

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
---	---

(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 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00184287.</p> <p>Complaint #IN00184287: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W104 and W249.</p> <p>Dates of Survey: 11/24, 11/25, 11/30, 12/2, and 12/3/2015.</p> <p>Facility number: 011602 Provider number: 15G748 AIM number: 200903760</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 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 2 of 2 sample clients (clients A and B) and 1 additional client (client C), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs</p>	W 0104	<p>W 104 483.410(a)(1) GOVERNING BODY</p> <p>The House Manager, QIDP,</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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>were completed at the group home, to ensure client A's window alarm was functional, and to ensure facility staff were attentive to answer the front door for clients A, B, and C.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During observation and interview on 11/24/15 from 2:30pm until 4:15pm, the group home was found to have maintenance/repair issues. This affected clients A, B and C. At 2:30pm, the RM (Residential Manager) indicated the group home was in need of repairs. The RM stated client A "caused most all the damage" during his aggressive behaviors. The RM stated the walls and damage throughout the group home "continued" to be repaired and client A "continued" to cause property damage. <p>-The RM stated four of four (4 of 4) dining room walls had "multiple unfinished dry wall patches, damage, and need repaired." -The hallway had two of two (2 of 2) walls with "multiple" unfinished dry wall repairs and needed to be painted. -The kitchen cabinets had two missing lower cabinet doors. -The side A living room had four of four (4 of 4) living room walls with unfinished dry wall repairs which needed</p>		<p>Maintenance Coordinator, and Area Director (AD) will review this Standard.</p> <ol style="list-style-type: none"> 1. The "multiple unfinished dry wall patches, damage" and holes to the dining room, living rooms, bathroom, and hallway walls will be repaired and finished/painted. 2. The two lower kitchen cabinet doors will be replaced. 3. The side A living room drapes will be replaced. 4. A sturdy television cabinet with Plexiglas is being constructed which will bolt to the wall and the television will be replaced. 5. Furniture will be moved back to the side A living room. 6. Client A's green material will be repaired/replaced and client A's bedroom door casing will be repaired. 7. Client A's bedroom window alarm has been repaired and the beeping has ceased. A protocol will be developed and staff trained to follow the protocol when the door and window chime system is not functioning properly. 8. All staff will be re-trained on ensuring the door is answered 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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 be finished.</p> <p>-The side A living room was missing the drapes to the windows. The RM stated client A had "torn" the drapes down.</p> <p>-The side A living room was missing the television from the television cabinet. The RM indicated client A had sprayed the television with water from the kitchen and the television was damaged.</p> <p>-The side A living room had no furniture to sit on. The RM indicated client A had damaged the furniture and the furniture had not been replaced.</p> <p>-The RM stated bathroom #2 had two of two (2 of 2) walls with "eight feet long" unfinished dry wall repairs on each wall.</p> <p>-The side B living room had four of four (4 of 4) walls with unfinished dry wall repairs which needed to be finished. The RM stated the side B living room had eleven (11) areas of unfinished dry wall, each area measuring from "six (6) inches to five (5) feet" long.</p> <p>-The side B living room ceiling had two (2) circular holes into the dry wall which needed to be repaired.</p> <p>-The RM indicated client A's bedroom had three of three (3 of 3) walls which had been reinforced with a steel material which was covered with a green colored cloth material that had tears, marks, and damage in the green material to expose the white colored reinforced material underneath.</p>		<p>promptly when a visitor arrives at the home.</p> <p>This home has an individual who regularly engages in property destruction and the maintenance department is continually repairing the damage caused by the individual. The individual's IDT is working together to monitor and revise, as necessary, this individual's BSP in an effort to assist him in reducing/eliminating his target behavior of property destruction.</p> <p>Ongoing, the House Manager and/or QIDP will inspect the home at least three times per week, to ensure all damage in the home has been repaired timely and ensure all staff are following the procedure to notify the maintenance department of any new damage, or other issues such as malfunctioning alarm systems. During these visits, they will also ensure staff promptly answers the door, and if staff does not answer promptly, they will investigate to determine the reason why the door was not promptly answered. The results of these visits will be provided to the Area Director, and if any issues are noted, the Area</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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 RM indicated client A's bedroom door casing was missing which exposed bare metal casings with sharp edges to the metal.</p> <p>On 11/24/15 from 2:30pm until 4:15pm, the inside group home alarms were beeping continuously and no staff communicated a problem or responded to inquire regarding the continuous alarm. At 3:05pm, the RM indicated the alarm beeping sound was client A's broken window alarm inside his bedroom. The RM stated client A broke the window alarm a few weeks ago, it was repaired "recently," and client A broke it again the next day. The RM stated client A's window alarm had been malfunctioning without a completed repair "for over a week" and the maintenance department had to "order a part." The RM indicated staff knew the alarm was broken and did not respond to the alarm. When asked what the plan was when the window alarms were malfunctioning, the RM indicated fifteen (15) minute checks were completed. When asked if clients A, B, and C had the skill to tell time, the RM indicated clients A, B, and C had the skill and would know when staff were coming to check on them. The RM indicated the governing body had not developed a plan for alerting staff when clients' window alarms were malfunctioning after</p>		<p>Director will follow-up with the maintenance department and/or staff responsible, to ensure this Standard is maintained in the home.</p> <p>Will be completed by: 1/2/16</p> <p>Persons Responsible: QIDP, House Manager, Maintenance Coordinator, and Area Director</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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>repeated incidents of client A's property damage.</p> <p>On 11/24/15 at 3:55pm, GHS (Group Home Staff) #6 stated client A kicks the walls after he tells the staff "usually he is bored." GHS #6 stated client A kicked the walls and "caused" property damage daily. GHS #6 and the RM both stated client A was happy one minute, then said he was bored, and kicked the "walls or tore things up." GHS #6 indicated client A had sprayed the living room television sets with water from the sprayer in the kitchen sink, and staff turned off the water to the sprayer. GHS #6 indicated client A damaged the walls throughout the group home.</p> <p>On 11/24/15 at 10:35am, the RM provided email correspondence between the maintenance department, the Area Director (AD), and the RM regarding maintenance and repairs. On 10/29/15 the correspondence indicated the following from a visitor's visit to the group home: "1. There is a hole in the living room wall behind an end table. 2. Chair in living room has area worn on arms of the chair. 3. Bathroom pocked door is bowed. 4. [Client C's] bedroom, twin bed on floor with no frame, room had no dresser, and no clothes hanging in the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/03/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929
---	---

(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>closet. His basket was sitting outside on the back patio since they smelled and the washer was broken and they would be going to the laundry mat (sic). 5. Holes have been repaired but not painted over. 6. 4 (sic) cabinet doors missing in the kitchen. 7. There is no oven door. 8. [Client B's] bedroom floor has something all over it, staff wasn't sure what it was. 9. 2 boards on windows in dining room, I thought they were dry erase boards for [client B]...barrier due to not having the right glass installed (in the two broken windows in the dining room). 10. Entertainment center in the spare living room is turned around and not in use. 11. [Client A's] room has constructed his own shelving system...no dresser...had 2 surge protectors in his room." A 11/20/15 email indicated additional maintenance issues to the previous list "exhaust fans in the restroom do not work." An email on 11/23/15 from the maintenance department to the Area Director indicated the list of pending maintenance issues had not been repaired.</p> <p>On 11/24/15 at 10:35am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the Residential Manager (RM). The QIDP and RM both indicated clients A, B, and C's group home was in the process</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(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>of being repaired. The RM and QIDP indicated no further information was available for review.</p> <p>On 12/3/15 at 3:30pm, an interview was conducted with the Area Director (AD). The AD indicated the maintenance list had been completed and stated "Now we have new repairs that need completed" from client A's continued property destruction behaviors.</p> <p>2. During observations on 11/24/15 from 7:15am until 7:34am, the surveyor stood outside clients A, B, and C's group home, rang the door bell six (6) times, knocked on the front door seven (7) times, and no staff and clients were observed inside the group home from the adjacent dining room window beside the front door. From 7:15am until 7:34am, three (3) vehicles were observed parked in the group home driveway, lights inside the group home were lit, and no movement in the dining room and kitchen was observed from the front porch window.</p> <p>On 11/24/15 at 2:30pm, the Residential Manager (RM) and the surveyor rang the doorbell and the bell rang throughout client A, B, and C's group home. At 2:30pm, the surveyor knocked again on the front door and the RM indicated the knock could be heard throughout the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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 0249 Bldg. 00	<p>group home.</p> <p>On 11/24/15 at 3:40pm, GHS (Group Home Staff) #6 indicated she was on duty on 11/24/15 at 7:15am. When asked why staff did not answer the doorbell and the knocking on the front door, GHS #6 stated the "staff did not hear the door" bell and knocking. GHS #6 stated clients A, B, and C did not get up until after 8:00am on 11/24/15.</p> <p>On 12/3/15 at 3:30pm, an interview was conducted with the Area Director (AD). The AD stated it "was unacceptable" for the facility staff not to answer the front door.</p> <p>This federal tag relates to complaint #IN00184287.</p> <p>9-3-1(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview, for 1 of 1 sampled client</p>	W 0249		01/02/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(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>(client B) who was at the group home on 11/24/15, the facility failed to implement client B's Individual Support Plans (ISP) and Behavior Support Plan (BSP) when opportunities existed.</p> <p>Findings include:</p> <p>On 11/24/15 from 2:30pm until 4:15pm, client B was observed at the group home. At 2:30pm, client B sat at the dining room table, was non verbal, and colored. At 2:30pm, client B greeted the surveyor, client B was asked his name, the Residential Manager introduced client B, and the Residential Manager prompted the surveyor to not ask client B more than one (1) question. The Residential Manager stepped into a private area and indicated client B became more aggressive when more than one question/request was made. From 2:30pm until 4:15pm, client B wore a tee shirt with dried spots on the front and the shirt had tears into the fabric around the collar. From 2:30pm until 3:00pm, client B sat alone in the dining room and colored at the dining room table. From 3:00pm until 3:40pm, client B went into his bedroom and closed the door. From 3:40pm until 4:15pm, client B watched cartoons in the living room and hummed to himself and no communication system was observed available for client B to use</p>		<p>W 249 483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>The House Manager, QIDP, Nurse, Behaviorist, and Area Director (AD) will review this Standard.</p> <ol style="list-style-type: none"> The QIDP will retrain all staff on Client B's ISP and BSP. The QIDP will retrain all staff on the Agency's Policy/Procedure concerning continuous active treatment. The QIDP will retrain all staff on ensuring all clients are dressed appropriately and prompted to change if wearing worn or dirty, or inappropriate clothing, and to ensure appropriate hygiene practices.. The QIDP will obtain the client B's pec book and pictures to communicate and ensure all staff are trained on how to assist Client B in using it. If necessary, QIDP will arrange for client B to be evaluated for a more appropriate communication device, that would assist him in communicating with others. <p>To ensure client B and his housemates' ISP and BSP are</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929			
(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 communicate with staff. From 2:30pm until 4:15pm, client B had three (3) facility staff in the group home and client B was not offered choice of activities. From 2:30pm until 4:15pm, client B was not interacted with regarding making choices of activities, using a communication system, and encouraging interaction with the facility staff.</p> <p>On 11/24/15 at 2:45pm, an interview was conducted with the RM (Residential Manager). The RM indicated client B had aggressive behaviors, client B would shake hands, and then became more aggressive towards others. The RM indicated the facility staff limit the requests made to client B in an attempt to decrease his physically aggressive behaviors.</p> <p>Client B's record was reviewed on 11/30/15 at 10:00am. Client B's 8/31/15 ISP (Individual Support Plan) and 11/2/15 BSP (Behavior Support Plan) indicated client B was non verbal and had goals/objectives to decrease his physically aggressive behaviors to less than five in three months, to decrease his non compliance behavior to less than seven in three months, to use a pec book and pictures to communicate, to wear clean clothes, to state the name of the town where he lives, to identify a penny</p>		<p>implemented at each opportunity, to ensure staff are adhering to each Individuals' ATS, the QIDP, House 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>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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>from other coins, to complete exercises, to clear the table after a meal, and to participate in a leisure activity of his choice for twenty minutes. Client B's BSP indicated "...targets staff when he is trying to escape a task or wants something he cannot have. [Client B's] size and strength is often takes multiple staff to restrain him for his safety...Target Replacement Behaviors: Physical Aggression toward others will be replaced by the individual utilizing coping skills and/or communication skills. Coping skills for [client B] include: writing/drawing, time away to his room/back porch, and increasing communication with staff...5. Keep [client B] busy with activity. More choices."</p> <p>On 12/3/15 at 3:30pm, an interview with the RM (Residential Manager) and the Area Director (AD) was conducted. The RM and AD both indicated client B's ISP objectives/goals and BSP should be implemented by the facility staff during formal and informal opportunities. The AD indicated the facility staff should interact with client B when opportunities existed.</p> <p>This federal tag relates to complaint #IN00184287.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/07/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G748	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 12/03/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 821 SUNSET DR FLORA, IN 46929		
(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	
	9-3-4(a)				