

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 04/16/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a 23 day revisit survey to the full annual recertification and state licensure survey which resulted in an Immediate Jeopardy at W122 that was not removed prior to exit on 3/25/15.</p> <p>Survey Date: 4/16/15</p> <p>Facility number: 011602 Provider number: 15G748 AIM number: 200903760</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0122 Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>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</p>	W 0122	W 122 483.420 CLIENT PROTECTIONS	04/17/2015

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/16/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(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>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>This noncompliance resulted in an Immediate Jeopardy 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 style="padding-left: 40px;">A. Behavioral and supervision/monitoring protocol for [client #1] has been revised to include the following:</p> <p style="padding-left: 80px;">i. 1-on-1 supervision at all times with designated staff person.</p>		<p>On 4/17/15, Client #1 was discharged from the facility and transported and admitted to Richmond State Hospital via Sheriff's Department, for more appropriate placement.</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 QDDP, Nurse, Behaviorist, and House Manager will each complete observations in the home at least weekly. An Area Director will continue to complete site visits at least monthly for the next 5 months, then quarterly thereafter.</p> <p>Will be completed by: 4/17/15</p> <p>Persons Responsible: QDDP, House Manager, Nurse, Behaviorist, and Area Director</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 04/16/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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>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 #1] and his housemates, ensuring their health and safety.</p> <p>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.</p> <p>iv. Designated staff person will keep [client #1] in consistent line-of sight during all waking hours.</p> <p>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.</p> <p>vi. Staff will be instructed to keep IDT informed promptly of any significant changes, incidents, aggression, or difficulty implementing his BSP or Protocol.</p> <p>vii. All staff will be trained on site on these revisions before working in the home.</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 04/16/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(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>viii. These revisions will be implemented immediately.</p> <p>B. [BDDS 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 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>III. QDDP (Qualified Developmental Disabilities Professional), House Manager, Nurse, and Behaviorist</p> <p>A. QDDP, House Manager, Nurse and Behaviorist will immediately begin</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 04/16/2015
--	---	--	---

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

(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>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 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</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 04/16/2015
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[client #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 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 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</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 04/16/2015
--	---	--	---

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

(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>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 and to ensure adequate staff were scheduled to work with client #1 to provide 1 to 1 supervision at the group home. 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> <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</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 04/16/2015
--	---	--	---

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

(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>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 his 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'. 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</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 04/16/2015
--	---	--	---

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

(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>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 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</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 04/16/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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	
	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 there was nothing they could do. Staff stated to her that neither the doctor nor 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 BDDS and State were involved. The nurse then said she would get a social worker. After				

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 04/16/2015
--	---	--	---

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

(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>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 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.</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 04/16/2015
--	---	--	---

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

(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
	-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 #4] 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			

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 04/16/2015
--	---	--	---

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

(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>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 (sic) 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 A.M. [client #1] was</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 04/16/2015
--	---	--	---

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

(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>engaging in some new erratic behaviors. He was giggling uncontrollably. When prompted or redirected he wouldn't acknowledge staff. At 10:15 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 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</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 04/16/2015
--	---	---	---

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

(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>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 he 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</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 04/16/2015
--	---	--	---

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

(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>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 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</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 04/16/2015
--	---	---	---

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

(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>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 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 Geodon. We did not request this, the nurse knew [client #1] from the last visit and stated that we can't wait till [client #1] gets 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</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 04/16/2015
--	---	--	---

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

(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>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 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</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 04/16/2015
--	---	--	---

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

(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>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 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.</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 04/16/2015
--	---	--	---

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

(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>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</p> <p>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]'s tremors increase significantly and blood vessels appear on his forehead and neck. At 9:50 we asked and received permission from [Nurse] to administer a prn. [Client #1] calmed enough at 10:12 to take the prn. [Physician] stated last night that it doesn't do us any good to try</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 04/16/2015
--	---	--	---

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

(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>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 approved BSP, 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</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 04/16/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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>approximately 2:00 A.M., [client #1] was admitted to [Hospital] ICU 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>The Immediate Jeopardy was removed on 4/16/15 when through observation, interview and record review, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that steps taken removed the immediacy of the problem. The Immediate Jeopardy was removed as the following actions were taken:</p> <p>During the 4/16/15 observation period between 12:00 P.M. and 12:30 P.M., at</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 04/16/2015
--	---	--	---

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

(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>the group home, client #1 was not observed to reside at the group home.</p> <p>An interview with Direct Support Professionals (DSPs) #1 and #2 was conducted on 4/16/15 at 12:15 P.M.. DSPs #1 and #2 indicated client #1 has been residing at a hotel with scheduled staff monitoring and providing services since his discharge from the hospital on 3/27/15. DSPs #1 and #2 indicated the behaviorist, Group Home Manager (GHM), Qualified Intellectual Disabilities Professional (QIDP), nurse and Area Directors (AD) have each come to the group home daily and interacted with clients #2, #3 and #4 and with the staff who work at the group home. DSPs #1 and #2 indicated the behaviorist has trained everyone at the home on each client's Behavior Support Plan and how to document and notify when needing assistance in times of crisis and when working at the hotel with client #1 to keep him in eyesight at all times.</p> <p>A review of client #1's record was conducted on 4/16/15 at 12:45 P.M.. Client #1's record indicated the facility was collecting/documenting specific data in regard to what aggressive behavior client #1 demonstrated. The documentation indicated client #1 was discharged from the hospital on 3/27/15</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 04/16/2015
--	---	--	---

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

(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>and since has resided at a hotel with the facility providing 24 hour staffing.</p> <p>The facility's Observation Reports for client #1 were reviewed on 4/16/15 at 1:00 P.M.. The facility's Observation report sheets indicated the facility's administrative staff were present in the group home daily (3/25/15 to 4/16/15) to monitor/supervise staff. The Observation reports indicated administrative staff provided on site training to staff when needed.</p> <p>An interview with administrative staff #1, #2 and the Area Director was conducted on 4/16/15 at 1:30 P.M. indicated administrative staff were supervising/monitoring the group home on a daily basis and at the hotel to ensure facility staff implemented client #1's behavior plan to decrease and/or prevent injury due to his physical aggression.</p> <p>Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at the Condition of Participation: Client Protections, as the facility needs to continue to complete monitoring/supervision of facility staff to ensure the effectiveness of its plan of correction. Client #1 still remains at the hotel.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2015
FORM APPROVED
OMB NO. 0938-0391

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 04/16/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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	
	9-3-2(a)				