

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 304 3RD ST FLORA, IN 46929
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00184288.</p> <p>Complaint #IN00184288: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W149 and W153.</p> <p>Dates of Survey: 11/24, 11/25, 11/30, 12/2, and 12/3/2015.</p> <p>Facility number: 011817 Provider number: 15G757 AIM number: 200940190</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/10/15.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 3 of 17 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client A), the facility neglected to ensure the implementation</p>	W 0149	<p>W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS The Area Director (AD), QIDP, and House Manager will review this Standard, and ensure Agency's abuse/neglect Policy</p>	01/02/2016

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>of their abuse/neglect prevention policy to immediately report client A's AWOL (Absent Without Leave) behaviors and neglected to supervise and to implement client A's BSP (Behavior Support Plan) according to her identified behavioral needs regarding suicidal threats and causing injuries to herself.</p> <p>Findings include:</p> <p>1. On 11/24/15 at 9:40am, the facility's Bureau of Developmental Disability Services (BDDS) reports from 5/1/15 through 11/24/15 indicated the following for client A for late reporting:</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 9:00pm indicated client A "eloped from (the group home) twice, then engaged in property destruction and refused her 8:00pm medications."</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 9:00pm indicated client A "had eloped twice from the home...Behaviorist (sic) advised staff to sweep [client A's] room and remove all objects that could be used to harm oneself due to her history of self harm and suicide attempts...[Client A] called the Behaviorist, Behaviorist refused to return [client A's] objects to harm oneself to her...[Client A] dumped all food out of</p>		<p>and Procedure is implemented at all times, that incidents of elopement are immediately reported per State law, that a BDDS report is submitted per State law, and to supervise and ensure all clients' BSPs are implemented according to each clients' identified behavioral needs. 1. QIDP, Behaviorist, and IDT will complete a thorough review of Client A's BSP, to ensure it proactively addresses her behavioral needs and prevents Abuse and Neglect. Based on this review, the Behaviorist will update the BSP as necessary, to ensure Client A's health and safety. 2. QIDP will retrain all staff on Agency reporting Policy/Procedure. 3. QIDP and House Manager will be retrained on ensuring all reportable incidents are reported to the State within 24 hours of the incident. 4. All staff will be retrained on Client A's BSP, supervision protocol, thorough room sweep procedures and documentation, and all protocol for preventing SIB. To ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, that incidents of elopement are immediately reported per State law, that a BDDS report is submitted per State law, and to supervise and ensure all clients' BSPs are implemented according to each clients' identified behavioral needs, the QIDP, House</p>				

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	<p>the refrigerator and freezer onto the floor, threw the microwave, skillet, and griddle onto the floor. [Client A] moved to the back common area and threw all craft items and paint. She moved to the dining area, pulled off the table cloth and pulled the curtains down. She moved to the front common area and threw tables, pulled curtains down, ripped cords out of game system component which also brought the TV down. She threw the game component multiple times, causing the artwork to fall from the wall and break. She moved to the bathroom pulled down curtains and threw everything on the floor."</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 7:00pm indicated client A "seemed upset but refused to talk to staff about what upset her. [Client A] ate her evening meal and after cleaning up went to her bedroom. At 7:00pm, [client A] eloped, walked a block south, and returned to the home. Staff had [client A] in sight at all times. [Client A] smoked on the deck and asked staff to leave her alone. Staff asked [client A] if she would like her PRN (as needed psychotropic medication), [client A] ignored the staff. At 7:15pm, [client A] eloped again and walked to the park. Staff kept [client A] in sight at all times. [Client A] used the swings and climbed</p>		<p>Manager, and/or Behaviorist will complete active treatment observations at the home at least three times per week to ensure compliance. Once compliance is demonstrated by all staff, a member of the above Team will complete these observations at least weekly and at random.</p> <p>Will be completed by: 1/2/16</p> <p>Persons Responsible: QDDP, House Manager, and Behaviorist</p>				

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	<p>the monkey bars to smoke. [Client A] returned home."</p> <p>On 11/24/15 at 12:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the Residential Manager (RM). Both professional staff indicated the agency followed the BDDS reporting policy and procedure to immediately report allegations of abuse, neglect, and/or mistreatment. The QIDP and RM indicated client A's incidents of AWOL and property destruction were not immediately reported to BDDS and in accordance with State Law.</p> <p>On 12/3/15 at 3:30pm, an interview was conducted with the Area Director (AD) and the RM. The AD indicated client A's 11/13/15 BDDS reports were not immediately reported to BDDS and in accordance to State Law.</p> <p>2. On 11/24/15 at 9:40am, the facility's Bureau of Developmental Disability Services (BDDS) reports from 5/1/15 through 11/24/15 indicated the following incidents of staff neglecting to supervise client A regarding her documented known behaviors:</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 9:00pm indicated client A</p>			

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	<p>"eloped from (the group home) twice, then engaged in property destruction and refused her 8:00pm medications."</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 9:00pm indicated client A "had eloped twice from the home...Behaviorist (sic) advised staff to sweep [client A's] room and remove all objects that could be used to harm oneself due to her history of self harm and suicide attempts...[Client A] called the Behaviorist, Behaviorist refused to return [client A's] objects to harm oneself to her...[Client A] dumped all food out of the refrigerator and freezer onto the floor, threw the microwave, skillet, and griddle onto the floor. [Client A] moved to the back common area and threw all craft items and paint. She moved to the dining area, pulled off the table cloth and pulled the curtains down. She moved to the front common area and threw tables, pulled curtains down, ripped cords out of game system component which also brought the TV down. She threw the game component multiple times, causing the artwork to fall from the wall and break. She moved to the bathroom pulled down curtains and threw everything on the floor."</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 7:00pm indicated client A</p>			

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	<p>"seemed upset but refused to talk to staff about what upset her. [Client A] ate her evening meal and after cleaning up went to her bedroom. At 7:00pm, [client A] eloped, walked a block south, and returned to the home. Staff had [client A] in sight at all times. [Client A] smoked on the deck and asked staff to leave her alone. Staff asked [client A] if she would like her PRN (as needed psychotropic medication), [client A] ignored the staff. At 7:15pm, [client A] eloped again and walked to the park. Staff kept [client A] in sight at all times. [Client A] used the swings and climbed the monkey bars to smoke. [Client A] returned home."</p> <p>-A 11/7/15 BDDS report for an incident on 11/6/15 at 3:30pm indicated client A "arrived home from the park and was breathing heavily. [Client A] asked to call behaviorist, who didn't answer. [Client A] then asked to call nurse (sic). Staff asked why, [client A] told staff something was wrong but she didn't want to tell staff. [Client A] had private telephone conversation with nurse in (her) bedroom. After speaking with [client A], nurse called the home and reported that [client A] told the nurse she had snorted bath salts and asked staff to call 9-1-1. Staff called 9-1-1, police arrived within 3 minutes of the call.</p>			

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	<p>Police and EMS personnel found [client A] on her bed. [Client A] respond laid on the bed (sic) with her eyes closed until an EMT (Emergency Medical Technician) touched her shoulder. EMT's checked her vitals and contacted Poison Control Center. EMT's report [client A] should be OK (sic), no toxins in bath salts...all vitals good, and EMT's left the home."</p> <p>-A 10/10/15 BDDS report for an incident on 10/9/15 at 6:00pm indicated client A was setting the table for dinner, exchanged words with a peer, and client A "eloped out the front door. Staff followed [client A] and kept her in line of sight at all times. [Client A] went to a local park and swung for a while, ignoring staff. [Client A] then walked down the highway, in line of staff the entire time. Second staff drove vehicle with flashers on next to [client A] on the highway as [client A] walked the Bern of highway (sic). At 8:00m [client A] decided to enter staff car and go home." The report indicated elopement behavior was added to her targeted behaviors in client A's Behavior Support Plan (BSP).</p> <p>-A 10/6/15 BDDS report for an incident on 10/5/15 at 2:45am indicated client A "was in the bathroom and called for staff, showed staff she cut both arms multiple</p>			

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	<p>times. [Client A] cut (the word) LISTEN into both arms. Used a razor from a makeup pencil sharpener and a sewing needle." The report indicated staff applied pressure to both arms, called EMS (Emergency Medical Services), and client A was transferred to the local Emergency Room then admitted to the Psychiatric Unit at the hospital.</p> <p>-A 10/9/15 Follow Up BDDS report to the 10/5/15 incident indicated client A had cut the word "Listen" into her arms "because she wanted to return to [city], she thought if she cut listen into her arms, someone would hear her desire to return to Ft. [city]." The report indicated client A's family member had hung up on her, client A had been given her PRN behavioral medication, client A became agitated, "Nurse noted healed and scarred cuts to [client A's] stomach and right thigh on 10/5/15 after [client A] was discharged from emergency room. [Client A] reported that she cut herself on 9/28/15. No incident of expressing suicidal thought or ideations." The report indicated client A was visually supervised by "staff every 30 minutes 24/7 (twenty-four hours a day/seven days a week). [Client A's] room was swept once for sharps and other items that could cause her harm. No Sharps have been allowed back in her room."</p>			

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	<p>On 11/24/15 at 1:15pm, an interview was conducted with the Behaviorist. The Behaviorist stated client A's behaviors had "escalated" during the times "just before the AWOL incidents," before the cutting incidents, and staff were to provide supervision to decrease the behaviors. The Behaviorist stated staff had "swept" client A's room before the cutting "Listen" into both arms on 10/5/15 at 2:45am. The Behaviorist stated client A had "obtained the razor from a pencil sharpener" she had broken to gain access to the blade and had "obtained the sewing needle from inside a sewing kit" which were "both in her bedroom" after the room sweep. The Behaviorist indicated staff had not gone through client A's drawers to locate sharp objects during the room sweep. The Behaviorist indicated client A had a history of AWOL, suicidal threats, and cutting herself before client A was admitted to the group home. The Behaviorist indicated client A had gained access to the bath salts while on a community outing with the staff from the group home.</p> <p>On 11/24/15 at 1:30pm, an interview was conducted with the Residential Manager (RM). The RM indicated neglect was the failure to provide staff supervision</p>			

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	<p>according to a clients identified needs.</p> <p>The RM indicated the staff neglected to supervise client A when she continuously left the group home AWOL, cut herself causing repeated injuries, and snorting bath salts which were accessed by client A on a community outing with the staff. No information was available for review regarding the healed cuts on client A's stomach. Client A was admitted to the group home on 9/4/15.</p> <p>On 12/3/15 at 3:30pm, an interview was conducted with the Area Director (AD). The AD indicated the staff neglected to provide supervision when client A had the ability to access sharps to cut herself on 10/5/15 at 2:45am, left the group home AWOL continuously, and snorted bath salts at the group home.</p> <p>Client A's record was reviewed on 11/25/15 at 9:30am. Client A's 11/16/15 BSP (Behavior Support Plan) indicated targeted behaviors of Verbal Aggression, Elopement, Suicide Attempt history, Self Harm attempts, SIB (Self Injurious Behavior), and Property Destruction. Client A's BSP indicated room sweeps were implemented by the staff after client A expressed "threats" of suicide. Client A's BSP indicated she had "attempted suicide by jumping off a bridge in January, 2015. She shattered her neck</p>			

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	<p>and tailbone, and broke her leg and needed several medical follow up to heal properly (sic)." Client A's BSP indicated staff were to provide direct supervision "in line of sight at all times" while client A was in the community.</p> <p>On 11/24/15 at 11:50am, the 4/2005 "BDDS Reportable Incidents to the Bureau of Developmental Disabilities Services" policy and procedure indicated "Reportable incidents are any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual...."</p> <p>On 11/24/15 at 11:50am, the facility's 4/2011 "Policy and Procedure Concerning Consumer Abuse and Neglect" indicated the agency prohibited abuse, neglect, and/or mistreatment. The policy and procedure indicated "All persons working in this organization's homes or providing a service within these homes are mandated by law to report suspected abuse or neglect" and "It is the policy of this organization to inform appropriate agencies of suspected or actual abuse, neglect, or exploitation and to cooperate fully with the investigation of such." The policy indicated "Any suspected incidents" should be reported immediately. The policy indicated</p>				

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W 0153 Bldg. 00	<p>"Physical Abuse is defined as any act which constitutes a violation of the assault...Non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress...Neglect-the failure to provide appropriate care, supervision or training, failure to provide food and medical services as needed, failure to provide a safe, clean, and sanitary environment...as indicated in the Individual Support Plan (ISP)."</p> <p>This federal tag relates to complaint #IN00184288.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on record review and interview, for 3 of 17 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client A), the facility failed to immediately report client A's AWOL (Absent Without Leave)</p>	W 0153	<p>W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS In conjunction with the Plan of Correction for W149, the Area Director (AD), QIDP, and House Manager will review this Standard, and ensure Agency's</p>	01/02/2016	

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	<p>behaviors to BDDS in accordance with State Law.</p> <p>Findings include:</p> <p>On 11/24/15 at 9:40am, the facility's Bureau of Developmental Disability Services (BDDS) reports from 5/1/15 through 11/24/15 indicated the following for client A for late reporting:</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 9:00pm indicated client A "eloped from (the group home) twice, then engaged in property destruction and refused her 8:00pm medications."</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 9:00pm indicated client A "had eloped twice from the home...Behaviorist (sic) advised staff to sweep [client A's] room and remove all objects that could be used to harm oneself due to her history of self harm and suicide attempts...[Client A] called the Behaviorist, Behaviorist refused to return [client A's] objects to harm oneself to her...[Client A] dumped all food out of the refrigerator and freezer onto the floor, threw the microwave, skillet, and griddle onto the floor. [Client A] moved to the back common area and threw all craft items and paint. She moved to the dining area, pulled off the table cloth and pulled</p>		<p>abuse/neglect Policy and Procedure is implemented at all times, that incidents of elopement are immediately reported per State law, that a BDDS report is submitted per State law, and to supervise and ensure all clients' BSPs are implemented according to each clients' identified behavioral needs. 1. QIDP, Behaviorist, and IDT will complete a thorough review of Client A's BSP, to ensure it proactively addresses her behavioral needs and prevents Abuse and Neglect. Based on this review, the Behaviorist will update the BSP as necessary, to ensure Client A's health and safety. 2. QIDP will retrain all staff on Agency reporting Policy/Procedure. 3. QIDP and House Manager will be retrained on ensuring all reportable incidents are reported to the State within 24 hours of the incident. 4. All staff will be retrained on Client A's BSP, supervision protocol, thorough room sweep procedures and documentation, and all protocol for preventing SIB. To ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, that incidents of elopement are immediately reported per State law, that a BDDS report is submitted per State law, and to supervise and ensure all clients' BSPs are implemented according to each clients' identified behavioral needs, the QIDP, House</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	
	<p>the curtains down. She moved to the front common area and threw tables, pulled curtains down, ripped cords out of game system component which also brought the TV down. She threw the game component multiple times, causing the artwork to fall from the wall and break. She moved to the bathroom pulled down curtains and threw everything on the floor."</p> <p>-A 11/15/15 BDDS report for an incident on 11/13/15 at 7:00pm indicated client A "seemed upset but refused to talk to staff about what upset her. [Client A] ate her evening meal and after cleaning up went to her bedroom. At 7:00pm, [client A] eloped, walked a block south, and returned to the home. Staff had [client A] in sight at all times. [Client A] smoked on the deck and asked staff to leave her alone. Staff asked [client A] if she would like her PRN (as needed psychotropic medication), [client A] ignored the staff. At 7:15pm, [client A] eloped again and walked to the park. Staff kept [client A] in sight at all times. [Client A] used the swings and climbed the monkey bars to smoke. [Client A] returned home."</p> <p>On 11/24/15 at 12:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and</p>		<p>Manager, and/or Behaviorist will complete active treatment observations at the home at least three times per week to ensure compliance. Once compliance is demonstrated by all staff, a member of the above Team will complete these observations at least weekly and at random.</p> <p>Will be completed by: 1/2/16</p> <p>Persons Responsible: QDDP, House Manager, and Behaviorist</p>		

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	<p>the Residential Manager (RM). Both professional staff indicated the agency followed the BDDS reporting policy and procedure to immediately report allegations of abuse, neglect, and/or mistreatment. The QIDP and RM indicated client A's incidents of AWOL and property destruction were not immediately reported to BDDS in accordance with State Law.</p> <p>On 12/3/15 at 3:30pm, an interview was conducted with the Area Director (AD) and the RM. The AD indicated client A's 11/13/15 BDDS reports were not immediately reported to BDDS in accordance to State Law.</p> <p>This federal tag relates to complaint #IN00184288.</p> <p>9-3-2(a)</p>				