STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G484	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	50605 WYANDOTTE GRANGER, IN 46530

(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
W0000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: August 20, 21, and 22, 2012. Facility number: 000998 Provider number: 15G484 AIM number: 100239800 Surveyor: Tim Shebel, Medical Surveyor III The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed August 27, 2012 by Dotty Walton, Medical Surveyor III.	W0000		

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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W0104	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 failed to keep light fixtures clean for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 additional clients (clients #4, #5, and #6). Findings include: The group home where clients #1, #2, #3, #4, #5, and #6 resided was inspected during the 8/21/12 observation period from 6:34 A.M. until 8:30 A.M. The ceiling light fixtures in the kitchen were discolored and had dead insects in the plastic coverings. The ceiling light fixture in the laundry area contained dead insects in the plastic covering. Program Director #1 was interviewed on 8/21/12 at 10:11 A.M. Program Director #1 indicated the facility's maintenance department was in charge of cleaning the lighting fixtures and they should be cleaned. 9-3-1(a)	W0104	To address the concern of the dirty lighting fixtures, we immediately placed a work order with Maintenance Personnel to clean or replace all light fixture covers, as needed.Going forward, whenever the need for a needed routine Maintenance is noted by a Program Director/QMRP or Program Coordinator during a site visit, a request will be generated to the Maintenance Department in writing, indicating the need for maintenance support. System wide, all Program Director/QMRPs, Program Coordinators and the Maintenance Department will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.	09/21/2012

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W0149	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. Based on record review and interview, and failed to ensure it's abuse/neglect policy indicated the results of all investigations to be reported to the administrator within five business days for 1 of 1 investigation of alleged staff to client abuse for 1 of 3 sampled clients (client #1). Findings include: The facility's records were reviewed on 8/20/12 at 1:23 P.M. The review indicated the following allegation of abuse: Name: (Client #1), Date of incident: 3/25/12, Date of knowledge: 3/26/12, Narrative: "The Program Coordinator was informed by CPS (Child Protective Services) about an allegation concerning [Client #1], who told his teacher that the staff who took him to church on Sunday (3/25/12) sweezed (sic) his (client #1's) nose and was bruised. The alleged staff was put on suspension pending investigation and disciplinary action will be taken according to the outcome of the investigation. Plan to Resolve: Staff will continue to closely monitor [Client #1]	W0149	We reviewed the circumstances of this particular investigation and found that while our agency's expectation is to complete all investigations of abuse within 5 business days, we failed to meet that expectation due to the involvement of DCS in the investigation, as the DCS caseworker conducting their investigation requested that he be given the opportunity to question the individual and staff members involved before our agency staff questioned them. Going forward, we will inform any outside agency involved in an investigation of this nature that we are required to conduct our investigation within 5 business days, and that we will work with them to the best of our ability, however we will not be able to put our investigation on hold to meet their timelines. In addition, we discovered that during the last revision of our agency policy on Abuse, Neglect and Exploitation, we inadvertently left out the wording that had previously been in the policy indicating that all investigations need to be completed with a summary of findings forwarded to the Administrator within five (5) business days. To rectify this, we are submitting a revision to our	09/21/2012

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	closely (sic) and a follow-up will be scheduled with his Primary Care Physician if necessary." A review on 8/20/12 at 2:10 P.M. of the facility's "Investigative Report" of the 3/25/12 alleged abuse incident indicated the date the investigation was completed was 4/17/12 and the administrator was notified on 4/17/12. The facility's "Policy and Procedure Concerning Individual Abuse, Neglect, and Exploitation", dated 4/4/12, was reviewed on 8/20/12 at 2:15 P.M. The policy did not indicate the facility's administrator would be notified within five business days of the results of facility investigations of alleged incidents of abuse/neglect/exploitation. Facility Director #2 was interviewed on 8/21/12 at 10:11 A.M. Facility Director #2 stated, "We (administrative staff) revised the facility's abuse and neglect policy recently and must have inadvertently left the section out which indicated the facility's administrator was to be notified of the results of investigations within five working days." 9-3-2(a)		Abuse, Neglect & Exploitation policy to reinstate this wording. This revision will be complete by 09/21/2012.Going forward, it is the intention of Dungarvin Indiana to comply with the expectation of the State of Indiana regarding written policies and procedures that prohibit mistreatment, neglect or abuse of the client.System wide, all Program Director/QMRPs and Program Coordinators will review this standard and ensure that this concern is beign addressed at all Dungarvin ICF-MRs.	

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W0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to ensure the results of 1 of 1 reviewed investigation of alleged staff to client abuse which involved 1 of 3 sampled clients (client #1) was reported to the facility's administrator within five business days. Findings include: The facility's records were reviewed on 8/20/12 at 1:23 P.M. The review indicated the following allegation of abuse: Name: (Client #1), Date of incident: 3/25/12, Date of knowledge: 3/26/12, Narrative: "The Program Coordinator was informed by CPS (Child Protective Services) about an allegation concerning [Client #1], who told his teacher that the staff who took him to church on Sunday (3/25/12) sweezed (sic) his (client #1's) nose and was bruised. The alleged staff was put on suspension pending investigation and disciplinary action will be taken according to the outcome of the investigation. Plan to Resolve: Staff will	W0156	We reviewed the circumstances of this particular investigation and found that while our agency's expectation is to complete all investigations of abuse within 5 business days, we failed to meet that expectation due to the involvement of DCS in the investigation, as the DCS caseworker conducting their investigation requested that he be given the opportunity to question the individual and staff members involved before our agency staff questioned them. Going forward, we will inform any outside agency involved in an investigation of this nature that we are required to conduct our investigation within 5 business days, and that we will work with them to the best of our ability, however we will not be able to put our investigation on hold to meet their timelines. In addition, we discovered that during the last revision of our agency policy on Abuse, Neglect and Exploitation, we inadvertently left out the wording that had previously been in the policy indicating that all investigations need to be completed with a summary of findings forwarded to the Administrator within five (5)	09/21/2012

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	continue to closely monitor [Client #1] closely (sic) and a follow-up will be scheduled with his Primary Care Physician if necessary." A review on 8/20/12 at 2:10 P.M. of the facility's "Investigative Report" of the 3/25/12 alleged abuse incident indicated the date the investigation was completed was 4/17/12. The facility's administrator was notified of the results of the investigation on 4/17/12. Program Director #1 was interviewed on 8/21/12 at 10:11 A.M.. Program Director #1 stated, "The investigation into the (3/25/12) alleged abuse incident was not completed until April 17th (2012) because we had to wait for CPS to complete their investigation." 9-3-1(b) 9-3-2(a)		business days. To rectify this, we are submitting a revision to our Abuse, Neglect & Exploitation policy to reinstate this wording. This revision will be complete by 09/21/2012.Going forward, it is the intention of Dungarvin Indiana to comply with the expectation of the State of Indiana regarding reporting the results of all investigations to the Administrator and other designated entities within five working days of the incident. System wide, all Program Director/QMRPs and Program Coordinators will review this standard and ensure that this concern is beign addressed at all Dungarvin ICF-MRs.	

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W0249	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, the facility failed to ensure staff implemented training objectives for 1 of 3 sampled clients (client #1). Findings include: Client #1 was observed at the group home during the 8/20/12 observation period from 3:45 P.M. until 7:00 P.M., and during the 8/21/12 observation period from 6:34 A.M. until 8:30 A.M. During the entirety of both observation periods, client #1 did not wear eyeglasses nor did direct care staff prompt or assist client #1 to wear his eyeglasses. Client #1's record was reviewed on 8/21/12 at 8:57 A.M. A review of the client's 3/8/12 Individual Program Plan indicated client #1 had the following objective: "Will wear his eyeglasses." Program Director #1 was interviewed on 8/21/12 at 10:11 A.M. Program Director #1 indicated direct care staff should have	W0249	All Wyandotte house staff are being retrained on the program objective for Client #1 to wear his eye glasses. Active treatment observations will be conducted by the Program Director/QMRP, House Lead Counselor, and/or Administrative Coordinator to ensure that direct support staff are consistently implementing this and other program objectives for Client #1 as well as for all individuals residing at the home. System wide, all Program Director/QMRPs will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MR's.	09/21/2012

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	implemented client #1's objective to wear his eyeglasses. 9-3-4(a)			

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W0382	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 a medication was locked except when it was being prepared for administration for 3 of 3 sampled clients (clients #1, #2, and #3), and 3 additional clients (clients #4, #5, and #6). Findings include: The group home where clients #1, #2, #3, #4, #5, and #6 resided was inspected during the 8/21/12 observation period from 6:34 A.M. until 8:30 A.M. At 6:45 A.M., a medication, Erythromycin Benzoyl Gel (topical anti-biotic cream) belonging to client #5 was laying, on a desk in the medication office area. The medication was in an unlocked, open area of the facility which was accessible by clients #1, #2, #3, #4, #5, and #6. Program Director #1 was interviewed on 8/21/12 at 10:11 A.M. Program Director #1 indicated direct care staff should have all medications locked when they are not being prepared for administration. 9-3-6(a)	W0382	We have reviewed the circumstances around this particular incident, and found that the medication that was laying on the desk in the medication area had just been delivered to the house from the pharmacy that afternoon. The staff on duty had failed to immediately secure this medication in a locked cabinet, as he was trained to do during his new staff orientation. While the medication was still in an unopened, sealed container, it was a risk to leave it lying on the table, accessible to all individuals in the home. To correct this, this incident is being addressed with the specific staff member responsible for leaving the medication out of the locked cabinet through re-training and disciplinary action. In addition, all staff at the Wyandotte home have received re-training on the expectation that all drugs and biologicals are required to be stored in a locked cabinet except when being prepared for administration.System wide, all Program Director/QMRPs and Facility Nurses will review this standard and ensure that this concern is being addressed at all Dungarvin ICF-MRs.	09/21/2012

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