It is a waste of our time and a</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
---	---

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	waste of his time. He suggested taking him to [Hospital #12] next time. [Client #1] is not safe to transport and ambulance won't take him to [City name] and [Psychiatrist] asked us not to take him to [Hospital #12]. So, our staff try to offer him meds, food etc in the 5 minutes or less of calmness, the housemates are staying in their rooms. All staff continue to follow [client #1]'s HRC (Human Rights Committee)approved BSP (Behavior Support Plan), obtain approval for all PRNs, and continue to follow the Plan for Removal of IJ. Team continues to agree [client #1] is a danger to himself and others, and is in dire need of psychiatric treatment for acute, new, unusual, and ongoing psychotic symptoms. APS (Adult Protection Services) was notified via telephone and being sent all updates via email and reports. Team is currently attempting to arrange to transport [client #1] to [Hospital #12] since this hospital has treated [client #1] via inpatient stays in the past, are familiar with him, and this was suggested by [Physician] and a Social Worker." The follow up report indicated: "Over the past 5 days, [client #1] has been to four different hospital emergency rooms and [Treatment Center] in an attempt to get him treatment for severe, worsening, and unusual psychotic symptoms. Today 3/3/15 (sic) at			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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	<p>approximately 2:00 A.M., [client #1] was admitted to [Hospital] ICU (Intensive Care Unit) due to elevated white blood cell count, fever, and elevated pulse. The outcome of the outpatient appointment was that [Outpatient facility] stated there was nothing else they could do for [client #1] and he was asked to leave and returned to his home. Eventually on 3/23/15, [client #1] was admitted to [Hospital] ICU for observation and treatment. No hospitals would admit [client #1] for inpatient psychiatric services due to being full or due to [client #1]'s diagnosis of Mild MR. His psychiatrist attempted to find [client #1] inpatient care, but was unable to do so. All staff have been trained on the plans in place. Staff will continue to follow the plans, the IDT will continue to monitor his care, follow up as needed and update all parties."</p> <p>An interview with the AD was conducted on 3/23/15 at 8:28 A.M.. The AD indicated client #1's psychotic symptoms had gotten worse over the weekend. The AD indicated client #1 was currently admitted at the hospital's ICU for testing. The AD indicated he was not sure when client #1 would be discharged and when he is discharged where he would go.</p> <p>An interview with the GHM was</p>				

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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	<p>conducted on 3/24/15 at 2:30 P.M.. The GHM indicated client #1 was out of ICU and in a regular room. The GHM indicated client #1 may be discharged any day and further indicated the facility was not sure where they would be able to get client #1 admitted to because no one would admit him.</p> <p>9-3-2(a)</p>			

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
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W 157  Bldg. 00	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, interview and record review for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #3), the facility failed to take sufficient/effective corrective measures in regard to preventing/addressing client #1's documented increase in physical aggression toward his peers.</p> <p>Findings include:  An evening observation was conducted at the group home on 3/16/15 from 8:00 P.M. until 9:30 P.M.. Upon entering the group home, Direct Support Professional (DSP) #1 immediately approached this surveyor and indicated to follow her into the staff office. Upon entering the office, DSP #1 stated "Stay out of [client #1]'s sight. He is very violent and will attack you at any time. He targets everyone." Client #1 then slowly walked into the office and sat in a chair facing surveyor and began staring at surveyor. DSPs #1, #2 and #3 immediately stood in front of</p>	W 157	<p><b>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS</b></p> <p>In conjunction with the Plan of Corrections for W100, W102, W104, W122, W149, W195, W196, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard, that the facility must implement its written policy and procedures to prevent abuse and/or neglect of clients. The House Manager, QDDP, Nurse, Behaviorist, and AD will be retrained on the Agency policy concerning Abuse/Neglect and/or Exploitation of Individuals Served.</p> <p>On 3/22/15, Client #1 was transported to Methodist Hospital for evaluation and treatment. Below is the Allegation of Removal of Immediate Jeopardy that occurred on</p>	04/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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	<p>surveyor blocking client #1's sight. Client #1 then walked out of the office and sat on a couch located in front of client #2's bedroom door, which was closed. DSPs #1, #2 and #3 walked into the living room area and watched client #1 from a distance. At 8:15 P.M., client #1 began yelling and screaming. DSPs #1, #2 and #3 tried to calm him by talking to him and asking him what was wrong. At 8:30 P.M., client #1 slowly walked into the staff office again, sat in a chair for 2 minutes, stared at DSPs #1, #2, #3 and surveyor, got up, walked into the living room, sat on the couch located in front of client #2's bedroom and stared down at the ground. Clients #2, #3 and #4 stayed in their bedrooms with the doors shut during the entire observation period.</p> <p>An interview with DSPs #1, #2 and #3 was conducted on 3/16/15 at 8:45 P.M.. DSP #1 indicated client #1 has always had physical and verbal aggression but indicated his physical and verbal aggression has increased within the last 6 months. DSPs #1, #2 and #3 indicated all staff who work at the group home and clients #2 and #3 "are scared of client #1" because of his escalation in physical aggression. DSPs #1, #2 and #3 indicated "client #1 is very quick and strong" and "beats up" staff when they</p>		<p>Monday, 3/23/15 for the above facility:</p> <p>-</p> <p>I. On 3/23/15, [Client #1] was admitted to Methodist Hospital ICU due to elevated temp, elevated white blood-cell count, and elevated pulse. Due to circumstances surrounding Immediate Jeopardy[Client #1's] IDT, Facility, and Agency agreed that [Client #1] will not return to the home, and will be provided supports by the Agency in an alternative setting until permanent, appropriate placement is secured for [Client #1] by BDDS.</p> <p>II. 3/27/15, [Client #1] was discharged from Methodist hospital inpatient psych unit. In order to ensure [Client #1] and the community's safety, the Agency arranged for 2 staff to support him 24/7 in his alternative setting.</p> <p>III. The current staff to Individual ratio will remain until his IDT determines that his safety can be assured with 1-on-1 staffing.</p> <p>IV. [Client #1] is visiting regularly with his sister and POA, [.....], who lives in the Lafayette</p>		

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	<p>attempt to protect clients #2 and #3 from being aggressed upon. DSP #1 indicated staff and clients #2 and #3 have locked themselves in the bedrooms or staff office to protect themselves from being physically aggressed upon. DSP #1 indicated clients #2 and #3 have to sleep with their doors locked because client #1 walks around the group home all night and will attack the clients while they are asleep. DSP #1 stated client #1 "targets" clients #2 and #3 and targets all staff. DSP #1 indicated client #1 punched her in the face and broke her nose about 6 months ago.</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. Upon entering the group home, clients #1, #2, #3 and #4 were in their bedrooms. Clients #2, #3 and #4's bedroom doors were shut and client #1's bedroom door was open. At 8:00 A.M., client #1 slowly walked into the staff office and stood in the middle of the room. DSPs #4 and #6 stood in front of surveyor blocking client #1's line of sight. DSP #5 stood by the door that led to the outside of the home, with the door partially open, as if she were going to exit the office. Client #1 turned around, exited the office and sat on the couch located near client #2's bedroom. DSPs #4, #5 and #6 stated it was "weird" for</p>		<p>area. He visited with her on Saturday, 3/28/15 from 2pm to 5pm, and on Sunday, 2/29/15 from 11:30a to 4:00pm. On both occasions, [.....] picked him up and took him to her home for the visits.</p> <p>V. At this time, [Client #1] is displaying appropriate behavior and is not exhibiting verbal or physical aggression.</p> <p>VI. [Client #1] will be placed in a permanent, appropriate living setting by BDDS at the earliest possible opportunity; he has not been to the above facility since 3/23/15 and <u>will not</u> return to the above facility in the future.</p> <p>VII. All Individuals who live at the above facility have been monitored regularly each day per the submitted, "Plan for removal of Immediate Jeopardy." By all accounts, these Individuals and current staff at the site have stated they are comfortable and feel secure and safe in their home now that [Client #1] is not there, have been participating in active treatment, have exhibited multiple signs that they feel safe and secure, and all observations support that they are comfortable in their environment.</p>		

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	<p>client #1 to sit on that couch, because he "always" sits in his recliner. DSP #6 stated client #1 must be waiting for client #2 to exit his room, and may be "targeting" client #2. At 8:45 A.M., client #2 exited his bedroom, DSPs #4 and #6 immediately stood in front of client #2, blocking him from client #1's line of sight. Client #2 was observed to lean down, attempting to hide behind DSPs #4 and #6. When client #1 looked down to the ground, DSPs #4 and #6 prompted client #2 to the office. Client #2 ran from the living room into the office and DSP #6 quickly followed behind. At 9:00 A.M., client #2 went back into his bedroom and shut the door. At 10:20 A.M., client #2 entered the kitchen and began preparing his breakfast. Client #3 began making a pitcher of tea. At 10:35 A.M., Client #2 sat at the dining table and began eating his breakfast. At 10:30 A.M., client #1 slowly walked into the dining area. Clients #2 and #3 immediately got up from the dining table and entered their bedrooms and shut the doors. Clients #2 and #3 stayed in their bedrooms the remainder of the observation period.</p> <p>An interview with DSPs #4 and #6 was conducted on 3/17/15 at 7:36 A.M.. DSPs #4 and #6 indicated client #1 had just lay down in his bed around 7:15</p>		<p>VIII. Observations at the home by a member of the local supervisory team will continue each day, for two weeks, to ensure the Individuals and staff remain comfortable in the home. Ongoing, supervisory visits will be completed at least weekly, and as needed, by each member of the oversight staff (House Manager, QDDP, Nurse, and Behaviorist). All supervisory visits will be reported to the Area Director. The Area Director will visit the home weekly for one month, then at least every quarter thereafter, to ensure all Individuals and staff remain comfortable and secure in the home. Staff will be encouraged to promptly notify the local supervisory team of any concerns regarding the Individuals' health and safety, and the local supervisory team will promptly notify the Area Director, to ensure any issues are promptly addressed.</p> <p>In the future, all allegations of Abuse and/or Neglect will be treated according to Agency Policy and Procedure. To ensure this Policy and Procedure is adhered to, the AD will be immediately notified of any allegation of abuse and/or neglect. AD will ensure Team implements immediate safety measures and each IDT works to ensure the Health and</p>		

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	<p>A.M.. DSPs #4 and #6 indicated client #1 was up all night walking the group home and "attacking" staff. DSP #4 indicated he was called in early this morning to assist the overnight staff due to client #1's physical aggression throughout the night and to ensure the safety of clients #2 and #3, who DSPs #4 and #6 stated client #1 "targets." DSPs #4 and #6 indicated client #1 sat outside of the bathroom located on the other end of the home near client #3's bedroom. DSPs #4 and #6 indicated client #1 sat outside the bathroom because he thought client #3 was still in the bathroom, but staff had escorted client #3 "safely" to his bedroom when client #1 walked over to the other side of the home. DSP #6 indicated client #1 entered client #3's bedroom, during the early morning, but client #3 had been escorted to the staff office so he could eat his breakfast "safely."</p> <p>A review of the facility's records was conducted on 3/17/15 at 12:20 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes, Emails and investigation record indicated:</p> <p>-Email Dated 3/17/15 from Nurse: "I</p>		<p>Safety of all Individuals. A member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations <b>at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>				

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	wanted to update everyone on [client #1]'s night last night. He was up the majority of the night chasing staff around the house. While they were attempting to do some cleaning (sic). I received a few phone calls regarding him. I spoke with [Staff name] and we discussed given (sic) his PRN (as needed) the med approval was given but the med was not due to his continued physical aggression towards staff. (per nurse this meant he refused this PRN). They called [GHM (Group Home Manager)] at 3 A.M. and she approved another staff member to come in and assist. During the night [client #1] went outside the front and attempted to enter staff's vehicle while being naked from the waste (sic) down. Staff attempted to redirect him back in the house with no success. He did return to house after multiple prompts from staff. Staff also reports that during the night they locked the office door due to [client #1] pacing and he repeatedly tried to open the door, nearly breaking the handle. While [client #3] was showering [client #1] was waiting outside the bathroom door. Staff reports that [client #1] did leave the area and [client #3] was able to leave and go to his room safely. [Client #3] wanted breakfast and staff felt for him to eat safely he should eat in the office due to [client #1] pacing the house and his continued aggression so they took him			

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	<p>out the front door, around the house and to the office so that he could eat in there. While [client #3] was eating [client #1] entered [client #3]'s room, staff was monitoring him at all times and he quickly exited the room. Night shift was unable to get him to take his 6 A.M. but once [DSP #4] arrived and began to give his 8 A.M. meds I gave approval for him to give the 6 A.M. meds as well, and [client #1] did take them without any difficulties...."</p> <p>-Email dated 3/16/15 from nurse: "Good Morning. I wanted to email everyone with an update on [client #1]. We have had an interesting weekend. Over the weekend he was still refusing to eat, get out of bed and we went from urinating everywhere to not urinating at all. We had no choice but to have him evaluated by the ER (Emergency Room). So on Sunday at approximately 1 P.M. he was taken to the ER. Once he arrived at the ER and got out of the van he tried to punch staff. Staff assisted him to the hospital lobby, he attempted to hit staff 3 times before making it there. A PATIENT at the hospital was trying to assist in getting a wheelchair for [client #1] and he attempted to hit him. He actually did make contact with said PATIENT while the hospital staff was trying to put on his hospital bracelet.</p>			
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	<p>Staff was trying to intervene without success. [Client #1] was taken back to the room, he did allow the nurse to take his blood pressure but then tried to hit the doctor. He did hit the doctor and he was unable to complete his examination. The doctor said he would not be treating [client #1] but he would see what the nurse could do. The nurses tried to assist him in getting an EKG (electrocardiogram-testing for heart) and he hit the nurse. The doctor then order (sic) a shot to try to calm him down. He appeared to be calm and got out of bed...staff tried to assist him back to bed and he swung at staff and walked out of his room into the hallway. Then he began walking the hallway with his pants falling down and his privates showing to everyone. He was asked multiple times by staff, nurses, hospital staff to return to his room. He refused and began hitting the nurse. Two nurses attempted to restrain him but he hit them and got away. He saw a patient being pushed in a bed and tried to hit them and was restrained again by those two nurses. They got him back to his room and the doctor ordered another shot and they called security. Security restrained him while he was given the shot. Once the medication began to work the nurses were able to do what they needed to and no further aggression was shown during</p>			

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	<p>the rest of the hospital visit. The doctor reported to staff that the tests showed there is no medical reason why he is not eating or urinating. And he was discharged home with no changes in medications. When he arrived home he did eat 100% of his meal, then went to bed. At the hospital he was given Haldol and Ativan injections. I know that we need to make a follow up appointment with [Physician name] but he told staff if he comes to his office aggressive again he will no longer serve him. So I am not sure at this point when it would be safe to take him for his follow up. No appointment scheduled at this time. This morning I received a phone call from [DSP #4] who is trying to get [client #1] ready for his psych appoint with [Psychiatrist name] and he has hit staff multiple times this morning. He hit staff during med pass and knocked meds out of their hands, spit meds out. Has attempted to hit staff 4 times and made contact twice. [DSP #4] was able to get him into the van to go to his appointment. These are the things he is saying, 'I shouldn't eat that, it might kill me.' 'I don't want those anymore.' 'I'm going to kill you and I am going to put you to death.' On Saturday he did sit at the dinner table with no clothes on from the waste (sic) down. He then went into the living room at (sic) sat on the couch with</p>			

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	<p>no clothes on. Staff tried to get clothes on him but he refused. His sister [Sister name] who is also his POA (Power of Attorney) has been updated on everything. So any help here?"</p> <p>-Email dated 3/16/15 from the nurse: "Good afternoon, I wanted to send another update on [client #1]. He was seen by (psych) [Psychiatrist name] today and has a med change. His Chlorpromazine 12.5 mg (schizophrenia) was increased back to 25 mg. Her progress note says: 1. Persistent aggressive behavior-hitting staff and medical personnel...2. Chlorpromazine 25 mg 1 tab by mouth every day at bedtime...3. Call with questions/concerns-please call by weeks end with update...4. If not eating or drinking (especially drinking) needs to be assessed in emergency department for dehydration...Once he returned to the home he was incontinent of bowel and refused to allow staff to clean him up. He also proceeded to sit on his recliner with bm all over himself and became physically aggression (sic) to any and all staff who tried to clean him up. Staff called [Behaviorist name] who went to the house to see if she could help."</p> <p>-Email dated 3/16/15 from the Behaviorist: "[Client #1] allowed myself</p>			

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	<p>and additional staff, for the lack of a better word, sponge bathe him. Refusing to move. He will not walk to the restroom and will not go near shower. I handed him a wet towel and he cleaned a small section of himself but he had a bowel movement from his hands to his feet and all over a chair. I was able to completely wipe him down and physically assisted him in getting clean clothes on. We are bleaching the entire (sic) now. [Client #1] did not say one word to me the entire time I was there, when he usually greets me right away and makes small conversation about what's for dinner, lunch or the weather. He wouldn't make eye contact. The only time he showed a response was when I would tap a limb and ask him to pick it up so I could wipe it down. He smiled at me a few times. This is a very drastic change even in the last 2 weeks. [Client #1] is drooling from the mouth and has excessive tapping of his feet/arms."</p> <p>-TLog (Electronic Daily Progress notations by DSP staff) dated 3/15/15 involving client #1: "Saturday [client #1] was in bed all morning. He refused to get up to eat breakfast and spit his medications out at med pass. He urinated on the floor one time and did not urinate the rest of the day. He got up for lunch but refused to put pants or underwear on.</p>			

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	<p>He sat at the table with only a shirt on refusing to wear pants at all. He ate a couple bites of corn and drank a sip of water then sat on the couch in common area front still refusing to wear pants or underwear. He sat there pantless for a couple hours then returned to his bedroom and put pants on. He laid down all afternoon. He swung at staff and told them to get out each time staff checked on him. [Client #1] refused to get up and eat dinner. When staff prompted him to eat [client #1] told staff, 'I shouldn't eat that, it might kill me.' He did not get up and did not use the restroom until 10 P.M.. He had a bm (bowel movement) on third shift and urinated once at 5 A.M.. He refused breakfast Sunday morning and laid in bed instead. He did take his medications but refused to get up for lunch. He went to the hospital and drank an entire Pepsi on the way and had multiple physical behaviors once he arrived. He tried hitting staff, patients, made contact with the doctor and several nurses. [Client #1] was given a shot of Geodon 20 mg (milligram), This seemed to work at first then he became very upset and went into hallway to leave and began to attack hospital staff when they asked him to return to his bed. After attacking several more hospital staff including security guard, [client #1] was restrained to the bed and given a shot of Haldol 5</p>			

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	<p>mg and a shot of Ativan 2 mg as instructed by the doctor...."</p> <p>-Email dated 3/13/15 from nurse: "Good afternoon, I wanted to let everyone know and get anyone's suggestions on what to do with him (client #1). He is continuing to refuse to come out of his room. He is still extremely incontinent of urine. Today he has refused meals. He only ate a couple slices of pizza yesterday and a bit of yogurt. He is refusing to get out of bed and refusing to come out of his room. Any suggestions?...I am assuming this is what is going on. Its (sic) just not his usual and I what (sic) to be sure and be on top of it with him because there is not very often there is a middle with him. He is either like this or he is smacking everyone. O2 (oxygen) sat is within normal limits. We will just monitor him through the weekend and reevaluate on Monday."</p> <p>-GER dated 3/6/15 involving clients #1 and #3: "1 peer got out of his chair and walked passed (sic) [client #1] over arm's length away. As peer passed near [client #1], he leaned over and slapped peer's arm (client #3) hard enough for slap to be heard and to make peer cry in pain. 1 staff member stayed in common area with [client #1] while the other staff got the peers to be seated at the table then</p>				

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	<p>walked back to the room. [Client #1] got up and ran after staff with his fist drawn. Staff was able to put (sic) get on the other side of the couch. [Client #1] walked back to his chair and sat down...."</p> <p>-GER dated 3/6/15 involving clients #1 and #2: "Peers were sitting at the table quietly (without speaking) waiting for dinner when [client #1] got up out of his chair and ran into the dining room and began trying to choke [client #2]. [Client #1] did not gave (sic) any warning, no words that he was coming. [Client #1] simply came out of his chair towards peer. As [client #1] was being separated from peer [client #1] began scratching and punching him in the head and pulling [client #2]'s hair causing peer to have facial bleeding and headache."</p> <p>-Email dated 3/6/15 from behaviorist: "...After doctor came into room, Doctor asked staff for his medication list. Staff informed him that medications were decreased and he now has a PRN for aggression. The QDDP (Qualified Developmental Disabilities Professional) talked to the doctor about possibly getting him tested for dementia. The doctor stated he could see the decline in [client #1] in the last few months. He stated he would refer [client #1] to a neurologist for testing. The staff also</p>				

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	<p>reported he had complained of eye pain and about the fall he took in the parking lot. The doctor visually scanned him due to physical aggression. He also talked about what the psychiatrist and [Hospital name] thought about his placement with us and him returning back to the home. Staff reported that [Psychiatrist] was trying to help us find appropriate placement for [client #1] due to him endangering others in the home. [Client #1] then turned without saying a word and punched behaviorist in the left arm. Behaviorist moved considerably farther away from [client #1]. The Doctor asked what would happen if he attempted to take [client #1] back to the psychiatric facility? Staff reported they probably would deny him since he has already been there 2 times in 3 months. [Client #1] continued to clam (sic) and then randomly attempted to hit Behavior Specialist. She blocked those hits and prompted [client #1] to return to his seat. Two minutes later [client #1] hit Behavior Specialist again. For a period of ten minutes [client #1] hit Behavior Specialist 5 times, and he attempted to kick both staff. Afterwards [client #1] was sitting in chair, before standing up and starting to hit staff and Behavior Specialist, before saying im (sic) ready to go and leaving. As behaviorist (sic) specialist was leaving, [Physician name]</p>			

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	<p>asked what would happen if he called the police right now. Behavior Clinician stated that was not the place for him and they wouldn't take him. Then she exited the room with the lead following [client #1]. QDDP stayed behind gathering paperwork and talking to the doctor about other options for [client #1]. [Client #1] walked out of room door and started walking down the hallway with staff right there with him. After walking out the front door Behavior Specialist and staff prompted [client #1] to wait before crossing the road, but [client #1] ignored staff and started walking across the street. There was a police officer driving down street but stopped when he saw him walking. [Client #1] then continued walking towards the van. [Client #1] got inside the van and fastened his seat belt."</p> <p>-Email dated 3/6/15 from nurse: "... [Behavior Specialist name] said that [Physician name] questioned during the visit why we don't call the police. [Behavior Specialist] informed him that jail was not the place for him and they wouldn't take him. So they discussed with the doctor about the possibility of dementia and medical issues for the aggression. [Physician name] said he was going to call and speak with his neurologist and see what they can come up for [client #1]. After the visit [DSP</p>			

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	<p>#4] called and reported that [Physician name]'s office called and stated that they spoke with the neurologist and they determined that the issues with [client #1] is (sic) Developmental Disability issues not a medical issue and that he needs to be placed in a different facility like [State Hospital name] or somewhere like that. But as far as medical it is determined that its (sic) not the issue. So my question to the team is where do we go from here?"</p> <p>-GER dated 3/5/15 involving clients #1 and #2: "[Client #1], his peers and staff were sitting in the dining room eating a family style lunch. [Client #1] said to staff member setting (sic) across from him that he was having a bad day and the staff member said that he was having a good day. [Client #1] went back to eating his food and his peers were eating their food and staff members were talking low and staff member updated the staff member about the person in the hospital. [Client #1] became upset and through (sic) his spoon at one of his peers (client #2) and made contact that was diagonally across from him and dish with food and drink between peer and staff member...."</p> <p>-Email dated 2/17/15 from nurse: "Good morning. I wanted to send another update on [client #1]. I called yesterday</p>			

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	<p>and spoke with the social worker. She said there has not been any change with [client #1] at this point. Still has been very physically aggressive. No discharge date as of yet. No med changes since he has been in [Hospital name]. There was a med change in his clozaril shortly before going to the hospital. Still having to use security when needing vital signs and doing blood draws. [Social Worker] said there has (sic) been talks about doing ECT. Electroconvulsive therapy (ECT) is a procedure in which electric currents are passed through the brain chemistry that can quickly reverse symptoms of certain mental illnesses. They have talked with [Sister name] and she is declining this treatment at this time. Again I am going to ask the team for any suggestions they have in regards to [client #1]. His physical aggression in the home is getting worse. [Behaviorist] and I have talked and he is not receptive in regarding to using coping skills. We have to think about the safety for everyone involved: [Client #1], other individuals in the home and staff. Thank you and have a great day."</p> <p>-Email dated 2/17/15 from GHM: "Im (sic) in hopes that being in the hospital this time will help with his aggression, but I feel that we are fighting a disease that is just going to keep getting worse. I</p>			

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	<p>feel that we need to find him a more suitable placement now before someone gets hurt."</p> <p>-Email dated 2/13/15 from nurse: "I just wanted to send an update on [client #1]. He has been at [Hospital name] since Wednesday. I called the hospital and spoke with [Hospital Nurse]. She said there has been no change in his behavior. No med changes noted. Vital signs stable. They still have to call security to help them when they want to draw blood or do vitals. He is dressing himself at this time and using the restroom without assistance. He was being physically aggressive on Wednesday but it is mild today. I want to put it (sic) this out to the team and I look forward to your suggestions...We need to come up with a way to do more documentation in regards to his physical aggression. [Staff name] mentioned doing more IR's (sic) (Internal Reports), so would it be possible for us to so an IR at the end of a bad day with times and descriptions of all the physical aggressions, so that she has more documentation and that will assist us in getting him transferred to somewhere more suitable for him? My other concern is that we are fighting a disease progression. [Behaviorist] has tried several coping strategies with no success. The 'voices' tell him to hit people. How</p>			

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	<p>are we going to get anywhere positive or productive with a disease progressively getting worse?"</p> <p>-Email dated 1/19/15 from Behaviorist: "Hello Everyone, I was contacted along with [Nurse name] and [GHM name] several times over the weekend about [client #1]'s physical and verbal aggression. There were 20+ BSP (Behavior Support Plan) notes written between Friday and this morning. The staff is aware and following the BSP, I gave several other recommendations for then (sic) to follow as well as to try to change [client #1]'s environment, give him time away, preparing positive things around tasks he avoids or dislikes, even trying to eat separately. [Nurse name] and I talked first thing this morning because we are all concerned. Since returning from his psychiatric stay he is consistently incontinent, which has not been the case for almost 2 years. [Client #1] is refusing things he normally participates in, and continues to avoid showers and changing clothes. This is concerning because now he is covered in body fluids and when staff prompt him to shower or change clothes he becomes aggressive. On top of that most of notes stated all of the other individual's (sic) in the home spent most of the weekend in their rooms because they could see how</p>			

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	<p>upset [client #1] was. The few times they came out and sat quietly [client #1] would verbally or physically attack them. He continues to throw items at almost every meal time and endangering the others. I am concerned because there are typically no antecedents to behavior. [Client #1] is sitting quietly in his chair, then jumping up and throwing furniture, punching it around and cornering staff. Staff is having a difficult time ensuring the others' safety because they cannot make the other individuals' (sic) stay in their room or separate them at mealtimes. He had over 10 physical aggressions in 60 hours and even more verbal. I am at a loss in figuring out not only how to keep him safe, but the other individuals' (sic) in the home. His new medication regimen does not seem to be working any better, if anything he's more aggressive, and now incontinent as well. [Nurse name] notified the psychiatrist via email with all the logs from the weekend, and he actually had a visit with her in person this morning. The staff just informed me that [Psychiatrist] would be contacting myself and [Nurse name] today and then think about readmitting him. Just wanted to keep everyone updated. Thank you."</p> <p>-Email dated 12/20/14 from nurse: "Good afternoon. I just spoke with [Hospital staff] and it looks like [client</p>				

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	<p>#1] will be discharged on Monday. He is coming out of his room more and engaging in conversations more. He hasn't made physical contact with anyone in a couple days. Today they were assisting him with a bath and he tried to swat the nurse. She told him NO and he stopped. He told her they (sic) voices made him do (sic) and asked her to help them (sic) make them stop. He is still on the clearly and it is now 400 mg at his (sic) and 100 mg every am. She said he allowed them to draw blood. I am sure hoping he does when he is in our care. I will call her again Monday with discharge."</p> <p>-Email dated 12/17/14 from nurse: "Good afternoon. I wanted to get everyone's input on [client #1]. Currently his discharge is on hold until they decide what they are going to do with him because he is refusing the blood draws for the clozaril. My fear is that they may discharge him without giving us proper notification. So I wanted to get everyone's input...if he is still aggressive in the home when he returns what steps are we going to put in place to keep his roommates and staff safe? I would greatly appreciate all suggestions because he is so unpredictable. I spoke with [Area Director (AD)] today and we wanted to make sure we had something</p>				

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	<p>in place and all staff was (sic) trained on it before he returns home. Thank you for your help."</p> <p>-Email dated 12/16/14 from the nurse: "Received a call from [client #1]'s sister and she has some concerns and states that not much has changed since his arrival at the hospital. She has been there to see him and he is still having physical aggression. He told her that he doesn't belong there. And she states she knows but explained to him that he is there to help with the medication changes. She just feels like him being there hasn't changed a thing. She asked to speak with the doctor but they told her that she has to call and set up a conference call, that he/she wouldn't meet with her while she was there. I have called and left [Psychiatrist name] a voicemail and I am waiting on a return call."</p> <p>-Email dated 12/16/14 from nurse: "Just wanted to let everyone know I received a call from [psychiatrist]'s nurse and [Psychiatrist] is aware that not much has changed with him as far as physical aggression goes. She knows that he is supposed to be discharged to us tomorrow. He will be having a follow up with [Psychiatrist] on Friday. They will call with a time. I will keep everyone</p>				

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	<p>posted. Thank you."</p> <p>-GER dated 10/23/14 involving clients #1 and #3: "[Client #1] was eating lunch with staff and peers in the dining room. [Client #1] had finished his sandwich and asked staff for another sandwich. Staff prompted [client #1] to eat his yogurt and peaches before getting another sandwich. [Client #1] stood up from his seat yelling 'You can't talk to me like that'. [Client #1] then picked up the empty chair beside him and swung it towards staff and then began hitting his peer with the chair. Striking his peer in the shoulder with the chair. The dining room chair broke."</p> <p>-GER dated 10/23/14 involving client #3: "[Client #3] was in the dining room eating lunch with staff and peers. [Client #3] has a red mark on the back of his left shoulder approximately the size of a softball. [Client #3] is complaining of pain in his shoulder." Further review of the report indicated the injury was from client #1 hitting client #3 with the dining room chair.</p> <p>A review of client #1's record was conducted on 3/17/15 at 4:00 P.M.. Review of his Behavioral data indicated:</p> <p>"March 2014- 5 incidents of physical aggression and 5 incidents of verbal</p>				

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	<p>aggression</p> <p>April 2014-12 incidents of physical aggression and 6 incidents of verbal aggression</p> <p>May 2014-8 incidents of physical aggression and 8 incidents of verbal aggression</p> <p>June 2014-8 incidents of physical aggression and 4 incidents of verbal aggression</p> <p>July 2014-6 incidents of physical aggression and 4 incidents of verbal aggression</p> <p>August 2014-10 incidents of physical aggression and 5 incidents of verbal aggression</p> <p>September 2014-13 incidents of physical aggression and 3 incidents of verbal aggression</p> <p>October 2014-18 incidents of physical aggression and 7 incidents of verbal aggression</p> <p>November 2014-10 incidents of physical aggression and 7 incidents of verbal aggression</p> <p>December 2014-4 incidents of physical aggression and 2 incidents of verbal aggression</p> <p>January 2015-28 incidents of physical aggression and 14 incidents of verbal aggression</p> <p>February 2015-13 incidents of physical aggression and 2 incidents of verbal aggression</p>			

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	<p>M</p> <p>arch 2015-18 incidents of physical aggression so far this month."</p> <p>No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence.</p> <p>An interview with the facility's Behaviorist, Qualified Intellectual Disabilities Professional (QIDP) and GHM was conducted on 3/17/15 at 2:00 P.M.. The Behaviorist indicated client #1 has had a recent increase in behaviors over the last 6 months. The Behaviorist and GHM indicated the staff who work at the group home and clients #2 and #3 "are scared of client #1" due to his "explosive" physical aggression. The GHM indicated client #1 also threatens clients and staff. The GHM indicated alternate placement for client #1 has not been considered because his sister, who is his POA (Power of Attorney) does not want him to move anywhere. When asked what measures were put in place to prevent recurrence of client #1's physical aggression, the behaviorist indicated group home staff are to keep client #1 away from clients #2 and #3. The GHM indicated clients #2 and #3 stay in their bedrooms to stay away from client #1.</p>						

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W 195 Bldg. 00	<p>9-3-2(a)</p> <p>483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. Based on observation, record review and interview for 4 of 4 clients who resided in the home (clients #1, #2, #3 and #4), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to ensure each client received a continuous, aggressive active treatment program. The facility failed to ensure staff implemented formal and informal training programs when opportunities existed and failed to develop individualized Active Treatment Schedules (ATS).</p> <p>Findings include:</p> <p>Please refer to W196: The facility failed to ensure each client received a continuous and aggressive active treatment program, both formally and informally, to address the training needs of client #1, #2, #3 and #4.</p>	W 195	<p><b>W 195 483.440 ACTIVE TREATMENT SERVICES</b></p> <p>In conjunction with the Plan of Corrections for W100, w102, W104, W122, W149, W157, W196, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this CONDITION.</p> <p>The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of</p>	04/07/2015	

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	<p>Please refer to W249: The Qualified Intellectual Disabilities Professional (QIDP) failed to ensure staff implemented clients' program plans and support objectives during formal and informal training opportunities for clients #1, #2, #3 and #4.</p> <p>Please refer to W250: The QIDP failed to develop individualized active treatment schedules for clients #1, #2, #3 and #4 which indicated when the clients were to receive training.</p> <p>9-3-4(a)</p>		<p>abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, <b>the House Manager, QDDP, Nurse, or Behaviorist</b>, will complete daily active treatment observations for the next two weeks, and until compliance is demonstrated; <b>the House Manager will complete site visits two times per week during the morning shift change and hour of morning medication administration, the QDDP will complete site visits two times per week during the alternative day program hours, lunch, and afternoon medication administration, the Behaviorist will complete site visits two times per week during the evening</b></p>	

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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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W 196  Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes		<p><b>medication administration, and the Nurse will complete site visits once per week during the hours of a medication administration. Furthermore, a member of this Team will complete a drop-in at least once per week and as needed, during the overnight hours. In the event one of these visits cannot be accomplished by the noted member of the Team above, another member of the Team will complete the visit. Thereafter, a member of this Team will complete these observations at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>		

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	<p>aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>Based on observation, interview and record review for 4 of 4 clients who resided in the home (clients #1, #2, #3 and #4), the facility failed to ensure each client received a continuous and aggressive active treatment program which addressed the training (formal and informal) needs of the clients.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/16/15 from 8:00 P.M. until 9:30 P.M.. During the entire observation period, clients #2, #3 and #4 stayed in their bedrooms with the bedroom doors shut. The clients stayed in their rooms with no activity or interaction from staff. Client #1 sat in the living room with no activity or staff interaction and would walk back and forth from the living room to the staff office. Direct Support Professionals (DSPs) #1, #2 and #3 failed to implement</p>	W 196	<p><b>W 196 483.440(a)(1) ACTIVE TREATMENT</b> In conjunction with the Plan of Corrections for W100, w102, W104, W122, W149, W157, W195, W249, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard. The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input</p>	04/07/2015			

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	<p>training objectives either formally or informally for clients #1, #2, #3 and #4. Clients #1, #2, #3 and #4 did not receive continuous active treatment.</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. From 7:30 A.M. until 8:45 A.M., clients #2 and #3 stayed in their bedroom with no activity or interaction. From 9:00 A.M. until 10:45 A.M., clients #2 and #3 stayed in their bedrooms with no activity or interaction. During the entire observation period, client #1 walked back and forth from the living room to the staff office with no activity or interaction. DSPs #4, #5 and #6 failed to implement training objectives either formally or informally for clients #1, #2, #3 and #4.</p> <p>An observation was conducted at the group home on 3/18/15 from 4:00 P.M. until 5:30 P.M.. During the entire observation period clients #2 and #3 sat in the living room watching television.</p> <p>An observation was conducted at the group home on 3/20/15 from 2:30 P.M. until 4:00 P.M.. During the entire observation clients #2 and #3 sat in the living room watching television.</p> <p>An interview with DSPs #1, #2 and #3</p>		<p>from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, <b>the House Manager, QDDP, Nurse, or Behaviorist</b>, will complete daily active treatment observations for the next two weeks, and until compliance is demonstrated; <b>the House Manager will complete site visits two times per week during the morning shift change and hour of morning medication administration, the QDDP will complete site visits two times per week during the alternative day program hours, lunch, and afternoon medication administration, the Behaviorist will complete site visits two times per week during the evening medication administration, and the Nurse will complete site visits once per week during the hours of a medication administration. Furthermore, a member of this Team will complete a drop-in at least once per week and as needed, during the overnight hours. In the event one of</b></p>				

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	<p>was conducted on 3/16/15 at 8:45 P.M.. When asked if each client had active treatment objectives, DSP #1 "Yes." DSPs #1, #2 and #3 indicated clients #1, #2 and #3 stayed in their rooms with no activity everyday because of client #1's physical aggression and targeting of clients.</p> <p>A review of client #1's record was conducted on 3/17/15 at 11:00 A.M.. The Individual Support Plan (ISP) dated 9/11/14 indicated: "Will assist in cleaning his area after each meal... Will take the trash out of his room daily... Will initiate a 2 minute positive conversation with staff or housemate daily... Will learn to identify certain coins... Will participate in an exercise... Will correctly name one of his 8 A.M. medications."</p> <p>A review of client #2's record was conducted on 3/17/15 at 11:30 A.M.. The ISP dated 9/11/14 indicated: "Will follow his chore chart daily... Will state his phone number... Will identify a penny from other coins... Will engage in some form of exercise... Will wear his eye glasses."</p> <p>A review of client #3's record was conducted on 3/17/15 at 12:15 P.M.. A review of client #3's ISP dated 9/10/14 indicated: "Will state his address and</p>		<p><b>these visits cannot be accomplished by the noted member of the Team above, another member of the Team will complete the visit.</b></p> <p>Thereafter, a member of this Team will complete these observations <b>at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>		

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	<p>phone number...Will learn to identify coins...Will engage in some form of exercise...."</p> <p>A review of client #4's record was conducted on 3/17/15 at 1:00 P.M.. A review of client #4's ISP dated 9/11/14 indicated: "Will develop better speech...Will learn to sort clothes...Will balance a checkbook...Will complete a daily chore...Will have a positive conversation daily with staff...Will participate in his physical therapy exercises...Will read a paragraph."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 3/17/15 at 3:45 P.M. The QIDP indicated active treatment should be ongoing and training should be both formal and informal.</p> <p>9-3-4(a)</p>				

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W 249  Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review and interview, the facility failed to assure 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4) received training and services consistent with their individual plans.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/16/15 from 8:00 P.M. until 9:30 P.M.. During the entire observation period, clients #2, #3 and #4 stayed in their bedrooms with the bedroom doors shut. The clients stayed in their rooms with no activity or interaction from staff. Client #1 sat in the living room with no activity or staff interaction and would walk back and forth from the living room to the staff office. Direct Support Professionals (DSPs) #1, #2 and #3 failed to implement training objectives either formally or informally for clients #1, #2, #3 and #4.</p>	W 249	<p><b>W 249 483.440(d)(1) PROGRAM IMPLEMENTATION</b></p> <p>In conjunction with the Plan of Corrections for W100, w102, W104, W122, W149, W157, W195, W196, W250, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard. The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and</p>	04/07/2015

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	<p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. From 7:30 A.M. until 8:45 A.M., clients #2 and #3 stayed in their bedroom with no activity or interaction. From 9:00 A.M. until 10:45 A.M., clients #2 and #3 stayed in their bedrooms with no activity or interaction. During the entire observation period, client #1 walked back and forth from the living room to the staff office with no activity or interaction. DSPs #4, #5 and #6 failed to implement training objectives either formally or informally for clients #1, #2, #3 and #4. Client #2 did not and was not prompted to wear his eyeglasses.</p> <p>An observation was conducted at the group home on 3/18/15 from 4:00 P.M. until 5:30 P.M.. During the entire observation period clients #2 and #3 sat in the living room watching television. Client #2 did not and was not prompted to wear his eyeglasses.</p> <p>An observation was conducted at the group home on 3/20/15 from 2:30 P.M. until 4:00 P.M.. During the entire observation clients #2 and #3 sat in the living room watching television. Client #2 did not and was not prompted to wear his eyeglasses.</p>		<p>develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules. To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, <b>the House Manager, QDDP, Nurse, or Behaviorist</b>, will complete daily active treatment observations for the next two weeks, and until compliance is demonstrated; <b>the House Manager will complete site visits two times per week during the morning shift change and hour of morning medication administration, the QDDP will complete site visits two times per week during the alternative day program hours, lunch, and afternoon medication administration, the Behaviorist will complete site visits two times per week during the evening medication administration, and the Nurse will complete site visits once per week during the hours of a medication administration. Furthermore, a member of this Team will complete a drop-in at least once per week and as needed, during the overnight</b></p>		

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	<p>An interview with DSPs #1, #2 and #3 was conducted on 3/16/15 at 8:45 P.M.. When asked if each client had active treatment objectives, DSP #1 "Yes." DSPs #1, #2 and #3 indicated clients #1, #2 and #3 stayed in their rooms with no activity everyday because of client #1's physical aggression and targeting of clients. DSPs #1, #2 and #3 further indicated client #1 was non-compliant with implementation of his training objectives due to his aggression towards staff and his peers.</p> <p>A review of client #1's record was conducted on 3/17/15 at 11:00 A.M.. The Individual Support Plan (ISP) dated 9/11/14 indicated the following training objectives which could have been implemented during the observation periods: "Will assist in cleaning his area after each meal...Will take the trash out of his room daily...Will initiate a 2 minute positive conversation with staff or housemate daily...Will learn to identify certain coins...Will participate in an exercise...Will correctly name one of his 8 A.M. medications."</p> <p>A review of client #2's record was conducted on 3/17/15 at 11:30 A.M.. The ISP dated 9/11/14 indicated the following training objectives which could have been implemented during the</p>		<p><b>hours. In the event one of these visits cannot be accomplished by the noted member of the Team above, another member of the Team will complete the visit.</b></p> <p>Thereafter, a member of this Team will complete these observations <b>at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>		

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	<p>observation periods: "Will follow his chore chart daily...Will state his phone number...Will identify a penny from other coins...Will engage in some form of exercise...Will wear his eye glasses."</p> <p>A review of client #3's record was conducted on 3/17/15 at 12:15 P.M.. A review of client #3's ISP dated 9/10/14 indicated the following training objectives which could have been implemented during the observation periods: "Will state his address and phone number...Will learn to identify coins...Will engage in some form of exercise...."</p> <p>A review of client #4's record was conducted on 3/17/15 at 1:00 P.M.. A review of client #4's ISP dated 9/11/14 indicated the following training objectives which could have been implemented during the observation periods: "Will develop better speech...Will learn to sort clothes...Will balance a checkbook...Will complete a daily chore...Will have a positive conversation daily with staff...Will participate in his physical therapy exercises...Will read a paragraph."</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 3/17/15 at 3:45 P.M. The QIDP indicated</p>				

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W 250 Bldg. 00	<p>staff should implement clients' training objectives as indicated in their ISPs during all times of opportunity.</p> <p>9-3-4(a)</p> <p>483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview, the facility failed for 4 of 4 clients residing at the group home (clients #1, #2, #3 and #4) to have Active Treatment Schedules (ATS) which reflected and directed their training programs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/17/15 at 11:00 A.M.. Client #1's record failed to have an ATS.</p> <p>Client #2's record was reviewed on</p>	W 250	<p><b>W 250 483.440(d)(2) PROGRAM IMPLEMENTATION</b></p> <p>In conjunction with the Plan of Corrections for W100, w102, W104, W122, W149, W157, W195, W196, W249, W268, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p>	04/07/2015

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	<p>3/17/15 at 11:30 A.M.. Client #2's record failed to have an ATS.</p> <p>Client #3's record was reviewed on 3/17/15 at 12:15 P.M.. Client #3's record failed to have an ATS.</p> <p>Client #4's record was reviewed on 3/15/15 at 1:00 P.M.. Client #4's record failed to have an ATS.</p> <p>An interview with Direct Support Professional #6 (DSP) was conducted on 3/17/14 at 9:14 A.M.. The DSP #6 indicated clients #1, #2, #3 and #4 did not have active treatment schedules.</p> <p>9-3-4(a)</p>		<p>The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these</p>		

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W 268 Bldg. 00	<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 and interview, the facility failed for 1 of 2 sampled clients (client #1), to promote his dignity by not ensuring he was shaved and his eyebrows were trimmed.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/16/15 from 8:00 P.M. until 9:30 P.M.. During the entire observation period, client #1 was observed to have his eyebrow hair growing towards the middle of his forehead and he was unshaven.</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. During the observation period, client #1 was</p>	W 268	<p>observations at least weekly and at random.</p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p> <p><b>W 268 483.450(a)(1)(i) CONDUCT TOWARD CLIENT</b></p> <p>In conjunction with the Plan of Corrections for W100, w102, W104, W122, W149, W157, W195, W196, W249, W250, W382, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p> <p>Client #1 was assisted in shaving and his eyebrows were trimmed. The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive</p>	04/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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	<p>observed to have his eyebrow hair growing towards the middle of his forehead and he was unshaven.</p> <p>An interview with Direct Support Professional (DSP) #6 was conducted on 3/17/15 at 9:10 A.M.. DSP #6 indicated client #1 needed to be groomed.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 3/25/15 at 4:30 P.M.. The GHM indicated clients should be groomed at all times. The GHM further indicated staff should have trimmed client #1's eyebrows and shaved him because he is unable to do so independently.</p> <p>9-3-5(a)</p>		<p>behavioral supports, and that addresses their training needs- including promoting each individuals' dignity by addressing their hygiene needs. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, <b>the House Manager, QDDP, Nurse, or Behaviorist</b>, will complete daily active treatment observations for the next two weeks, and until compliance is demonstrated; <b>the House Manager will complete site visits two times per week during the morning shift</b></p>		

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			<p><b>change and hour of morning medication administration, the QDDP will complete site visits two times per week during the alternative day program hours, lunch, and afternoon medication administration, the Behaviorist will complete site visits two times per week during the evening medication administration, and the Nurse will complete site visits once per week during the hours of a medication administration. Furthermore, a member of this Team will complete a drop-in at least once per week and as needed, during the overnight hours. In the event one of these visits cannot be accomplished by the noted member of the Team above, another member of the Team will complete the visit. Thereafter, a member of this Team will complete these observations at least three times per week and at random. For four weeks, the Area Director will complete weekly site visits to ensure compliance. Once compliance is demonstrated, the AD will complete at least monthly visits for six months. Thereafter, the AD will complete at least quarterly site visits to ensure compliance is maintained.</b></p> <p><b>Will be completed by: 4/7/15</b></p>		

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W 382  Bldg. 00	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, for 4 of 4 clients (clients #1, #2, #3 and #4) who lived in the group home, the facility failed to maintain proper medication security.</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. From 8:40 A.M., Direct Support Professional (DSP) #5 began preparing client #2's medications in the office with the door open. At 8:47 A.M. DSP #5 walked out of the office and left client #2's medications on the counter unattended and left the medication cabinet open which contained all clients #1, #2, #3 and #4's prescribed medication. DSP #5 left the medications unattended until 8:58 A.M..</p> <p>An interview with the Group Home Manager (GHM) was conducted on 3/25/15 at 4:35 P.M.. The GHM indicated the medications should be</p>	W 382	<p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p> <p><b>W 382 483.460(I)(2) DRUG STORAGE AND RECORDKEEPING</b></p> <p>In conjunction with the Plan of Corrections for W100, W102, W104, W122, W149, W157, W195, W196, W249, W250, W268, W436, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p> <p>The responsible staff person will be retrained in Agency medication administration Policy and Procedure. After this training, the Nurse will conduct a medication observation of responsible staff to ensure they are following policy and procedure.</p> <p>To ensure all medications are being passed according to Policy and</p>	04/07/2015	

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W 436 Bldg. 00	<p>locked at all times except when being administered and if staff needed to leave the area they needed to lock the medications in the cabinet.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients who wore eyeglasses (client #2), the facility failed to encourage and teach him to wear his eyeglasses.</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/16/15 from 8:00 P.M. until 9:30 P.M.. During the entire observation period, client #2 did not and</p>	W 436	<p>Procedure, a member of the above Team will complete daily active treatment observations, including a med pass, for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations at least weekly and at random.</p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p> <p><b>W 436 483.470(g)(2) SPACE AND EQUIPMENT</b></p> <p>In conjunction with the Plan of Corrections for W100, W102, W104, W122, W149, W157, W195, W196, W, 249, W250, W268, W382, W440, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p>	04/07/2015	

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	<p>was not prompted to wear his eyeglasses.</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. During the entire observation period, client #2 did not and was not prompted to wear his eyeglasses</p> <p>An observation was conducted at the group home on 3/18/15 from 4:00 P.M. until 5:30 P.M.. During the entire observation period, client #2 did not and was not prompted to wear his eyeglasses.</p> <p>An observation was conducted at the group home on 3/20/15 from 2:30 P.M. until 4:00 P.M.. During the entire observation period client #2 did not and was not prompted to wear his eyeglasses.</p> <p>A review of client #2's record was conducted on 3/17/15 at 11:30 A.M.. A review of client #2's Individual Support Plan dated 9/11/14, indicated: "Will wear his eyeglasses."</p> <p>An interview was conducted with Direct Support Professional (DSP) #2 on 3/20/15 at 3:20 P.M.. DSP #6 indicated client #2 wore eyeglasses.</p> <p>An interview with the Group Home Manager (GHM) was conducted on 3/25/15 at 4:10 P.M.. The GHM</p>		<p>The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs- including use of any adaptive equipment. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home. Staff will be trained to follow these schedules.</p> <p>To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, to ensure all Individuals are free from abuse/neglect, to ensure all Individuals' living spaces are maintained in a sanitary condition, and to ensure each Individual is encouraged to use their adaptive equipment including prescription</p>		

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W 440 Bldg. 00	<p>indicated staff should prompt and train client #2 to wear his eyeglasses.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills which affected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4).</p> <p>Findings include:</p> <p>A request for the group home evacuation drills was made on 3/17/15 at 8:47 A.M.. No evacuation drills were available for review for the year of 2014. A second request for the group home evacuation drills was made on 3/17/15 at 11:00 A.M.. No evacuation drills were available for review for the first, second, third and fourth quarters of 2014 (January</p>	W 440	<p>eyeglasses, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations at least weekly and at random.</p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p> <p><b>W 440 483.470(i)(1) EVACUATION DRILLS</b></p> <p>In conjunction with the Plan of Corrections for W100, W102, W104, W122, W149, W157, W195, W196, W, 249, W250, W268, W382, W436, W454, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p> <p>The House Manager will determine where the 2014 and 1st quarter 2015</p>	04/07/2015	

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	<p>1 to March 31), (April 1st to June 30th), (July 1st to September 30th) and (October 1st to December 31st) for the morning shift (8:00 A.M. to 4:00 P.M.), evening shift (4:00 P.M. to 12:00 A.M.) and overnight shift (12:00 A.M. to 8:00 A.M.).</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 3/18/15 3:45 P.M.. The QIDP indicated evacuation drills are to be conducted during each quarter for each shift of personnel. The QIDP further indicated there was no written documentation to indicate the facility conducted evacuation drills during each quarter for each staff shift.</p> <p>9-3-7(a)</p>		<p>evacuation drills are located and ensure they are immediate filed in the house Life Safety book. The House Manager and Lead will be retrained to adhere to Agency Policy and Procedure regarding evacuation drills. All evacuation drills will be conducted per Agency Policy and filed in the Life Safety binder at the home.</p> <p>To ensure these drills are conducted and filed per Policy, the House Manager will check the Life Safety book at the home each week, to ensure these drills are conducted and filed per Policy. The QDDP will check the Life Safety book at the home each month, to ensure these drills are conducted and filed per Policy, and the AD will check the Life Safety book at the home each quarter, to ensure these drills are conducted and filed per Policy.</p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, and Area Director</b></p>		
W 454  Bldg. 00	<p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p>				

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	<p>Based on observation and interview, the facility failed to maintain proper hygiene practices and prevent cross contamination, for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. Upon entering the group home and walking past the bathroom located near clients #1 and #2's bedrooms, there was a strong odor. At 7:35 A.M., upon entering the bathroom, there was a pair of black shorts with fecal matter laying on the floor in front of the toilet and fecal matter was smeared all over the floor. The fecal matter was cleaned by DSP (Direct Support Professional) #7 at 9:35 A.M..</p> <p>An evening observation was conducted at the group home on 3/18/15 from 4:30 P.M. to 5:30 P.M.. At 5:05 P.M., client #2 asked this surveyor to enter his room to see his new chair. Upon entering client #2's room, there was a strong odor. There was no linen on the bed and no soiled linen in the bedroom.</p> <p>An interview with DSP #8 was conducted on 3/18/15 at 5:15 P.M.. DSP #8 indicated client #2 urinates in his bed</p>	W 454	<p><b>W 454 483.470(I)(1) INFECTION CONTROL</b></p> <p>In conjunction with the Plan of Corrections for W100, w102, W104, W122, W149, W157, W195, W196, W249, W250, W268, W382, W436, W440, and W9999, the House Manager, QDDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p> <p>The House Manager, QDDP, Nurse, and Behaviorist will be retrained on this Standard. All staff will be retrained on maintaining proper hygiene practices and prevent cross contamination by ensuring all areas of the facility are maintained in a sanitary condition at all times.</p> <p>To ensure staff are maintaining proper hygiene practices and prevent cross contamination by ensuring all areas of the facility are maintained in a sanitary condition at all times a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these</p>	04/07/2015	

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W 999  Bldg. 00	<p>every night and further indicated staff at the group home have tried getting the urine smell out of client #2's bedroom, but have had no success at doing so. An interview with the GHM was conducted on 3/25/15 at 4:10 P.M.. The GHM indicated the facility washes his clothes everyday and indicated the facility replaced his bed two weeks ago and mops the bedroom with bleach everyday. The GHM indicated client #2's bedroom should not smell of urine. The GHM indicated the staff should try to prompt clients to clean up when they have a toileting accident or should ensure the accident is cleaned up quickly.</p> <p>9-3-7(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-4 Active Treatment Services.</p> <p>(b) The provider shall obtain day services for each resident which: (1) meet</p>	W 999	<p>observations at least weekly and at random.</p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p> <p><b>W 9999 FINAL OBSERVATIONS</b></p> <p><b>460 IAC 9-3-4 Active Treatment Services</b></p> <p>In conjunction with the Plan of Corrections for W100, w102, W104, W122, W149, W157, W196, W195, W249, W250, W268, W382, W436, W440, W454, and W454, the House Manager, QDDP, Nurse, Behaviorist,</p>	04/07/2015			

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	<p>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 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 2 of 2 sampled clients and 1 additional client residing at the group home (clients #1, #2 and #3).</p> <p>Findings include:</p> <p>An evening observation was conducted at the group home on 3/16/15 from 8:00 P.M. until 9:30 P.M.. During the entire observation period, clients #2, #3 and #4 stayed in their bedrooms with the bedroom doors shut. The clients stayed in their rooms with no activity or interaction from staff. Client #1 sat in the living room with no activity or staff interaction and would walk back and forth from the living room to the staff office. No alternative day service was</p>		<p>and Area Director (AD) will review this State rule.</p> <p>The QDDP will review all individuals' ISPs to ensure a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs including Vocational and Day services. In the event an Individual's ISP is lacking in a continuous and aggressive active treatment program which addresses their rights to be free of abuse/neglect, to receive behavioral supports, and that addresses their training needs, including vocational, the QDDP will coordinate with the Individual's IDT to complete their program per this Standard. The QDDP will coordinate and develop with input from each Individuals' IDT, an individualized Active treatment Schedule (ATS) for all Individuals living in the home and a day program/meaningful day schedule for any individual not attending an outside day program. Staff will be trained to follow these schedules.</p> <p>To ensure these programs are implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS and day</p>		

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	<p>observed to be provided.</p> <p>A morning observation was conducted at the group home on 3/17/15 from 7:30 A.M. until 10:45 A.M.. From 7:30 A.M. until 8:45 A.M., clients #2 and #3 stayed in their bedrooms with no activity or interaction. From 9:00 A.M. until 10:45 A.M., client #2 and #3 stayed in their bedrooms with no activity or interaction. During the entire observation period, client #1 walked back and forth from the living room to the staff office with no activity or interaction. No alternative day service was observed to be provided.</p> <p>An observation was conducted at the group home on 3/18/15 from 4:00 P.M. until 5:30 P.M.. During the entire observation period clients #2 and #3 sat in the living room watching television. No alternative day service was observed to be provided.</p> <p>An observation was conducted at the group home on 3/20/15 from 2:30 P.M. until 4:00 P.M.. During the entire observation clients #2 and #3 sat in the living room watching television. No alternative day service was observed to be provided.</p> <p>Client #1's records were reviewed on 3/17/15 at 11:00 A.M.. The review of the</p>		<p>program/Vocational schedule, to ensure all Individuals are free from abuse/neglect, and to ensure all Individuals' living spaces are maintained in a sanitary condition, a member of the above Team will complete daily active treatment observations for the next two weeks and until compliance is demonstrated. Thereafter, a member of the Team will complete these observations at least weekly and at random.</p> <p><b>Will be completed by: 4/7/15</b></p> <p><b>Persons Responsible: QDDP, House Manager, Nurse, and Behaviorist</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  03/25/2015
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
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	<p>client's record failed to indicate he attended a day service.</p> <p>Client #2's records were reviewed on 3/17/15 at 11:30 A.M.. The review of the client's record failed to indicate he attended a day service.</p> <p>Client #3's records were reviewed on 3/17/15 at 12:15 P.M.. The review of the client's record failed to indicate he attended a day service.</p> <p>An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 3/17/15 at 3:45 P.M.. The QIDP indicated clients #1, #2 and #3 do not currently attend day services.</p> <p>9-3-4(b)(1)(2)</p>				