

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/27/2013	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561			
(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: September 23, 24, 25, 26, and 27, 2013.</p> <p>Facility number: 000974 Provider number: 15G460 AIM number: 100244830</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 10/3/13 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/27/2013	
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561			
(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			
W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview, the governing body failed to exercise operating direction over the facility to keep cold air vents in a clean condition for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 additional clients (clients #5, #6, #7, and #8).</p> <p>Findings include:</p> <p>The group home where clients #1, #2, #3, #4, #5, #6, #7, and #8 resided was inspected during the 9/25/13 observation period from 3:34 P.M. until 5:45 P.M.. The cold air vents in the living room, dining room and all client bedrooms were covered in dust.</p> <p>Program Director #2 was interviewed on 9/26/13 at 10:47 A.M.. Program Director #2 indicated direct care staff were to clean the cold air vents in the group home.</p> <p>9-3-1(a)</p>	W000104	<p>The cold air vents in the living room, dining room, and all client bedrooms have been cleaned. A cleaning checklist has been put in place which includes these specific areas, and it will address regular cleaning of all parts of the home. The Program Director/QDDP will conduct weekly site checks to ensure that the home remains clean, and also complete a Site Risk Management checklist monthly which includes documentation of any environmental concerns at the house. System wide, all Program Director/QMRP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. Persons Responsible: Program Director /QDDP</p>	10/25/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/27/2013
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561		
(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	
W000263	<p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed to obtain written consent for the guardian prior to implementing a restrictive Behavior Intervention Plan for 1 of 2 sampled clients (client #4) with a Behavior Intervention Plan.</p> <p>Findings include:</p> <p>Client #4's records were reviewed on 9/26/13 at 10:55 A.M.. The review indicated client #4 had the services of a guardian. Review of the client's 2/29/13 Behavior Intervention Plan indicated the client was receiving Risperdal (anti-psychosis medication) for the management of targeted behaviors of Verbal Aggression and Abuse, Property Destruction, Refusal to Self-Care, and Elopement. Further review of client #4's Behavior Intervention Plan indicated the plan was implemented on 2/29/13 but the client's guardian did not approve the use of the plan until 5/30/13.</p> <p>Program Director #2 was interviewed on 9/26/13 at 11:09 A.M.. Program Director #2 indicated she had sent client #4's</p>	W000263	<p>The Program Director/QDDP will be retrained on assuring that the emancipated person served or their guardian approves the Behavior Intervention Plan that is restrictive in nature, prior to implementing the plan. Quarterly, Program Director/QDDP's will conduct audits of the client files. This audit will include assuring that approvals by the Person Served or their Guardian is obtained for any restrictive Behavior Plans. 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>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/27/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561
-----------------------------------------------------------	----------------------------------------------------------------------------

(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>Behavior Intervention Plan to the client #4's guardian for approval on or around 2/29/13 but did not receive guardian approval until 5/30/13.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/27/2013
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561		
(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	
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 9/25/13 observation period from 3:34 P.M. until 5:45 P.M. and during the 9/24/13 observation period from 6:29 A.M. until 8:30 A.M.. During the above observation periods, the living room, family room, open, 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, and kitchen/dining area of the facility where</p>	W000264	<p>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. 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. 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's. Persons Responsible: Program Director/ QDDP, Area Director</p>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/27/2013
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561		
(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 motion sensors were located.</p> <p>House Manager #1 was interviewed on 9/25/13 at 3:37 P.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 9/26/13 at 9:07 A.M.. A review of the facility's Human Rights Committee minutes, from 9/1/12 to 9/26/13, 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 9/27/13 at 8:57 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>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/27/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561
-----------------------------------------------------------	----------------------------------------------------------------------------

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/27/2013
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561		
(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	
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 #4) with a Behavior Intervention Plan.</p> <p>Findings include:</p> <p>Client #4's records were reviewed on 9/26/13 at 8:07 A.M.. A review of the client's 9/13 Medication Administration Record indicated client #4 was receiving Risperdal (Anti-psychosis medication) for Verbal Aggression and Abuse, Property Destruction, Refusal to Self-Care, and Elopement.</p> <p>Client #4's records were further reviewed on 9/26/13 at 10:55 A.M.. A review of the client's 5/30/13 Individual Support Plan and his 2/29/13 Behavior Intervention Plan failed to indicate the use of Risperdal was addressed in the client's Active Treatment program</p> <p>Program Director #2 was interviewed on</p>	W000312	<p>The Behavior Intervention Plan and IPP for Client #4 has been updated and includes the use of Risperdal for identified behavioral concerns. All staff at the home will be retrained on this new plan. Quarterly, Program Director/QDDP's will conduct audits of the client files. This audit will include assuring that any medications that are prescribed to address behavioral concerns are identified in that person's Behavior Plan and IPP. 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>	10/25/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/27/2013
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561
-----------------------------------------------------------	----------------------------------------------------------------------------

(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>9/26/13 at 11:40 A.M.. Program Director #2 indicated client #4's use of Risperdal had not been incorporated into his Individual Support Plan.</p> <p>9-3-5(a)</p>			