

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G673	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/27/2013
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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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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>This survey was conducted in conjunction with the post certification revisit to the investigation of complaint #IN00131495.</p> <p>Dates of Survey: September 23, 24, 25, 26, and 27, 2013.</p> <p>Facility number: 009114 Provider number: 15G673 AIM number: 100244780</p> <p>Surveyor: Tim Shebel, LSW</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/7/13 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all 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) did not wear the same clothing for two consecutive days, and 1 of 4 additional clients (client #8) wore his shirt correctly.</p> <p>Findings include:</p> <p>1. Client #2 was observed during the 9/23/13 observation period from 3:43 P.M. until 6:00 P.M.. Client #2 was wearing a camouflage shirt with camouflage shorts. Client #2 was noted to wear these clothes throughout the 9/23/13 observation period.</p> <p>Client #2 was observed during the 9/24/13 observation period from 6:20 A.M. until 8:30 A.M. Client #2 wore the same camouflage shirt with camouflage shorts which he wore during the 9/23/13 observation period. Direct care staff #4, 5, and #6 did not prompt or assist client #2 to change clothing.</p> <p>2. Client #8 was observed during the 9/24/13 observation period from 6:20</p>	W000137	<p>All staff will be retrained on the expectation of assuring that each individual is appropriately dressed and in clean clothing at all time. Daily checks will be conducted by the staff and documentation will be completed noting that clean clothing is worn by all men. At least weekly observations will be conducted by the Program Director/QDDP or designee to ensure that this expectation is being carried out. Immediate feedback will be given to staff during these observations in regards to this issue. System wide, all Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-DD's. Change from original POC: "Daily checks will be conducted by the staff and documentation will be completed noting that clean clothing is worn by all men." Persons Responsible: Program Director/ QDDP</p>	11/15/2013			

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	<p>A.M. until 8:30 A.M.. Client #8 was wearing a button up golf shirt with the back of the shirt facing the front. Direct care staff #4, #5, and #6 did not prompt or assist client #8 to turn the shirt to face his front.</p> <p>Program Director #1 was interviewed on 9/25/13 at 2:53 P.M.. Program Director #1 indicated direct care staff should have assured client #2 wore different clothing on 9/24/13 and direct care staff should have assisted client #8 to turn his shirt around during the 9/24/13 observation period.</p> <p>9-3-2(a)</p>			

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W000210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, the facility failed to obtain a speech evaluation within 30 days of admission for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 9/25/13 at 1:47 P.M.. A review of his 9/12/13 Individual Support Plan indicated client #1 "communicated verbally and can be difficult to understand." Further review of the client's Individual Support Plan indicated the client was admitted to the facility on 8/14/13 and failed to indicate client #1 had a speech evaluation completed within 30 days of admission.</p> <p>Program Director #1 was interviewed on 9/25/13 at 2:53 P.M.. Program Director #1 indicated client had not yet had a speech evaluation completed.</p> <p>9-3-4(a)</p>	W000210	<p>W 210 483.440 Individual Program Plan A Speech Evaluation has been completed for individual #1. The Program Director/QDDP and facility nurse will be retrained on the expectation that the Speech Evaluation needs to be completed within 30 days of admission. An audit of the individual's files will be completed to assure that all required speech evaluations have been completed for any other people at this home. This audit will be reviewed by the Area Director. System-wide, all Program Directors will review this information to assure that this same concern is not happening at other Dungarvin ICF-DD's. At least quarterly, audits will be conducted for all individual's files, and the Program Director/QDDP will review speech evaluation needs at that time and assure that all persons needing this evaluation is having it completed timely. Persons Responsible: Program Director/QDDP</p>	10/27/2013			

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed to implement active treatment programs during times of opportunity for 1 of 4 additional clients (client #8).</p> <p>Findings include:</p> <p>Client #8 was observed during the group home observation period on 9/23/13 from 3:43 P.M. until 6:00 P.M.. Client #8 laid awake on the couch from 3:43 P.M. until 5:16 P.M. without activity or meaningful interaction from direct care staff #1, #2, and #3. Direct care staff #1, #2, and #3 were not observed to assist client #8 to set the dinner table, practice sign language, or assist client #8 to clear the dinner room table after the evening meal.</p> <p>Client #8's record was reviewed on 9/25/13 at 2:00 P.M.. Review of client #8's 10/26/12 Individual Support Plan indicated the client had active treatment objectives which could have been implemented during the 9/23/13</p>	W000249	W249 483.440 Program Implementation All staff working at the site will be retrained on each person's activity calendars and their goals and objectives as identified in their Individual Program Plans. All staff will document daily on each person's goal data and narrative entries that the goals and activities were completed for that specific shift. This will be reviewed by the Program Director to assure that all goals and activities are being completed each day. At least weekly for the first month, and then random observations will be conducted by the Program Director or designee to assure that each staff is implementing those goals and objectives. Immediate feedback will be given to the staff during those observations. This observation will be documented on an Active Treatment Observation form. A copy of those forms will be given to the Area Director for review and follow up. System wide, all Program Director/QDDP's will review this standard and assure that this concern is being	11/15/2013			

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	<p>observation period: "1. Set dinner table, 2. Practice sign language, 3. Clear dinner table after dinner."</p> <p>Program Director #1 was interviewed on 9/25/13 at 2:53 P.M.. Program Director #1 stated, "[Client #8's] active treatment program should be implemented whenever there is an opportunity."</p> <p>9-3-4(a)</p>		<p>addressed at all Dungarvin ICF-DD's. Change to original POC: "All staff will document daily on each person's goal data and narrative entries that the goals and activities were completed for that specific shift. This will be reviewed by the Program Director to assure that all goals and activities are being completed each day."</p> <p>Persons Responsible: Program Director/QDDP, Area Director</p>		

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE 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. Based on record review and interview, the facility failed to assure the facility's Human Rights Committee approved the behavior intervention plan of 1 of 4 additional clients with behavior intervention plans (client #8) prior to the plan's implementation.</p> <p>Findings include:</p> <p>Client #8's records were reviewed on 9/25/13 at 2:00 P.M.. A review of the client's 8/5/13 Behavior Intervention Plan indicated the client was being administered Divalproex and Seroquel (mood stabilizing and anti-psychosis medication) for behavioral and psychiatric concerns. Further review of the client's 8/5/13 Behavior Support Plan failed to indicate the facility's Human Rights Committee approved the use of the plan prior to the plans implementation.</p> <p>Program Director #1 was interviewed on 9/26/13 at 9:53 A.M.. Program Director #1 indicated he could not find the Human Rights Committee approval for client #8's</p>	W000262	<p>W262 Program Monitoring and Change The Program Director/QDDP will be retrained on assuring that the Dungarvin Human Rights Committee approves the Behavior Intervention Plans that include the use of behavioral medications that are restrictive in nature for any of the individuals at this home. Quarterly, Program Director/QDDP's will conduct audits of the client files. This audit will include assuring that approvals by the Human Rights Committee are made based on identified need for any restrictions including Behavior Plans and medications. These audits will be reviewed by the Area Director for follow up assurance. System wide, all Program Director/QDDP's will review this standard and the need to assure that this concern is being addressed at all Dungarvin ICF-DD's. Persons Responsible: Program Director/ QDDP, Area Director</p>	10/27/2013

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	8/5/13 Behavior Intervention Plan.  9-3-4(a)			
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W000264	<p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review, and interview, the facility's Human Rights Committee failed to review the facility's practice of motion sensors in the living room, family room, open office area, and kitchen/dining area which affected 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 of 4 additional clients (clients #5, #6, #7, and #8) living in the facility.</p> <p>Findings include:</p> <p>Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home during the 9/23/13 observation period from 3:43 P.M. until 6:00 P.M. and during the 9/24/13 observation period from 6:20 A.M. until 8:30 A.M.. During the above observation periods, the living room, family room, open office area, and kitchen/dining area were noted to have motion sensors. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed to have unimpeded access to the living room, family room, open office area, and</p>	W000264	<p>W264 Program Monitoring and Change The Program Director/QDDP will assure that the Dungarvin Human Rights Committee is asked to review the use of motion sensors in the main living areas of the home. The Program Director will review the requirement of doing this at all homes going forward. System wide, all Program Director/QDDP's will review this standard and the need to assure that this concern is being addressed at all Dungarvin ICF's. Persons Responsible: Program Director/ QDDP, Area Director</p>	10/27/2013			

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	<p>kitchen/dining area of the facility where the motion sensors were located.</p> <p>House Manager #1 was interviewed on 9/24/13 at 8:14 A.M.. House Manager #1 indicated the motion sensors were operating and were to monitor direct care staff's movements throughout the home during the overnight hours to assure they were actively supervising the clients. When asked if the motion sensors also sense and monitor the movements of clients #1, #2, #3, #4, #5, #6, #7, and #8, House Manager stated, "Yes."</p> <p>The facility's records were reviewed on 9/25/13 at 1:10 P.M.. A review of the facility's Human Rights Committee minutes, from 9/1/12 to 9/25/13, failed to indicate the facility's Human Rights Committee had reviewed the facility's systemic practice of using motion sensors in the home where clients #1, #2, #3, #4, #5, #6, #7, and #8 lived.</p> <p>Area Director #1 was interviewed on 9/26/13 at 9:20 A.M.. Area Director #1 indicated the facility's Human Rights Committee had not reviewed the facility's systemic practice of using motion sensors in the home where clients #1, #2, #3, #4, #5, #6, #7, and #8 lived.</p> <p>9-3-4(a)</p>						

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W000312	<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 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) with a Behavior Intervention Plan.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 9/24/13 at 8:06 A.M.. A review of the client's 9/13 Medication Administration Record indicated client #1 was receiving Zoloft and Abilify (Anti-depression and psychosis medications) for mood disorder.</p> <p>Client #1's records were further reviewed on 9/25/13 at 12:55 P.M.. A review of the client's 7/21/13 Individual Support Plan indicated the use of Zoloft and Abilify was not addressed in the client's Individual Support Plan.</p> <p>Program Director #1 was interviewed on 9/25/13 at 2:53 P.M.. Program Director #1 indicated client #1's use of Zoloft and</p>	W000312	W312 483.450 Drug Usage A Behavior Protocol has been written to address the behavioral concerns that correlate with the use of an anti-depressant and psychosis medication for client #1. All staff at the site will be trained on this protocol. This plan and corresponding data will be reviewed by this person's IDT and prescribing physician on a quarterly basis and recommendations for reductions of that medication will be considered based on the objectives of the protocol being met. System wide, all Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF-DD's. Persons Responsible: Program Director/QDDP	10/27/2013			

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	Abilify had not been incorporated into his Individual Support Plan.  9-3-5(a)			

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, the facility failed to assure nursing services reconciled the physician's order for Loratadine (allergy medication) for 1 of 4 additional clients (client #6).</p> <p>Findings include:</p> <p>Client #6 was observed taking prescribed medications on 9/24/13 at 7:24 A.M.. Direct care staff #7 administered a 10 mg (milligram) Loratadine tablet to client #6.</p> <p>Client #6's Loratadine medication container information was reviewed on 9/24/13 at 7:26 A.M.. The prescribing information on the Loratadine container indicated the client was to receive "one 10 mg Loratadine tablet prn (as needed)."</p> <p>The client's 9/13 Medication Administration Record was reviewed on 9/24/13 at 7:33 A.M.. The review indicated the client was to receive "one 10 mg Loratadine tablet once a day."</p> <p>Nurse #1 was interviewed on 9/26/13 at 9:12 A.M.. Nurse #1 stated, "I had gotten two orders from [client #6's] physician. One order indicated [client #6] was to receive one tablet of Loratadine prn and the other order indicated [client #6] was</p>	W000331	<p>W331 483.460 Nursing Services The physicians order for the medication Loratadine for individual #6 was clarified by the physician. It had just been changed prior to the survey but was not clear on the order. All staff have been trained on this new order. The facility nurse will review all new orders prior to medication administration and approve that the MAR is correct. Weekly, the facility nurse will meet with the Program Director and the staff responsible for completing doctor appointments and will review the MAR's and physician orders at that time also. System-wide, all Program Director/QDDP's for ICF-DD's will review this tag and assure that this standard is in compliance at all other Dungarvin homes. Persons Responsible: Program Director/ QDDP, Facility Nurse</p>	10/27/2013			

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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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(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 receive on tablet of Loratadine once a day." When asked if she had reconciled the order with client #6's physician to indicate how the Loratadine was to be administered, nurse #1 stated, "No."</p> <p>9-3-6(a)</p>			