

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G673	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2015
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NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3521 OXFORD SOUTH BEND, IN 46615
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W 0000  Bldg. 00	This visit was for a fundamental recertification and state licensure survey.  Dates of Survey: November 12, 13, and 16, 2015.  Facility number: 009114 Provider number: 15G673 AIM number: 100244780  The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/23/15.	W 0000		
W 0104  Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure the environment of the facility was in good repair for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 3 of 3 additional clients (clients #5, #6, and #7).	W 0104	A maintenance request has been completed and the doors and trim in the hallway, front closet, and west bathroom will be repainted by 12/16/15. Dungarvin's Maintenance Coordinator submitted a request to replaced the carpet in the hallway and living room in the home with the 2016 Major Projects Budget and that request is pending approval. In the	12/16/2015

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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W 0137  Bldg. 00	<p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, #6, and #7 resided was inspected during the 11/13/15 observation period from 5:54 A.M. until 8:24 A.M. The doors in the hallway, front closet, and west bathroom were scratched with paint peeling in various locations on each door. Carpeting in the hallway was stained and worn.</p> <p>Direct care staff #7 was interviewed on 11/13/15 at 8:35 A.M. Direct care staff #7 stated, "We (the facility) are getting things done (repaired), but it is taking time to get it done."</p> <p>Program Director #1 was interviewed on 11/13/15 at 11:12 A.M. Program Director #1 stated, "We are slowly getting items repaired and replaced at the group home."</p> <p>9-3-1(a)</p> <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all</p>		<p>meantime, a maintenance request will be completed to schedule a carpet cleaning by 12/16/15. For two weeks and then until compliance has been demonstrated, the Program Director will complete twice weekly site visits to ensure the home is free of hazards and/or any health and safety issues concerning the maintenance of the home and furniture therein. Thereafter, the Program Director will complete these checks at least weekly. System wide, all Program Director/QIDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-IDs.</p>		

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	<p>clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, the facility failed to assure 1 of 4 sampled clients (client #2) wore a shirt free of stains.</p> <p>Findings include:</p> <p>Client #2 was observed during the group home observation period on 11/13/15 from 5:54 A.M. until 8:24 A.M. Client #2 was wearing a gray shirt with a 4 inch by 6 inch dark stain on the chest area of the shirt. Direct care staff #3, #4, #5, and #7 did not assist or prompt the client to put on a clean shirt.</p> <p>Program Director #1 was interviewed on 11/13/15 at 11:12 A.M. Program Director #1 stated, "They (direct care staff) should not have allowed [client #2] to wear a stained shirt."</p> <p>9-3-2(a)</p>	W 0137	<p>The Program Director/QIDP and all facility staff will review this standard. All facility staff are being retrained on client rights and on the findings of this survey. This training will include the client right to clothing in good repair. The Lead DSP will ensure that client #2's shirt is replaced. The Lead DSP will also do a systemic check to ensure that all other clients at the facility also have clothing that is free from stains and in good repair. Any needed items will be purchased. Once the training is complete, for four weeks and then until compliance has been demonstrated, observations will be conducted 5 times per week to ensure that all individuals are dressed appropriately and that staff are prompting and supporting the clients to wash soiled items and choose clothing that is free from stains. These observations will be documented and turned in to the Area Director for review on a weekly basis. Thereafter, the Lead DSP and/or Program Director will complete these checks at least weekly. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/IDs.</p>	12/16/2015	

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W 0262  Bldg. 00	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE</p> <p>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility failed to assure the facility's Human Rights Committee reviewed and monitored the restrictive technique of searching a client's room for food for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 11/13/15 at 8:45 A.M. A review of the client's 3/4/15 Individual Program Plan indicated the client had an objective of "Let staff search [client #1's] room for food." Further review of client #1's record and review of the facility's Human Rights Committee minutes from 11/1/14 to 11/13/15 failed to indicate the facility's Human Rights Committee had reviewed or monitored the practice of searching client #1's room for food.</p> <p>Direct care staff #7 was interviewed on 11/13/15 at 8:47 A.M. Direct care staff #7 stated, "We just have verbal approval to search his (client #1's) room from [client #1]. We did not get HRC (Human</p>	W 0262	The QIDP and the staff at the facility will be trained by 12/16/15 that all restrictive techniques must be reviewed and approved by the Human Rights Committee. Client #1's restrictive room searches will be reviewed and approved by the Human Rights Committee by 12/16/15. An audit will be conducted by 12/16/15 to ensure that each individual at the facility that has a restrictive technique in their Behavior Plan has a current HRC reviewed and approved plan. Going forward, the QIDP will verify that all restrictive techniques have received human rights committee approval prior to being implemented in a Behavior Plan for each individual in the facility. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/IDs.	12/16/2015

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W 0268 Bldg. 00	<p>Right Committee) approval."</p> <p>The facility's records were reviewed on 11/13/15 at 9:00 A.M. A review of the facility's Human Rights Committee minutes from 11/1/14 to 11/13/15 failed to indicate the committee reviewed or monitored client #1's objective to let direct care staff search his room for food.</p> <p>Program Director #1 was interviewed on 11/13/15 at 11:12 A.M. Program Director #1 stated, "The Human Rights Committee did not review the searching of [client #1's] room for food."</p> <p>9-3-4(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure 2 of 4 sampled clients (clients #3 and 4's) hair was neat and combed.</p> <p>Findings include:</p>	W 0268	<p>Clients #3 &amp; #4 received support to get haircuts immediately. All staff and the Program Director/QIDP of the home will receive retraining by 12/16/15 on the expected frequency of haircuts and the responsibility of the facility in assisting the</p>	12/16/2015

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W 0336	<p>Clients #3 and #4 were observed at the group home on 11/12/15 from 3:45 P.M. until 6:00 P.M. and on 11/13/15 from 5:54 A.M. until 8:24 A.M. Clients #3's and #4's hair was observed to be long and disheveled and needed combing. Direct care staff #1, #2, #3, #4, #5, #6, #7, and #8 did not prompt or assist clients #3 and #4 in combing their hair.</p> <p>Program Director #1 was interviewed on 11/13/15 at 11:12 A.M. Program Director #1 stated, "Staff (direct care staff #1, #2, #3, #4, #5, #6, #7, and #8) should have prompted or assisted [clients #3 and #4] to comb their hair to have a nice appearance."</p> <p>9-3-5(a)</p>		<p>individuals in promoting their growth, development, and independence in the area of their own personal appearance, including prompting to comb hair on an at least daily basis and as needed thereafter. Dungarvin has reviewed this concern for all individuals residing at the home to ensure they have all received proper support in regularly receiving haircuts. Once the training is complete, for four weeks and then until compliance has been demonstrated, observations will be conducted 5 times per week to ensure that all individuals' hair is groomed appropriately and that staff are prompting and supporting the clients to comb their hair daily and as needed thereafter. These observations will be documented and turned in to the Area Director for review on a weekly basis. Thereafter, the Lead DSP and/or Program Director will complete these checks at least weekly. The Program Director/QDDP will be responsible, in conjunction with the Lead DSP, to ensure that the clients in the home receive haircuts on a regular schedule going forward. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/IDs.</p>		
	483.460(c)(3)(iii)				

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Bldg. 00	<p><b>NURSING SERVICES</b></p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to assure health status assessments were conducted at least quarterly (every ninety days) for 4 of 4 sampled clients (clients #1, #2, #3, and #4).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 11/13/15 at 8:45 A.M. A review of the client's quarterly quarterly health assessments from 9/30/14 to 11/13/15 indicated the client received an annual physical on 9/21/15 and quarterly health assessments on 9/15/15, 6/17/15, and 2/28/15, and 10/14/14. The review failed to indicate the client received a health status assessment within ninety day periods.</p> <p>Client #2's records were reviewed on 11/13/15 at 9:17 A.M. A review of the client's quarterly quarterly health assessments from 9/30/14 to 11/13/15 indicated the client received an annual physical on 4/25/15 and quarterly health assessments on 9/14/15, 6/17/15, and 2/28/15, and 10/17/14. The review failed</p>	W 0336	We have reviewed this concern for all 7 individuals residing at the facility. The previous facility nurse left employment in November 2014 and other nurses employed by Dungarvin were filling in until January 2015 when the current, permanent facility nurse took over. Since then the nursing quarterlies for all individuals in the home have been updated and are current. The Program Director / QIDP, and the facility nurse have been retrained on the expectation that a full year of nursing quarterlies are expected to be filed in the medical file at any given time and will be completed at least quarterly for every client in the home. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/IDs.	12/16/2015

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	<p>to indicate the client received a health status assessment within ninety day periods.</p> <p>Client #3's records were reviewed on 11/13/15 at 9:42 A.M. A review of the client's quarterly quarterly health assessments from 9/30/14 to 11/13/15 indicated the client received an annual physical on 4/25/15 and quarterly health assessments on 9/16/15, 6/17/15, and 3/15/15, and 10/17/14. The review failed to indicate the client received a health status assessment within ninety day periods.</p> <p>Client #4's records were reviewed on 11/13/15 at 10:07 A.M. A review of the client's quarterly quarterly health assessments from 9/30/14 to 11/13/15 indicated the client received an annual physical on 4/14/15 and quarterly health assessments on 9/15/15, 6/17/15, and 2/28/15, and 10/17/14. The review failed to indicate the client received a health status assessment within ninety day periods.</p> <p>Nurse #1 was interviewed on 11/13/15 at 10:47 A.M. Nurse #1 stated, "Another nurse had this case load (clients #1, #2, #3, and #4) for a period of time and that is probably why there is a time lapse in ninety day assessments (health status</p>			

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W 0391 Bldg. 00	<p>assessments)."</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, the facility failed to assure 1 of 10 administered medications was labeled with administration information for 1 of 3 additional clients (client #5).</p> <p>Finding include:</p> <p>Client #5 was observed during the 11/13/15 observation period from 5:54 A.M. until 8:24 A.M. At 7:10 A.M., direct care staff #7 administered a Metamucil packet (stool softener) with 8 ounces of water to client #5.</p> <p>The client's 11/15 Medication Administration Record was reviewed on 11/13/15 at 7:13 A.M. The review indicated the following dosage and administration information: "Metamucil packet, 1 teas (teaspoon) with 8 oz (ounces) water twice daily." Review of</p>	W 0391	<p>The Metamucil packet came from the pharmacy in a bag with dosage and administration information for Client 5 on it. Staff lost track of the bag and dosage information after the medication was delivered to the home, however it was later found and the Metamucil packets were replaced in the properly labeled container. All medications in the home will be checked by the Program Director to verify that they have a pharmacy label with a physician's order and dosage information. All staff in the home will be retrained by 12/16/15 on the expectation that the Metamucil packets remain in the pharmacy labeled bag and that the dosage information and medication order are verified prior to administering any medication. Once the training is complete, for four weeks and then until compliance has been demonstrated, observations will</p>	12/16/2015

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	<p>the Metamucil packet failed to indicate dosage and administration information.</p> <p>Direct care staff #7 was interviewed on 11/13/15 at 8:47 A.M. Direct care staff #7 stated, "I think the package (Metamucil packets) came in a bag with administration information on it but I can't find it."</p> <p>Nurse #1 was interviewed on 11/13/15 at 10:47 A.M. Nurse #1 stated, "The Metamucil packet came in a bag with dosage and administration information on it for [client #5]. I'll have to make sure they (facility's direct care staff) have it."</p> <p>9-3-6(a)</p>		<p>be conducted 5 times per week to ensure that the Metamucil packets remain in the pharmacy labeled bag prior to administration. Three times weekly for four weeks and until compliance has been demonstrated the Program Director, Lead DSP and/or Nurse will observe medication administration to ensure that medication labels with dosage information and physician orders are verified prior to medication administration. These observations will be documented on a medication administration observation form, which will be turned in to the Area Director on a weekly basis for review. Thereafter, the Program Director/QIDP, in conjunction with the Lead DSP and Nurse, will complete checks of one client's medications on an at least weekly basis to ensure that the medications have pharmacy labels going forward. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/IDs.</p>				
W 0460 Bldg. 00	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, the facility failed to assure 4 of 4 sampled clients' (clients #1, #2, #3 and</p>	W 0460	All staff at the home will be retrained by the Program Director/QIDP on the use of the	12/16/2015			

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	<p>#4's) menu and diet recommendations were followed for the morning meal.</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed during the 11/13/15 group home observation period from 5:54 A.M. until 8:24 A.M. Clients #1, #3, and #4 did not eat breakfast and direct care staff #3, #4, #5, and #7 did not prompt or assist the clients to eat breakfast. Client #2 had a bowl of cold cereal and milk. No other foods were offered to the client.</p> <p>The facility's records were reviewed on 11/13/15 at 8:33 A.M. A review of the facility's menu for the 11/13/15 morning meal indicated clients #1, #2, #3 and #4 were to be offered the following regular diet menu items for breakfast: "juice of choice, asst (assorted) hot or cold cereal, asst muffins, margarine, 1% milk, beverage of choice."</p> <p>Client #1's records were reviewed on 11/13/15 at 8:45 A.M. Review of the client's 4/25/15 Nutritional Assessment indicated the client was on a low carbohydrate diet.</p> <p>Client #2's records were reviewed on 11/13/15 at 9:17 A.M. Review of the client's 4/25/15 Nutritional Assessment</p>		<p>menu, client choices, and the diets for each client in the home by 12/16/15. Going forward, the Program Director/QIDP or designee will observe the facility during mealtime five times per week for four weeks, to ensure that each staff is implementing the menu choices for all clients in the home, providing immediate feedback to staff. Documentation of these observations will be made on Active Treatment Observation forms. The five observations will taper to one observation per week for quality assurance, once the Program Director/QIDP is satisfied that the staff have demonstrated full competency of the standard. System wide, all Program Director/QIDPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF/IDs.</p>		

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	<p>indicated the client was on a mechanical soft diet.</p> <p>Client #3's records were reviewed on 11/13/15 at 9:42 A.M. Review of the client's 4/25/15 Nutritional Assessment indicated the client was on a mechanical soft diet.</p> <p>Client #4's records were reviewed on 11/13/15 at 10:07 A.M. Review of the client's 4/25/15 Nutritional Assessment indicated the client was on a mechanical soft diet.</p> <p>Program Director #1 was interviewed on 11/13/15 at 11:12 A.M. Program Director #1 stated, "Staff (direct care staff) should have offered the items on the menu to [clients #1, #2, #3 and #4]."</p> <p>9-3-8(a)</p>			