

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G520	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2015
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6386 ELLSWORTH PL MERRILLVILLE, IN 46410
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W 0000  Bldg. 00	<p>This visit was for the post certification revisit to the investigation of complaint #IN00170119 conducted on April 20, 2015.</p> <p>Complaint #IN00170119: Corrected.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of survey: June 11 and 12, 2015</p> <p>Facility number: 001034 Provider number: 15G520 AIM number: 100245230</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0153  Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p>	W 0153		07/10/2015

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.

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	<p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client A), to report a client elopement/allegation of neglect immediately to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 6/11/15 at 10:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>-BDDS report dated 5/16/15...Date of Knowledge: 5/18/15...Submitted Date: 5/19/15 involving client A indicated: "[Client A] and her housemates had gone to the movies on Saturday afternoon. Following the movie, while exiting the theatre, [client A] stated that she had to go to the bathroom. [Client A] then exited the group and went to what she thought was the bathroom. The staff was loading up the other ladies when they realized that [client A] was no longer with the group. Upon re-entering the theater [client A] was found at the locked door, thinking it was the bathroom. [Client A] was assisted with finding the bathroom and returning with to her group. [Client A]'s time of being unsupervised was less than ten minutes. The staff involved was suspended for</p>		<p>All staff that work in the facility are trained upon hire and on an annual basis on Dungarvin's policy and procedure concerning Abuse, Neglect and Exploitation. In addition, the training includes the expectation that all allegations of mistreatment, neglect or abuse and other major incidents are reported immediately to a supervisor. DSP #13 and DSP #14 received written warnings for failing to notify a supervisor in a timely manner. DSP #13 and DSP #14 did recognize Client A was alone and provided oversight to her while trying to locate her staff. DSP #15 was not present at the time of the incident, however, she was aware that it occurred during the same shift she worked at the facility. DSP #15 was previously put on probation for failing to report an incident in a timely manner to a supervisor. She has been terminated. DSP #16 failed to cooperate/participate in the investigation. She has been terminated. DSP #17 was placed on probation for not reporting the incident in a timely manner to a supervisor. DSP #17 thought that DSP #16 was going to report it. She was retrained on the expectation that it is everyone's responsibility to ensure that allegations of abuse, neglect, exploitation and other major incidents are reported to a supervisor in a timely manner. All staff that work at the facility will receive training from the QIDP by</p>	

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	<p>negligence. The other staff received disciplinary action for failure to report an incident in the designated time frame."</p> <p>Review of the attached investigation record indicated: "Investigation Report: Nature of event under investigation: Negligence...Date/Time of alleged incident: May 16, 2015...Dates of Investigation: 5/16/15 (sic) -5/29/15...History/Background: [Client A] has been with [Facility name] for 2 1/2 years. She is diagnosed with moderate mental retardation, epilepsy, and has a pace maker. [Client A] has drop seizures which give no warnings. [Client A] wears a helmet because of her seizure condition and is to be supervised during all hygiene tasks. [Client A] has a current fall risk plan that calls for supervision/assistance when accessing the community. Claims and Responses: On May 18, 2015 [Direct Support Professional (DSP) #13] and [DSP #14] reported to the Program Director (PD) that they had concerns regarding the Saturday outing. According to both staff members, there was a period of time that [client A] was unattended. According to [DSP #13] and [DSP #14], they were exiting the theater with their clients and noticed [client A] attempting to enter a locked door with no staff present. Witness/Evidence: [Client A] was</p>		<p>July 10, 2015 on the policy on Abuse, Neglect, Exploitation and the protocol for reporting major incidents to a supervisor. The training will also stress the importance to the staff that reporting an incident is a shared responsibility and does not rest solely in the hands of the person assigned to work with a particular client during a particular shift. All staff that work in the facility will receive training by July 10, 2015 from the QIDP on responding to the needs (Rights, Dignity, and Advocacy) of the all the individuals in the facility. The staff did not respect Client A's stated need to use the restroom. If Client A had been provided proper supervision, she would not have been found struggling to get into a restroom. All staff that work in the facility will receive training by July 10, 2015 from the QIDP on the duties outlined in the Dungarvin DSP job description. Going forward, the QIDP will continue to train the staff (as needed) on the importance of reporting major incidents in a timely manner. In addition, the QIDP will ensure that the appropriate disciplinary action is given in any instance where a staff member fails to report an allegation of abuse, neglect or exploitation or any other major incident.</p>	

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	interviewed and she stated that she had to go to the bathroom and staff wouldn't take her. [Client A] stated that she went to the bathroom on her own. [Client A] could not relate how long she was alone; she does not function on that level. [Client A] is also unable to read or sign witness statement. According to [client B], she told the staff that [client A] was not present. According to [client B], when they entered the bus, [client B] said, 'Where is [client A]?' and that's when the staff realized they had left her in the cinema. [Client F] stated that [client A] had been left in the cinema. [DSP #15] stated that she had taken another individual back to the group home because that individual was hollering and screaming. However, upon arrival back at the cinema she said that staff returned to the van without [client A]. [DSP #15] stated that she spoke with the staff who was supposed to be watching [client A] was on the phone (sic). [DSP #15] also stated that she spoke with the staff and informed her that she needed to contact the PD on call and [DSP #15] was under the impression that the staff, [DSP #16], was going to contact the PD on call. When asked why she did not contact the PD on call [DSP #15] stated that the other staff had said she was going to do so (DSP #16). When staff questioned [DSP #17] she stated			

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	<p>that she had all of the other ladies and that [DSP #16] was walking far behind the group. [DSP #17] stated that she completed a head count and realized that [client A] was gone. [DSP #17] stated that she asked [DSP #16] where [client A] was and [DSP #16] said she did not know. [DSP #16] went back to look for [client A] and realized that [client A] had wandered off in search of the bathroom. According to both [DSP #13] and [DSP #14] they were exiting the cinema with their individuals when they noticed [client A] pulling on a locked door. They spoke with [client A] and realized [client A] was trying to go to the bathroom. They convinced [client A] to come with them and they returned her to the staff from [Group Home name]. According to them both [DSP #16] was on the phone as she was looking for [client A]. [DSP #16] never removed the phone from her ear. Findings of Fact: [Client A] was left unattended for several minutes. Staff from other sites found her and returned her to her staff. None of the staff involved reported this incident to a live supervisor. Conclusion Based on Facts: [DSP #14] and [DSP #13] should receive warnings because they were not on duty with [Group Home name] but they did witness a reportable incident and did not report it. [DSP #16] should be placed on probation for negligence and failure to</p>			

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W 0189 Bldg. 00	<p>report an incident. [DSP #17] should be terminated because she is already on probation for failure to report a reportable incident."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 6/12/15 at 10:45 A.M.. The QIDP indicated the staff should have immediately reported the incident. The QIDP further indicated the staff did not immediately report the allegation of neglect.</p> <p>9-3-2(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client A), to ensure staff were sufficiently trained to assure competence in providing proper supervision and to immediately report an incident of neglect.</p>	W 0189	All staff that work in the facility are trained upon hire and on an annual basis on Dungarvin's policy and procedure concerning Abuse, Neglect and Exploitation. In addition, the training includes the expectation that all allegations	07/10/2015

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	<p>Findings include:</p> <p>A review of the facility's records was conducted on 6/11/15 at 10:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>-BDDS report dated 5/16/15...Date of Knowledge: 5/18/15...Submitted Date: 5/19/15 involving client A indicated: "[Client A] and her housemates had gone to the movies on Saturday afternoon. Following the movie, while exiting the theatre, [client A] stated that she had to go to the bathroom. [Client A] then exited the group and went to what she thought was the bathroom. The staff was loading up the other ladies when they realized that [client A] was no longer with the group. Upon re-entering the theater [client A] was found at the locked door, thinking it was the bathroom. [Client A] was assisted with finding the bathroom and returning with to her group. [Client A]'s time of being unsupervised was less than ten minutes. The staff involved was suspended for negligence. The other staff received disciplinary action for failure to report an incident in the designated time frame."</p> <p>Review of the attached investigation</p>		<p>of mistreatment, neglect or abuse and other major incidents are reported immediately to a supervisor. DSP #13 and DSP #14 received written warnings for failing to notify a supervisor in a timely manner. DSP #13 and DSP #14 did recognize Client A was alone and provided oversight to her while trying to locate her staff. DSP #15 was not present at the time of the incident, however, she was aware that it occurred during the same shift she worked at the facility. DSP #15 was previously put on probation for failing to report an incident in a timely manner to a supervisor. She has been terminated. DSP #16 failed to cooperate/participate in the investigation. She has been terminated. DSP #17 was placed on probation for not reporting the incident in a timely manner to a supervisor. DSP #17 thought that DSP #16 was going to report it. She was retrained on the expectation that it is everyone's responsibility to ensure that allegations of abuse, neglect, exploitation and other major incidents are reported to a supervisor in a timely manner. All staff that work at the facility will receive training from the QIDP by July 10, 2015 on the policy on Abuse, Neglect, Exploitation and the protocol for reporting major incidents to a supervisor. The training will also stress the importance to the staff that reporting an incident is a shared</p>				

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	<p>record indicated: "Investigation Report: Nature of event under investigation: Negligence...Date/Time of alleged incident: May 16, 2015...Dates of Investigation: 5/16/15 (sic) -5/29/15...History/Background: [Client A] has been with [Facility name] for 2 1/2 years. She is diagnosed with moderate mental retardation, epilepsy, and has a pace maker. [Client A] has drop seizures which give no warnings. [Client A] wears a helmet because of her seizure condition and is to be supervised during all hygiene tasks. [Client A] has a current fall risk plan that calls for supervision/assistance when accessing the community. Claims and Responses: On May 18, 2015 [Direct Support Professional (DSP) #13] and [DSP #14] reported to the Program Director (PD) that they had concerns regarding the Saturday outing. According to both staff members, there was a period of time that [client A] was unattended. According to [DSP #13] and [DSP #14], they were exiting the theater with their clients and noticed [client A] attempting to enter a locked door with no staff present. Witness/Evidence: [Client A] was interviewed and she stated that she had to go to the bathroom and staff wouldn't take her. [Client A] stated that she went to the bathroom on her own. [Client A] could not relate how long she was alone;</p>		<p>responsibility and does not rest solely in the hands of the person assigned to work with a particular client during a particular shift. All staff that work in the facility will receive training by July 10, 2015 from the QIDP on responding to the needs (Rights, Dignity, and Advocacy) of the all the individuals in the facility. The staff did not respect Client A's stated need to use the restroom. If Client A had been provided proper supervision, she would not have been found struggling to get into a restroom. All staff that work in the facility will receive training by July 10, 2015 from the QIDP on the duties outlined in the Dungarvin DSP job description. Going forward, the QIDP will continue to train the staff (as needed) on the importance of reporting major incidents in a timely manner. In addition, the QIDP will ensure that the appropriate disciplinary action is given in any instance where a staff member fails to report an allegation of abuse, neglect or exploitation or any other major incident.</p>	

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	<p>she does not function on that level. [Client A] is also unable to read or sign witness statement. According to [client B], she told the staff that [client A] was not present. According to [client B], when they entered the bus, [client B] said, 'Where is [client A]?' and that's when the staff realized they had left her in the cinema. [Client F] stated that [client A] had been left in the cinema. [DSP #15] stated that she had taken another individual back to the group home because that individual was hollering and screaming. However, upon arrival back at the cinema she said that staff returned to the van without [client A]. [DSP #15] stated that she spoke with the staff who was supposed to be watching [client A] was on the phone (sic). [DSP #15] also stated that she spoke with the staff and informed her that she needed to contact the PD on call and [DSP #15] was under the impression that the staff, [DSP #16], was going to contact the PD on call. When asked why she did not contact the PD on call [DSP #15] stated that the other staff had said she was going to do so (DSP #16). When staff questioned [DSP #17] she stated that she had all of the other ladies and that [DSP #16] was walking far behind the group. [DSP #17] stated that she completed a head count and realized that [client A] was gone. [DSP #17] stated</p>			

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	<p>that she asked [DSP #16] where [client A] was and [DSP #16] said she did not know. [DSP #16] went back to look for [client A] and realized that [client A] had wandered off in search of the bathroom. According to both [DSP #13] and [DSP #14] they were exiting the cinema with their individuals when they noticed [client A] pulling on a locked door. They spoke with [client A] and realized [client A] was trying to go to the bathroom. They convinced [client A] to come with them and they returned her to the staff from [Group Home name]. According to them both [DSP #16] was on the phone as she was looking for [client A]. [DSP #16] never removed the phone from her ear. Findings of Fact: [Client A] was left unattended for several minutes. Staff from other sites found her and returned her to her staff. None of the staff involved reported this incident to a live supervisor. Conclusion Based on Facts: [DSP #14] and [DSP #13] should receive warnings because they were not on duty with [Group Home name] but they did witness a reportable incident and did not report it. [DSP #16] should be placed on probation for negligence and failure to report an incident. [DSP #17] should be terminated because she is already on probation for failure to report a reportable incident."</p>			

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W 9999  Bldg. 00	<p>An interview with the Program Director/Qualified Intellectual Disabilities Professional Designee (PD/QIDP) was conducted on 6/12/15 at 10:45 A.M.. The PD/QIDP indicated staff should have immediately reported the incident to the on-call PD. The PD/QIDP further indicated staff should have provided supervision of client A at all times during the outing. The PD/QIDP indicated staff neglected to provide proper supervision and failed to immediately report this incident. The PD indicated all staff were trained on client specific needs before working at the group home.</p> <p>9-3-3(a)</p> <p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p>	W 9999	The incident reporting management system is a tool used to ensure the health and safety of the individuals served and the quality of care is compromised if an incident is not reported within the designated timeframe. The QIDP will be retrained by 7/10/15 on the	07/10/2015

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	<p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 additional client (client H), to report a hospitalization to the Bureau of Developmental Disabilities Services (BDDS) in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 6/11/15 at 10:30 A.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports indicated:</p> <p>-BDDS report dated 4/22/15...Date of Knowledge: 4/22/15...Submitted Date: 4/29/15 involving client H indicated: "[Client H] had a catheter that had been pulled out. Her doctor stated that he wanted to see her before making a decision regarding the re-insertion of the catheter. [Client H] was seen in the Urologist's office and he ordered lab work. [Client H]'s lab work came back revealing that she needed to be admitted</p>		<p>reporting policy standard. The QIDP will be retrained by 7/10/15 on the expectation that she is required to complete a reportable incident within 24 hours of knowledge of the incident. The QIDP will be reminded that if she is unable to report the incident (due to time constraints) that there are additional QIDPs that are a part of the management team that would be able to file an incident report on her behalf. Going forward, the Area Director will monitor the timeliness of the reportable incidents that are filed by the QIDP. If there are any further reporting errors noted, the QIDP will receive disciplinary action according to Dungarvin policy.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G520	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/12/2015
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6386 ELLSWORTH PL MERRILLVILLE, IN 46410
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	<p>to the hospital. The doctor phoned on 4/22/14 (sic) and did a direct admit to the hospital. [Client H] remained in the hospital and was treated for kidney failure (a diagnosis she has had for years) and C Diff (bacterial infection of the intestine). [Client H] remained in the hospital until 4/28/15. She was discharged to [Hospital name]. [Client H] will remain there until a negative C Diff test result. This incident was submitted late due to an oversight of the Program Director. [Client H] is currently in a nursing home. She will remain there until her doctor feels it is safe for her to return to the group home." Further review of the record failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 6/11/15 at 4:15 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS....Incidents to be reported to BDDS...11. An emergency intervention for the individual resulting from a. a</p>			

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	<p>physical symptom b. a medical or psychiatric condition c. any other event."</p> <p>An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 6/12/15 at 10:45 A.M.. The QIDP indicated the incident should have been reported within 24 hours to BDDS. The QIDP further indicated the incident was not reported to BDDS in a timely manner.</p> <p>9-3-1(b)</p>				