

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/16/2015
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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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W000000	<p>This visit was for the post certification revisit to the investigation of complaint #IN00159794 conducted on December 5, 2014.</p> <p>COMPLAINT #IN00159794: Not corrected.</p> <p>Date of Survey: January 16, 2015</p> <p>Facility number: 011817 Provider number: 15G757 AIM number: 200940180</p> <p>Surveyor: Christine Colon, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/28/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000149	<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.</p> <p>Based on record review and interview for</p>	W000149	W 149 483.420(d)(1) STAFF TREATMENT of CLIENTS	02/09/2015

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>1 of 2 sampled clients (client B), the facility failed to implement written policy and procedures to prevent abuse and neglect in regards to conducting investigations.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigations was conducted on 1/16/15 at 1:10 P.M.. Review of the records indicated:</p> <p>-BDDS report dated 1/5/15 at the outside day program involving client B indicated: "When [client B] returned from break, another consumer sitting near her workstation said something that she felt was inappropriate. [Client B] became very upset with the comment. She became verbally aggressive with the peer and stood up and was ready to physically fight. Staff were able to calm [client B] down and she expressed that she wanted to go home because she was worried that she would not be able to remain calm and did not want to be in a fight. Staff went to call her a ride. When staff returned and told [client B] that a ride was on the way, but it would be approximately a half hour before it was here, [client B] decided that was too long to wait and</p>		<p>In conjunction with the Plan of Correction for W154, the Area Director, House Manager, and QDDP have reviewed this Standard. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect through ensuring thorough investigations are conducted into any allegation of abuse/neglect. Client B's IDT has met and are discussing the revision and/or needed addition to Client B's protocol to further support her in reducing/eliminating her desire to elope. After the incident noted, Client B's IDT agreed that until a Protocol is agreed upon where the day program provider agrees they can safely ensure Client B's Health and Safety during any attempted elopement and all staff are trained at the day program, Client B will not return to participate in her day program.</p> <p>The House Manager and/or QDDP will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard and Agency Policy/Procedure.</p>		

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	<p>vacated the workshop. Staff tried to get her to return to the building, however, [client B] refused to acknowledge that she was being talked to and kept walking. Staff followed her as she continued to walk 6 blocks. Another staff brought a car to try and give her a ride because it was very cold. [Client B] also refused to get in the car. Staff continued to follow her and eventually was able to persuade her to enter the workshop. [Client B] then went to the office and waited for her ride to arrive and went home for the day. staff (sic) will continue to follow [client B]'s behavior plan." Further review of the record failed to indicate the facility conducted an investigation in regard to the incident of elopement.</p> <p>A review of the facility's records was conducted at the facility's administrative office on 1/16/15 at 1:30 P.M.. Review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14, indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a</p>		<p>Will be completed by: 2/9/15</p> <p>Persons Responsible: Area Director, House Manager, and QDDP</p>				

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	violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Emotional/verbal abuse is defined as 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, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...Neglect is defined as 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 and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)....The Supervisor, or Program Coordinator/Senior Director, or his/her delegate will conduct a thorough investigation of the reported incident. The investigation will include the following:						

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	<p>1. Review of witnesses.</p> <p>2. Any evidence or previous abuse or neglect.</p> <p>3. All other evidence to determine the veracity and seriousness of the charge.</p> <p>...The facility investigation will be completed within five (5) business days, and a summary of results of the investigation will be forwarded to the administrator within five (5) business days of the incident."</p> <p>An interview with the Area Director (AD) was conducted on 1/16/15 at 2:30 P.M.. The AD indicated staff should follow the facility's abuse/neglect policy. The AD indicated clients should be free of abuse and neglect. The AD indicated the facility did not conduct an investigation in regard to the incident of elopement from the outside day program.</p> <p>This deficiency was cited on 12/5/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 1 of 1 incident of elopement involving 1 of 2 sampled clients (client B), to provide evidence a thorough investigation was completed.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS), Internal Reports (IR) and investigation records was conducted on 1/16/15 at 1:10 P.M.. Review of the reports indicated:</p> <p>-BDDS report dated 1/5/15 at the outside day program involving client B indicated: "When [client B] returned from break, another consumer sitting near her workstation said something that she felt was inappropriate. [Client B] became very upset with the comment. She became verbally aggressive with the peer and stood up and was ready to physically fight. Staff were able to calm [client B] down and she expressed that she wanted to go home because she was worried that she would not be able to remain calm and did not want to be in a fight. Staff went</p>	W000154	<p>W 154 483.420(d)(3) STAFF TREATMENT of CLIENTS</p> <p>In conjunction with the Plan of Correction for W149, the Area Director, House Manager, and QDDP have reviewed this Standard. The Area Director, House Manager, and QDDP have been retrained on ensuring the facility implements its written policies and procedures to prevent abuse/neglect through ensuring thorough investigations are conducted into any allegation of abuse/neglect. Client B's IDT has met and are discussing the revision and/or needed addition to Client B's protocol to further support her in reducing/eliminating her desire to elope. After the incident noted, Client B's IDT agreed that until a Protocol is agreed upon where the day program provider agrees they can safely ensure Client B's Health and Safety during any attempted elopement and all staff are trained at the day program, Client B will not return to participate in her day program.</p> <p>The House Manager and/or QDDP</p>	02/09/2015

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	<p>to call her a ride. When staff returned and told [client B] that a ride was on the way, but it would be approximately a half hour before it was here, [client B] decided that was too long to wait and vacated the workshop. Staff tried to get her to return to the building, however, [client B] refused to acknowledge that she was being talked to and kept walking. Staff followed her as she continued to walk 6 blocks. Another staff brought a car to try and give her a ride because it was very cold. [Client B] also refused to get in the car. Staff continued to follow her and eventually was able to persuade her to enter the workshop. [Client B] then went to the office and waited for her ride to arrive and went home for the day. staff (sic) will continue to follow [client B]'s behavior plan."</p> <p>Further review of the record failed to indicate the facility conducted an investigation in regard to the incident of elopement.</p> <p>An interview with the Area Director (AD) was conducted on 1/16/15 at 2:30 P.M.. The AD indicated the facility did not conduct an investigation in regard to the incident of elopement. The AD indicated she did not know an investigation should be conducted since the outside day program documented the</p>		<p>will promptly report to the Area Director, per Policy, and the Area Director will monitor and ensure compliance with this Standard and Agency Policy/Procedure in regards to completing thorough investigations.</p> <p>Will be completed by: 2/9/15</p> <p>Persons Responsible: Area Director, House Manager, and QDDP</p>				

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	<p>BDDS report of the incident. No written documentation was submitted for review to indicate the facility conducted an investigation to ensure the outside day program did not neglect to provide proper supervision of client B in regard to her elopement.</p> <p>This deficiency was cited on 12/5/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>				