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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G484 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 09/21/2015 |
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| NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 50605 WYANDOTTE GRANGER, IN 46530 |
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| W 0000 Bldg. 00 | <p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 15, 16, 17, 18, and 21, 2015.</p> <p>Facility number: 000998 Provider number: 15G484 AIM number: 100239800</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 9/22/2015.</p> | W 0000 | | |
| W 0104 Bldg. 00 | <p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>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 clean and in good repair for 2 of 2 sampled clients (clients #1 and #2), and 2 of 2 additional clients (clients #3 and #4).</p> <p>Findings include:</p> | W 0104 | <p>Work orders have been submitted to the Maintenance Director to address the bugs in the light fixture and the loose carpeting in the medication room. The Program Director is completing a site risk management checklist to ensure that no other environmental concerns have been overlooked that could affect any of the individuals living at the facility. Going forward, the staff at the</p> | 10/21/2015 |

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>The group home where clients #1, #2, #3, and #4 resided was inspected during the 9/15/15 observation period from 2:34 P.M. until 4:30 P.M. Dead insects were noted in the overhead lighting fixtures in the kitchen area and the carpet in the office and medication room was wrinkled and loose. These areas of the facility were utilized by clients #1, #2, #3, and #4.</p> <p>Program Director #1 was interviewed on 9/17/15 at 10:44 A.M. Program Director #1 stated, "The maintenance man is the person who is to keep the lighting clean of dead insects and he (maintenance man) is the one who would see that the carpet is in good repair."</p> <p>9-3-1(a)</p> | | <p>home and the Lead DSP are all responsible to report needed repairs to the Maintenance Director on a day to day basis. The Program Director visits the home at least weekly to check health and safety issues. The Maintenance Director visits the home at least monthly, though usually more frequently, to check these issues as well. The Area Director completes at least a quarterly check to verify that nothing has been missed. All responsible staff - the DSPs, Lead DSP, Program Director, Area Director, and Maintenance Director will all receive retraining on the expectations regarding this deficiency and each person's role in ensuring that it does not recur.</p> | | | | |
| W 0112 Bldg. 00 | <p>483.410(c)(2) CLIENT RECORDS</p> <p>The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation and interview, the facility failed to protect confidential information regarding a seizure health</p> | W 0112 | <p>This risk plan had been printed to place in the client file, however the staff who printed it accidentally became distracted</p> | 10/21/2015 | | | |

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| W 0312 Bldg. 00 | <p>care plan for 1 of 2 additional clients (client #3).</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed during the group home observation period on 9/16/15 from 5:52 A.M. until 7:45 A.M. A document entitled "Confidential Seizure Health Care Plan" for client #3 was laying on top of the printer in the office and medication area of the facility. The document was in full view of clients #1, #2, #3, and #4 during the entire observation period.</p> <p>Program Director #1 was interviewed on 9/17/15 at 10:44 A.M. Program Director #1 stated, "The document ("Confidential Seizure Health Care Plan") for [client #3] should have been put away so the others (clients #1, #2, and #4) could not have access to it."</p> <p>9-3-1(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the</p> | | <p>before filing it appropriately. All staff at the facility are being retrained on the protection of confidential client information. All staff are responsible to ensure that confidentiality is maintained. The Program Director will observe for any violations or practices which could compromise this information during site visits, at least weekly. Violations will be addressed through retraining and employee counseling. Going forward, all staff are trained on this issue on a yearly basis through the annual conditions of employment trainings.</p> | | |

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| | <p>reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed to assure psychotropic drug usage was addressed in the Individual Program Plan of 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 9/16/15 at 8:29 A.M. The review of the client's 9/15 Medication Administration Record indicated the client was receiving Seroquel (anti-psychosis medication), Prozac (anti-depressant medication), Lamictal (mood stabilizing medication), and Vyvanse (medication for hyperactivity). Review of the client's 11/19/14 Individual Support Plan, and 4/15 Behavior Support Plan failed to indicate an active treatment component had been implemented which addressed client #1's use of the Seroquel, Prozac, Lamictal, and Vyvanse and the management of the client's associated symptomatic behaviors.</p> <p>Program Director #1 was interviewed on 9/17/15 at 10:44 A.M. Program Director #1 stated, "The medications (Seroquel, Prozac, Lamictal, and Vyvanse) should be in his (client #1's) plan (4/15 Behavior</p> | W 0312 | The behavior plan for Client #1 is completed by an outside consultant. When the QIDP e-mailed the consultant for clarification on the medication reduction plan, he discovered that the medication reduction plan was included in a separate document, the Psychotropic Medication Treatment Plan, which is provided as an addendum to the BSP. The QIDP was not familiar with the placement of the medication reduction plan in this addendum. The QIDP has received re-training regarding the structure of the behavior plans provided by this agency, so that he can maintain proper oversight of the required elements of a behavior support plan as the QIDP. A systemic review of all behavior support plans in place at the home is being completed to ensure that all current psychotropic drug usage is being addressed and that medication reduction plans are in place in all plans. Going forward, the QIDP will have the ultimate responsibility to ensure that all behavior support plans in place have all required elements, and that the drugs used for control of inappropriate behaviors are used only as an integral part of the client's individual program plan. | 10/21/2015 | | | |

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| W 0336 Bldg. 00 | <p>Support Plan). It must have been overlooked."</p> <p>9-3-5(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</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 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 9/16/15 at 8:29 A.M. A review of the client's quarterly health assessments from 7/1/14 to 9/16/15 indicated the client received an annual physical on 8/26/15 and quarterly health assessments on 5/29/15, 3/20/15, and 12/28/14. The review failed to indicate the client received a health status assessment during the ninety day period from 7/1/14 through 9/30/14.</p> | W 0336 | <p>The facility nurse for the home during the period where the assessment was not completed is no longer with Dungarvin. The new facility nurse for this home and the nursing services manager are being retrained on this standard. Nursing assessments for all clients at this home have been completed within the last quarter. Weekly, the facility nurse will meet with the Program Director or staff responsible for medical appointments to review all recent orders, documentation, and health concerns. This will be documented on the MSDSP/Nurse Meeting Agenda form. This form will include an audit of one file each week, including a tracking of quarterly nursing assessments. This form is to be submitted to the nursing services coordinator and the area director for oversight to ensure</p> | 10/21/2015 | |

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| W 0436 Bldg. 00 | <p>Program Director #1 was interviewed on 9/17/15 at 10:44 A.M. Program Director #1 stated, "Our nurse left employment last August (8/14) and we had missed completing some of our quarterly nursing assessments."</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to assure 1 of 2 clients with adaptive equipment (client #2) was prompted to wear his prescribed eyeglasses.</p> <p>Findings include:</p> <p>Client #1 was observed at the group home during the 9/16/15 observation period from 5:52 A.M. until 7:45 A.M. During the observation period, client #1 did not wear eyeglasses. Direct care staff #1, #4, and #5 did not prompt or assist client #1 to wear his eyeglasses</p> | W 0436 | <p>that all assessments are being completed timely.</p> <p>It is the intention of Dungarvin Indiana to furnish, maintain in good repair, and teach clients to use and to make informed choices about all recommended adaptive equipment. All staff at the home are being re-trained in the adaptive equipment needs for all individuals at the home, including the reason for the equipment, how to maintain the equipment, and how to utilize all teaching moments throughout the day to encourage the individuals to use their adaptive equipment as appropriate. In particular, all staff will be trained on the recommendations for the use of the eye glasses prescribed for</p> | 10/21/2015 | | | |

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| W 0441 Bldg. 00 | <p>Client #1's record was reviewed on 9/16/15 at 8:29 A.M. A review of the client's 8/25/14 Vision Exam indicated a recommendation for client #1 to "wear eyeglasses."</p> <p>Program Director #1 was interviewed on 9/17/15 at 10:44 A.M. Program Director #1 stated, "[Client #1] should have been prompted to wear his eyeglasses."</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. Based on record review and interview, the facility failed to conduct evacuation drills for 2 of 2 sampled clients (clients #1 and #2), and 2 additional clients (clients #3 and #4), during over night hours.</p> <p>Findings include: The facility's evacuation drills, from 9/1/14 to 9/15/15, were reviewed on 9/15/15 at 3:28 P.M. The review failed to indicate clients #1, #2, #3, and #4, and direct care staff #1, #2, #3, #4, and #5</p> | W 0441 | <p>client #1. Going forward, the need for adaptive equipment and its incorporation into the IPP will be discussed at annual staff trainings on the Individual Program Plan, either whenever a new IPP is developed by the team, or when any new equipment is ordered for the individual.</p> <p>The evacuation drills were reviewed for the past year and while there were drills done on each quarter for the overnight shift of 11p-6a, it was identified that all drills were being done either at the very beginning of the overnight, between 11pm-11:45pm or at the very end of the shift, between 5:30am-6am. All responsible staff are being retrained on the expectation that the drills be varied in the time of the shift, in order to give the individuals the opportunity to respond at different times and in order to recognize</p> | 10/21/2015 | |

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| W 0460 Bldg. 00 | <p>participated in evacuation drills, during over night shift, between the hours of 11:45 P.M. and 5:36 A.M., during the review period.</p> <p>Program Director #1 was interviewed on 9/17/15 at 10:44 A.M. Program Director #1 stated evacuation drills during the over night hours "should be done."</p> <p>9-3-7(a)</p> <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 menus and dietary recommendations were followed for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed during the 9/16/15 group home observation period from 5:52 A.M. until 7:45 A.M. For breakfast, client #1 had a slice of</p> | | | W 0460 | <p>training needs or other variables that could effect the ability of the individuals to exit in a timely fashion at various times of the night. An overnight drill is being scheduled by the Program Director to be completed by 10/21/15 between the hours of 11:45pm-5:30am. Going forward, the Program Director will be responsible to ensure that drills occur with the expected frequency as well as with a variety of times and scenarios, both scheduled and unscheduled. The Program Director is to track these drills with the assistance of the Lead DSP and to maintain the documentation of the drills in the site emergency drill book for at least a year.</p> <p>We have contacted the contracted dietician to schedule a staff training for all staff working at this facility. A review of all diets and the menus will be completed at this training. Staff will also be trained on appropriate substitutions and the expectations regarding the documentation of menu substitutions that do occur. The QIDP and nurse will also participate in this training to discuss strategies to use in the case of individuals refusing to follow the menu and the</p> | | 10/21/2015 |

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| | <p>strawberry cheesecake, two pieces of string cheese, and a sausage egg muffin sandwich. Client #2 had a bowl of cold cereal. Direct care staff #1, #3, #4, and #5 did not prompt or assist the clients in eating foods from the dietary menu.</p> <p>The facility's records were reviewed on 9/16/15 at 7:22 A.M. The review of the facility's menus for clients #1 and #2 failed to indicate a menu was available for client meals.</p> <p>Direct care staff #1 was interviewed on 9/16/15 at 7:47 A.M. When asked if client meals were prepared from dietary menus, direct care staff #1 stated, "The menus are in this book (pointing to binder) but we don't use them regularly."</p> <p>Client #1's records were reviewed on 9/16/15 at 8:29 A.M. Review of the client's 9/21/14 Nutritional Assessment indicated the client was on a regular diet.</p> <p>Client #2's records were reviewed on 9/16/15 at 9:39 A.M. Review of the client's 9/21/14 Nutritional Assessment indicated the client was on a regular diet.</p> <p>Program Director #1 was interviewed on 9/16/15 at 10:44 A.M. Program Director #1 stated, "Staff (direct care staff) should be using the menus to prepare meals and</p> | | documentation to complete when this occurs. This training will be completed. Going forward, the Program Director will be required to review the documentation completed by the staff regarding compliance with the menu and any substitutions made during weekly site visits. Any concerns noted will be reviewed at the weekly Nurse/Med Support meeting and relayed back to the Area Director and the dietician as needed for follow up training, program implementation, or disciplinary action as needed. | | | | |

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| W 0462 Bldg. 00 | <p>then write substitutions when having foods that aren't on the menu."</p> <p>9-3-8(a)</p> <p>483.480(a)(3) FOOD AND NUTRITION SERVICES If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services. Based on observation, record review, and interview, the facility failed to assure the dietitian met with direct care staff to review the menus and dietetic needs for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed during the 9/16/15 group home observation period from 5:52 A.M. until 7:45 A.M. For breakfast, client #1 had a slice of strawberry cheesecake, two pieces of string cheese, and a sausage egg muffin sandwich. Client #2 had a bowl of cold cereal. Direct care staff #1, #3, #4, and #5 did not prompt or assist the clients in</p> | W 0462 | <p>We have contacted the contracted dietitian to schedule a staff training for all staff working at this facility. A review of all diets and the menus will be completed at this training. Staff will also be trained on appropriate substitutions and the expectations regarding the documentation of menu substitutions that do occur. The QIDP and nurse will also participate in this training to discuss strategies to use in the case of individuals refusing to follow the menu and the documentation to complete when this occurs. This training will be completed. Going forward, the Program Director will be required to review the documentation completed by the staff regarding compliance with the menu and</p> | 10/21/2015 |

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| | <p>eating foods from the menu.</p> <p>The facility's records were reviewed on 9/16/15 at 7:22 A.M. The review of the facility's menus for clients #1 and #2 failed to indicate a menu was available for client meals.</p> <p>Direct care staff #1 was interviewed on 9/16/15 at 7:47 A.M. When asked if client meals were prepared from dietary menus, direct care staff #1 stated, "The menus are in this book (pointing to binder) but we don't use them regularly."</p> <p>Client #1's records were reviewed on 9/16/15 at 8:29 A.M. Review of the client's 9/21/14 Nutritional Assessment indicated the client was on a regular diet. Further review failed to indicate the facility's dietician had reviewed client #1's menu and dietary needs with direct care staff at the facility.</p> <p>Client #2's records were reviewed on 9/16/15 at 9:39 A.M. Review of the client's 9/21/14 Nutritional Assessment indicated the client was on a regular diet. Further review failed to indicate the facility's dietician had reviewed client #1's menu and dietary needs with direct care staff at the facility.</p> <p>Program Director #1 was interviewed on</p> | | <p>any substitutions made during weekly site visits. Any concerns noted will be reviewed at the weekly Nurse/Med Support meeting and relayed back to the Area Director and the dietician as needed for follow up training, program implementation, or disciplinary action as needed.</p> | |

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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 |
| W 0488 Bldg. 00 | <p>9/16/15 at 10:44 A.M. Program Director #1 stated, "The dietician has not reviewed the dietary needs of [clients #1 and #2] with the staff (direct care staff)."</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview, the facility failed to encourage 2 of 2 sampled clients (clients #1 and #2), to eat family style during the morning meal.</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed during the 9/16/15 group home observation period from 5:52 A.M. until 7:45 A.M. For breakfast, client #1 had a slice of strawberry cheesecake, two pieces of string cheese, and a sausage egg muffin sandwich. Client #2 had a bowl of cold cereal. The clients ate separately and direct care staff #1, #3, #4, and #5 did not prompt or assist the clients in preparing and eating foods in a family style manner.</p> | | | W 0488 | <p>All staff will be retrained by 10/21/15 on the expectation that each client is able to participate in meal preparation in a manner that is consistent with his or her developmental level. This training will also include the expectation that staff are to encourage the individuals to participate in family style dining at the table whenever possible. The Program Director/QIDP will ensure that six observations a week for the next four weeks are completed during mealtimes to monitor that each individual is being offered the opportunity to participate in family style dining. The six weekly observations will taper to weekly observations once staff have demonstrated full competence and compliance with this standard of care. Going forward the</p> | | 10/21/2015 |

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| | <p>Direct care staff #1 was interviewed on 9/16/15 at 7:47 A.M. When asked if clients eat their meals in a family style manner, direct care staff #1 stated, "These (clients #1 and #2) are boys who are turning into young men. They eat pretty much the way they want to."</p> <p>Program Director #1 was interviewed on 9/16/15 at 10:44 A.M. Program Director #1 stated, "They (clients #1 and #2) should eat family style meals when possible and staff (direct care staff) should prompt or assist them in doing so."</p> <p>9-3-8(a)</p> | | <p>Program Director/QIDP will monitor the dining service area through weekly unannounced site visits and record the observation on the active treatment observation form at least once per month. Feedback will be given to the DSPs immediately during these observations. The form will be submitted to the Area Director on a monthly basis for quality review.</p> | |