STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G750	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	60680 LILAC RD SOUTH BEND, IN 46614

(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 000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: March 31 and April 1, 2, and 6, 2015 Facility number: 011765 Provider number: 15G750 AIM number: 200908290 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.	W 000		
W 104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure molding and closet doors were repaired for 1 of 2 sampled clients (client #1), and a couch and chair in the south living room area were in good repair for 1 of 2 sampled clients (client #1), and 1 additional client (client #3).	W 104	**W104 483.410(a)(1)** **GOVERNING BODY** The Program Director/ QDDP and Lead DSP will review this Standard. The Maintenance Coordinator visited the home and evaluated all molding	05/06/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Findings include: The group home where clients #1, #2, #3, and #4 resided was inspected during the 4/1/15 observation period from 6:24 A.M. until 8:30 A.M. Door molding on client #1's bedroom door was pulled away from the frame and the closet doors in client #1's bedroom were off of the hinges. The couches in the south living room utilized by clients #1 and #3 had broken seat springs and the chair in the south living room was scuffed and worn. Area Director #1 was interviewed on 4/2/15 at 11:55 A.M. Area Director #1 stated, "I'm not sure if a maintenance order has been completed to repair those items (door molding, closet doors). I'll have to check. As for as the couch and chair, we are looking at purchasing new furniture." 9-3-1(a)		and doors. Maintenance then repaired the molding on client #1's bedroom door and fixed client#1's closet doors, then fixed any other molding or door issues in the home. The PD/Q will do a site visit and evaluate all of the furniture, door molding, and doors in the home. For any furniture that is not in good repair, the Program Director will arrange to repair or replace the item. For any other issues noted in the home, the PD/Q will immediately submit a Maintenance request for the damaged or non-functioning item to be repaired promptly. For two weeks and then until compliance has been demonstrated, the Program Director will do site-visits at least three times per week to ensure the home is free of any furniture in bad repair or any broken items in the home such as doors, molding, etc., and arrange for it to be promptly replaced or repaired. The Lead DSP will be retrained on reporting to the PD any items that are not in good repair so they can be repaired or replaced promptly, and to promptly complete a maintenance request when any part of the facility is needed of repair. The Lead DSP will be trained to notify the PD/Q in the event an item is not promptly repaired, so the PD/Q can then follow-up. Thereafter, the Program Director will complete these checks at least weekly.	

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			Will be completed by: 5/6/15 **Persons Responsible: Program Director/QDDP and Lead DSP**	
W 331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, the facility's nurse failed to assure 1 of 2 sampled clients (client #1) was referred to the dentist to have his dentures repaired. Findings include: Client #1 was observed at day programming on 3/31/15 from 10:27 A.M. until 11:45 A.M., and at the group home on 3/31/15 from 3:23 P.M. until 5:30 P.M., and on 4/1/15 from 6:24 A.M. until 8:30 A.M. During all observations, client #1 was wearing upper dentures with a front tooth that was chipped off. Client #1's record was reviewed on 4/2/15 at 9:04 A.M. A review of the client's 7/11/14 dental examination indicated his dentures had been adjusted on 7/11/14 and he was to return for any	W 331	**W331 483.460(c)** **NURSING SERVICES** The Program Director/ QDDP, Lead DSP, and Nurse will review this Standard. An appointment has been made for client #1 to get his dentures fixed. All staff have been trained on monitoring all Individuals' adaptive equipment and to report any that is in bad repair, broken, or missing. For two weeks and then until compliance has been demonstrated, the Program Director/QDDP will do site-visits at least three times per week to ensure all Individuals' adaptive equipment is in good repair. Thereafter, the Program Director will complete these checks at least weekly. **Will be completed by: 5/6/15 Persons**	05/06/2015

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	additional work on an as needed basis. Further review failed to indicate client #1 had been referred to the dentist to have his dentures repaired. Area Director #1 was interviewed on 4/2/15 at 11:55 A.M. Area Director #1 stated, "I was unaware of [client #1's] dentures being chipped. We will look into it." When asked who was responsible to assure client #1 had been referred to the dentist to have his dentures repaired, Area Director #1 stated, "Ultimately it is the nurse's responsibility." 9-3-6(a)		**Responsible: Program Director/QDDP, Nurse, and Lead DSP**	
W 367 Bldg. 00	483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration. Based on observation and interview, the facility failed to assure medications for 2 of 2 sampled clients (clients #1 and #2) were not prepared into medication cups prior to administration and the medications were identifiable up to the point of administration. Findings include:	W 367	**W367 483.460(k) DRUG ADMINISTRATION** The Program Director/ QDDP, Lead DSP, and Nurse will review this Standard. The staff responsible for administering pre-prepared medications has been re-trained and	05/06/2015

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	Clients #1 and #2 were observed receiving medications during the 4/2/15 observation period from 6:24 A.M. until 8:30 A.M. Direct care staff #4 left the medication room and prompted client #2 to come and get his morning medications. Direct care staff #4 entered the medication room with client #2 and unlocked the medication closet. On a shelf in the closet were eight medication cups containing various tablets, liquids and powders. Direct care staff #4 took four of the medication cups and gave them to client #2. Client #2 self administered the tablets, mixed the powder with water and drank it, and drank the liquid medication which was in a medication cup. Direct care staff then locked the closet and escorted client #2 out of the room. Direct care staff #4 retrieved client #1, unlocked the closet and handed two medication cups which contained various tablets to client #1 who self administered them. Direct care staff #4 then locked the closet and left the room with client #1 and the surveyor. Area Director #1 was interviewed on 4/2/15 at 11:55 A.M. When asked if staff were to prepare medications into medication cups prior to administration, Area Director #1 stated, "No." When asked if the medications were identifiable up to the point of administration, Area		observed passing medications appropriately. All staff have been re-trained on the proper administration of medications per Policy and Procedure. For two weeks and then until compliance has been demonstrated, the Program Director/QDDP or Nurse will do site-visits at least three times per week and observe medication administration, to ensure all medication is administered per Policy and Procedure. Thereafter, the Program Director/QDDP or Nurse will complete these observations at least weekly. **Will be completed by: 5/6/15** **Persons Responsible: Program Director/QDDP and Nurse**	

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	Director #1 stated, "I would think not. That's not the way staff are to pass medications." 9-3-6(a)			
W 436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, the facility failed to maintain in good condition 1 of 2 sampled client's (client #1's) dentures. Findings include: Client #1 was observed at day programming on 3/31/15 from 10:27 A.M. until 11:45 A.M., and at the group home on 3/31/15 from 3:23 P.M. until 5:30 P.M., and on 4/1/15 from 6:24 A.M. until 8:30 A.M. During all observations, client #1 was wearing upper dentures with a front tooth that was chipped off. Client #1's record was reviewed on 4/2/15 at 9:04 A.M. A review of the	W 436	**W436 483.470(g)(2) SPACE AND EQUIPMENT** The Program Director/ QDDP, Lead DSP, and Nurse will review this Standard. An appointment has been made for client #1 to get his dentures fixed. All staff have been trained on monitoring all Individuals' adaptive equipment and to report any that is in bad repair, broken, or missing. For two weeks and then until compliance has been demonstrated, the Program Director/QDDP will do	05/06/2015

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	client's 7/11/14 dental examination indicated his dentures had been adjusted on 7/11/14 and he was to return for any additional work on an as needed basis. Area Director #1 was interviewed on 4/2/15 at 11:55 A.M. Area Director #1 stated, "I was unaware of [client #1's] dentures being chipped. We will look into it." 9-3-7(a)		site-visits at least three times per week to ensure all Individuals' adaptive equipment is in good repair. Thereafter, the Program Director will complete these checks at least weekly. **Will be completed by: 5/6/15** **Persons Responsible: Program Director/QDDP, Nurse, and Lead DSP**	