

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 10/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 3521 OXFORD SOUTH BEND, IN 46615
---	--

(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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 20, 21, 22, 23, and 24, 2014.</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 10/29/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed to provide privacy for toileting for 1 of 4 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1 was observed during the group</p>	W000130	<p>Direct Care Staff #7 is receiving retraining on ensuring Client #1's privacy rights during treatment and personal care needs are maintained. In addition, all direct care staff at the home will receive training on client rights by 11/23/14 to ensure all client rights in the home are protected. The Program Director/QIDP will make</p>	11/23/2014

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: 15G673		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/24/2014	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3521 OXFORD SOUTH BEND, IN 46615			
(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			
W000268	<p>home observation on 10/21/14 from 2:48 P.M. until 5:25 P.M. Upon entering the group home, client #1 was sitting on the toilet with his pants down and the bathroom door open. Direct care staff #7 walked past the bathroom and leaned in and said to client #1, "You need to close the door when you use the bathroom." Direct care staff #7 then walked away leaving the bathroom door open. Direct care staff #7 did not assist in closing the bathroom door for client #1's privacy as the client used the toilet.</p> <p>Program Director #1 was interviewed on 10/22/14 at 11:29 A.M. Program Director #1 stated, "[Direct care staff #7] should have closed the bathroom door for [client #1]."</p> <p>9-3-2(a)</p> <p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure 1 of 4 sampled clients (client #4) was clean shaven.</p> <p>Findings include:</p>	W000268	<p>three observations per week at the home for four weeks to monitor the staff and observe how client rights are upheld. These observations will be documented on Active Treatment assessment forms. If the Program Director/QIDP observes that a staff member has not maintained the rights of a client, the Program Director will intervene and retrain the staff immediately. The Active Treatment forms will be submitted to the Area Director for review. Once the forms indicate that client rights are being met with 100% of all observations, the Program Director will no longer document on the Active Treatment form but will continue to monitor that the client rights are upheld during weekly observation visits at the home.</p> <p>Client #4 received support to shave his face immediately. All staff and the Program Director/QIDP of the home are receiving re-training on the expected frequency of shaving and the responsibility of the facility in</p>	11/23/2014			

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 10/24/2014	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3521 OXFORD SOUTH BEND, IN 46615			
(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			
W000382	<p>Client #4 was observed during the group home observation period on 10/20/14 from 6:34 A.M. until 8:40 A.M., and on 10/21/14 from 2:48 P.M. until 5:25 P.M. During both observations, client #4 had an unkept appearance with a week's growth of facial hair.</p> <p>Program Director #1 was interviewed on 10/22/14 at 11:29 A.M. Program Director #1 stated, "Yes, [client #4] is particular about which staff shaves him. He does sometimes go for a long period of time without a shave."</p> <p>9-3-5(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7).</p> <p>Findings include: Direct care staff #1 was observed passing</p>	W000382	<p>assisting the individuals in promoting their growth, development, and independence in the area of their own personal appearance. Dungarvin has reviewed this concern for all individuals residing at the home to ensure they have all received proper support in regularly shaving. The Program Director/QDDP will be responsible, in conjunction with the Lead DSP, to ensure that the clients are shaven on a regular schedule going forward. Client #4's IST will also work to develop a goal to increase his independence with and tolerance of shaving.</p> <p>Direct Care Staff #1 is receiving retraining on the expectation that all drugs and biologicals are to be kept locked except when being prepared for administration. She is also receiving disciplinary action according to Dungarvin policy. The facility nurse and/or Program Director/QIDP will observe Direct Care Staff #1 during a medication pass to ensure proper procedure is</p>	11/23/2014			

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 10/24/2014	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 3521 OXFORD SOUTH BEND, IN 46615			
(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>medications during the 10/20/14 observation period from 6:34 A.M. until 8:40 A.M. At 7:16 A.M., direct care staff #1 retrieved client #4's medications and placed them on a table in the medication area. Direct care staff #1 left the medication room for 35 seconds with medications unattended in the medication area. The door to the medication area was left open which allowed access to the area by clients #1, #2, #3, #4, #5, #6, and #7.</p> <p>Program Director #1 was interviewed on 10/22/14 at 11:29 A.M. Program Director #1 stated, "Medications are to be locked when they aren't being administered."</p> <p>9-3-6(a)</p>		<p>followed. This observation will occur by 11/23/14. In addition, all staff that work in the home received training from the Program Director and Area Director on this expectation on 10/24/2014 to ensure the clients are not allowed to access medications or other potentially harmful substances. Going forward, the Program Director and the facility nurse will monitor compliance with this standard during their weekly visits at the home. Minutes from the weekly observations at the home will be sent by the facility nurse to the Area Director on a weekly basis for review and quality assurance.</p>				