

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00170468.</p> <p>Complaint #IN00170468: Substantiated, Federal/state deficiencies related to the allegations are cited at W102, W104, W120, W122, W149, W153, W154, W156, W157, W159, W189, W249 and W331.</p> <p>Unrelated deficiency cited at W248.</p> <p>Dates of Survey: May 21, 27, 28, 29 and June 1, 2015.</p> <p>Facility number: 012557 Provider number: 15G791 AIM number: 201017960A</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0102	483.410			

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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Bldg. 00	<p>GOVERNING BODY AND MANAGEMENT</p> <p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview, the Governing Body failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (clients A and B). The Governing Body neglected to prevent alleged neglect and/or abuse by not developing and/or implementing systematic policies and protocols in regard to alleged staff abuse and neglect of clients A and B resulting in significant injuries (fractured foot and self injury resulting in 21 stitches). The Governing Body neglected to ensure behavioral services by the behaviorist were provided at the group home, to clients A and B for their identified behavioral needs. The Governing Body neglected to ensure the facility's nursing services provided thorough assessments and medical care after alleged staff abuse/neglect. The Governing Body neglected to ensure the facility conducted thorough investigations in regard to alleged staff abuse and/or neglect.</p> <p>Findings include:</p> <p>1. Please refer to W122. The Governing Body failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (clients A and B). The</p>	W 0102	<p>W 102 483.410 GOVERNING BODY AND MANAGEMENT</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this CONDITION, and ensure Agency's abuse/neglect Policy is implemented at all times, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p>	07/01/2015

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	<p>Governing Body neglected to implement its written policy and procedures to prevent alleged abuse and/or neglect of clients, which resulted in significant injuries (fractured foot and self injury resulting in 21 stitches). The Governing Body neglected to put in place measures to prevent harm and recurrence in regard to alleged staff abuse and/or neglect.</p> <p>2. Please refer to W104. The Governing Body neglected to exercise general policy and operating direction over the facility for 2 of 2 sampled clients (clients A and B), in a manner to provide oversight to ensure their abuse and neglect policy was implemented. The facility's Governing Body neglected to immediately report incidents of alleged client abuse/neglect and failed to report the results of investigative findings in a timely manner. The facility's Governing Body neglected to exercise general operating direction in a manner to put measures in place to prevent alleged staff physical abuse and neglect which resulted in significant injuries (a fractured foot and self injury resulting in 21 stitches). The facility's Governing Body neglected to provide oversight to ensure clients A and B were provided behavior services as contracted with the Behaviorist. The facility's Governing Body neglected to exercise general operating direction in a manner to</p>		<p>B. All current and new staff have will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director,</p>	

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	<p>provide oversight to ensure staff showed competency in their job duties in regard to immediately reporting incidents of alleged abuse/neglect, documentation, implementing clients A and B's Behavior Support Plans (BSPs) as written to prevent alleged abuse/neglect and neglected to take effective/sufficient corrective action to prevent alleged abuse/neglect of clients A and B which resulted in significant injuries.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-1(a)</p>		<p>QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p>		

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			<p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential</p>	

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 2 of 2 sampled clients (clients A and B), the facility's Governing Body neglected to exercise general operating direction in a manner to provide oversight to ensure their abuse and neglect policy was implemented. The facility's Governing Body neglected to immediately report</p>	W 0104	<p>abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p> <p>W 104 483.410(a)(1) GOVERNING BODY</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure</p>	07/01/2015

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	<p>incidents of alleged staff to client abuse/neglect and failed to report the results of investigative findings in a timely manner. The facility's Governing Body neglected to exercise general operating direction in a manner to put measures in place to prevent alleged staff physical abuse and neglect which resulted in significant injuries (a fractured foot and self injury resulting in 21 stitches). The facility's Governing Body neglected to provide oversight to ensure clients A and B were provided behavior services as contracted with the Behaviorist. The facility's Governing Body neglected to exercise general operating direction in a manner to provide oversight to ensure staff showed competency in their job duties in regard to immediately reporting incidents of alleged abuse/neglect, documentation, implementing clients A and B's Behavior Support Plans (BSPs) as written to prevent alleged abuse/neglect and neglected to take effective/sufficient corrective action to prevent alleged abuse/neglect of clients A and B which resulted in significant injuries.</p> <p>Findings include:</p> <p>Please refer to W120: The Governing Body neglected to exercise general operating direction over the facility to</p>		<p>Agency's abuse/neglect Policy is implemented at all times, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of</p>	

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	<p>ensure the contracted behaviorist provided sufficient staff training and oversight to meet the behavioral support needs of 2 of 2 sampled clients (clients A and B).</p> <p>Please refer to W149: The Governing Body neglected to exercise general operating direction over the facility for 2 of 2 sampled clients residing at the group home (clients A and B), by not ensuring implementation of its written policy and procedure to prevent alleged abuse and neglect of clients. The facility neglected to ensure clients A and B did not sustain significant injuries (fractured foot and self injury resulting in 21 stitches). The facility neglected to ensure client A received timely nursing services in regard to assessing her injuries after alleged staff physical abuse. The facility neglected to conduct thorough investigations in regard to abuse and/or neglect allegations.</p> <p>Please refer to W153: The Governing Body neglected to exercise general operating direction over the facility by not ensuring for 2 of 2 sampled clients (clients A and B), to report allegations of staff abuse/neglect immediately to the administrator.</p> <p>Please refer to W154: The Governing Body neglected to exercise general</p>		<p>incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various</p>	

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	<p>operating direction over the facility for 2 of 2 sampled clients (clients A and B), to provide written evidence thorough investigations were conducted in regard to alleged abuse and/or neglect.</p> <p>Please refer to W157: The Governing Body neglected to exercise general operating direction of the facility for 2 of 2 sampled clients (clients A and B), to take sufficient/effective corrective measures in regard to preventing/addressing alleged staff abuse and neglect.</p> <p>Please refer to W189: The Governing Body neglected to exercise general operating direction over the facility for 2 of 2 sampled clients (clients A and B), to ensure all staff who worked with clients A and B were sufficiently trained to assure competence in regard to the clients' behavioral needs/plans.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-1(a)</p>		<p>and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and</p>	

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			<p>in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the</p>	

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W 0120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview, the facility failed to ensure the contracted behaviorist provided sufficient staff training and oversight to meet the behavioral support needs of 2 of 2 sampled clients (clients A and B).</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident</p>	W 0120	<p>Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p> <p>W 120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy is implemented at all times, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards</p>	07/01/2015	

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	<p>that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP</p>		<p>to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ol style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All</p>	

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	<p>that the [Name] that works at her home in the evening is the [Name] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14." Further review of the record failed to indicate the behaviorist retrained all staff at the group home on proper implementation of client B's BSP/Behavior Support Plan. Review of the record failed to indicate the behaviorist revisited client B's BSP after</p>		<p>assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
(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 documented incident.</p> <p>-BDDS report dated 5/23/15...Date of Knowledge: 5/24/15...Submitted Date: 5/25/15 involving client B indicated: "On 5/23/15 at approximately 4:03 P.M., [client B] was sitting at the dining room table talking with her birth mother on the telephone. Staff observed her crying and wiping the tears from her eyes. Later, staff then heard the back door slam, and staff ran down the hall, through the door in the common area in the back and out the door outside calling out to [client B]. [Client B] continued to run, and staff was able to stop her at the fence. [Client B] turned around and staff noticed a large cut on he neck. Staff called to co-worker for assistance, applied pressure to the injury until EMT's (sic) (Emergency Medical Technician), and coworker called 911, Area Director and nurse. The police officer arrived first and asked [client B] what happened. [Client B] went into details about the mom telling her that her sister ran away and was placed back into foster care. The officer explained to [client B] that there are other ways to deal with anger. [Client B] said she understood. Plan to Resolve: Staff followed protocol, called 911, applied first aid and notified nurse and administrator. Staff stayed in contact with the Nurse the whole duration of the</p>		<p>provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p>		

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>incident. EMTs transported [client B] to [Hospital] were (sic) she received 21 stitches from [Physician]. [Psych Hospital] was notified by hospital personnel due to suicide attempt. [Psych hospital] arrived and stated said (sic) that they had no facility for [client B] and that they told us this before and that her psych Doctor has a facility that he could admit her to in Indianapolis. [Client B] received a tetanus shot and blood was drawn (sic) the hospital served [client B] dinner. The ER (Emergency Room) Doctor refused to release [client B] to go home because of the fact that it was attempted suicide at 2:00 A.M. on 5/24/15. [Hospital] admitted [client B] to the hospital. AD/QIDP talked with staff on 5/25/15 and they stated they had been following protocol, and after the incident, they found a broken jar of Jalapeno's (sic) outside in the back of the house. AD/QIDP and [client B]'s IDT (Interdisciplinary Team) will evaluate this incident and develop further procedures to assist in ensuring [client B]'s health and safety at all times, before she returns to her home. Staff will continue to follow protocol and reporting procedure." Further review of the record failed to indicate the behaviorist retrained all staff at the group home on proper implementation of client B's BSP. Review of the record failed to indicate</p>		<p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>	

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>the behaviorist revisited client B's BSP after the documented incident.</p> <p>2. -Investigation record dated 3/26/15-4/9/15 for an incident that occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 approximately 10:25 A.M....Persons involved: [Client A] and [Staff #13]. Dates of Investigation: 3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated 12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch [client A]. [Staff #13] stated that he did not harm the individual. [Client A] stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but the (sic) was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The nurse was called between 7 P.M. and 8 P.M. on 3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due to an unsubstantiated allegation. I recommend all staff be retrained on properly documenting incidents. Date investigation was completed: 4/9/15." Review of the record failed to indicate the behaviorist retrained all staff in regard to client A's BSP. The record failed to indicate the behaviorist revisited client A's BSP in regard to the documented incident.</p> <p>-BDDS report dated 3/26/15 involving client A indicated: "On 3/26/15 [client A] told the QIDP that a staff bent her toe back breaking it after an incident in which she was agitated. The individual was seen by a doctor who told her to keep her leg elevated. Staff was suspended pending the out come of the investigation. Incident Follow-Up Report dated 4/10/15 indicated: "Was further treatment needed for the fractured foot? She is now wearing a boot prescribed by her podiatrist. What part of the foot is the fracture located? The front of the left foot between the upper foot and the toes. The result of the allegation is unsubstantiated."</p> <p>A review of client A's record was conducted on 5/27/15 at 10:50 A.M..</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Review of the record indicated a most current BSP dated 1/27/15. Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client A at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious Behavior (SIB). The record did not indicate the behaviorist revisited client A's 1/27/15 BSP after the documented incident.</p> <p>A review of client B's record was conducted on 5/27/15 at 11:30 A.M.. Review of the record indicated a most current BSP dated 4/7/14. Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client B at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious Behavior (SIB). The record did not indicate the behaviorist revisited client B's 4/7/14 BSP after the documented incidents. Review of client B's Behavioral Support Plan (BSP) dated 4/7/14 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>BEHAVIORS/PROBLEM</p> <p>BEHAVIORS): Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and scratching her lower forearms and face to the point of skin breakdown. [Client B] has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>Proactive Strategies:</p> <p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home from any community outing. This</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>strategy was discussed at a team meeting and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p> <p>...Staff should always be mindful of observing [client B]'s affect for moods that correlate with this target behavior....</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Walking with or accompanying/escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and yours, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder.</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual." Client B's BSP did not indicate staff should have "Taken down" client B. Further review of the record failed to indicate the contract behaviorist provided behavior services weekly at the group home for client B.</p> <p>FOLLOW-UP:</p> <p>All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness." Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client B at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
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	<p>Behavior (SIB). The record did not indicate the behaviorist retrained staff after each incident and did not indicate the client's BSP was revisited after the incidents.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 5/29/15 at 1:30 P.M.. DSP #1 indicated she had not been trained on clients A and B's BSPs by the behaviorist. DSP #1 indicated she has many questions and is confused in regard to how to implement the clients' BSPs because she gets different information from different people. DSP #1 indicated when she asked the behaviorist how to address clients A and B's identified needs, the behaviorist informed her to ignore the clients behavior and give them space.</p> <p>An interview with the Area Director (AD) was conducted on 5/29/15 at 4:15 P.M.. The AD indicated the contract Behaviorist should be at the group home at least 10 hours per week. When asked for documentation to indicate when the behaviorist went to the group home weekly, the AD indicated there was no documentation at the facility to indicate the facility kept track of when the contract behaviorist provided services at the group home on a weekly basis. The AD further indicated the facility should</p>				

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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(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>have written documentation to indicate when the contract behaviorist provided contracted services to the clients and staff at the group home.</p> <p>A review of the contract Behaviorist contract dated 12/16/13 was conducted on 5/27/15 at 6:00 P.M.. Review of the contract indicated in part, but was not limited to: "...Time Devoted by Behavioral Consultant. It is anticipated the behavioral consultant will spend approximately 40-45 hours per month in each ESN (extensive support needs) home for a total of 80-90 hours per month in fulfilling its obligation under this contract. The particular amount of time may vary from day to day or week to week with the exception being the behavior consultant will spend 10 hours of direct observation in each home weekly. However, the behavior consultant shall devote a minimum of 40 hours per month per home to its duties in accordance with this agreement....Review services: The Behavioral Consultant will perform reviews of Behavioral Support Plans...The review will be completed as each document is written/rewritten for each consumer, generally upon admission, annually, and as new behavioral needs emerge...."</p> <p>This federal tag relates to complaint</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0122 Bldg. 00	#IN000170468. 9-3-1(a) 483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (clients A and B). The facility neglected to implement its written policy and procedure to prevent alleged abuse and/or neglect of clients A and B, which resulted in significant injuries (fractured foot and a self injury	W 0122	W 122 483.420 CLIENT PROTECTIONS In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this CONDITION, and ensure Agency's abuse/neglect Policy and	07/01/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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(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>resulting in 21 stitches).</p> <p>Findings include:</p> <p>1. Please refer to W149: The facility neglected for 2 of 2 sampled clients (clients A and B), to implement its written policy and procedure to prevent alleged neglect and/or abuse of a client. The facility neglected to ensure client A was not neglected by staff. The facility neglected to ensure client A received timely nursing services in regard to conducting an assessment of injuries after staff alleged physical abuse.</p> <p>2. Please refer to W153: The facility neglected for 1 of 2 sampled clients (client A), to report an allegation of staff abuse/neglect immediately to the administrator.</p> <p>3. Please refer to W154: The facility neglected for 2 of 2 sampled clients (clients A and B), to provide written evidence thorough investigations were conducted in regard to alleged physical abuse and/or neglect.</p> <p>4. Please refer to W156: The facility neglected to report the results of 3 of 3 reviewed investigations of allegations of staff abuse and Self Injurious Behaviors (SIB) resulting in significant injury (21</p>		<p>Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
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	<p>stitches), involving 2 of 2 sampled clients (clients A and B), to the administrator within five business days.</p> <p>5: Please refer to W157: The facility neglected for 2 of 2 sampled clients (clients A and B), to take sufficient/effective corrective measures in regard to addressing alleged staff neglect of clients which resulted in Self Injurious Behavior (SIB) with injury.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-2(a)</p>		<p>Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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			<p>day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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			<p>in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0149 Bldg. 00	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, the facility neglected for 2 of 2 sampled clients (clients A and B), to implement its written policy and procedure to prevent alleged abuse and neglect of clients. The facility neglected to ensure clients A and B were sufficiently monitored by staff which resulted in significant injuries (fractured foot and self injury resulting in 21 stitches). The facility neglected to ensure client A received timely medical attention and nursing services in regard to assessing her injuries resulting in a fractured foot. The facility neglected to prevent client B from elopement which led to her incarceration. The facility neglected to conduct thorough investigations in regard to allegations of staff abuse and neglect.	W 0149	affect the health and safety of the Individuals served. Will be completed by: 7/1/15 Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and	07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and</p>		<p>ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
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	denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead Staff name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Male Group Home Staff Name] that works at her home in the evening is the [Staff #13] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The		of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record. D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc. E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect. A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These		

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
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	<p>investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14." Review of this record failed to indicate all staff who worked at the group home were interviewed. Review of the record failed to indicate all clients who reside at the group home were interviewed. Review of the record failed to indicate this incident of alleged staff abuse was immediately reported to the administrator. Review of this record failed to indicate this investigation of alleged staff abuse was concluded, and the findings were reported to the administrator within 5 business days. Review of the record failed to indicate all staff who worked at the group home were retrained on the clients' plans. Review of this record failed to indicate the facility put measures in place to prevent recurrence.</p> <p>-BDDS report dated 5/11/15 involving client B indicated: "On 5/11/15 at approximately 6:30 P.M. [client B] had just finished eating dinner. House mate asked staff could she talk to her. Staff</p>		<p>visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p>		

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
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	<p>went and sat with other house mate to see what she wanted. [Client B] then went outside. She was in the line of sight. Staff let her stay out there for 3-5 minutes before going to talk to her. When housemate talked to her she said she didn't want to come back into the house. When staff tried to talk to [client B], she was verbally aggressive. Staff then redirected [client B] and asked her did she want to get her jello. [Client B] then stated that she didn't want to be in this house any more because her house mate gets away with everything. This is when [client B] took off from staff. Staff yelled for other staff to come so that they could prevent her from leaving. She made it out of the sub-division. Staff followed her on foot, and other staff was driving behind us. [Client B] was picking up sticks and rocks a long (sic) the way throwing them at staff on foot and the van. AD coached staff and staff followed her behavior protocol and followed her to ensure her health and safety. [Client B] never got close to the neighbor or her property. She was being verbally and physically aggressive towards staff. At one point, [client B] picked up landscaping stone and threw it at the van, shattering the windshield. [Client B] refused to go back to the home, continued walking and ended up walking along a highway. Since it was</p>		<p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>becoming dark, and she was walking along a busy highway, to ensure her health and safety, the AD instructed staff to call the police for assistance. Before the police arrived, staff tried talking to [client B] again, telling her that she needed to calm down so that we can talk about what's going on and that they needed to get back to the house. She started yelling and saying that she hates this house and she doesn't want to go back. When the police arrived, they asked [client B] what was the problem, and she began being aggressive. They told her if she calms down she can go back to the house. When staff was explaining to her the same thing, she charged towards staff and that is when the police grabbed her and handcuffed her. While she was in handcuffs, the police officers were still trying to calm her down but she wasn't calming down, she charged at staff again, and that is when they put her in the car and stated they were taking her to jail. While in the car, [client B] was banging her head on the door. Plan to Resolve: Staff followed [client's HRC (Human Rights Committee) approved BSP protocol, followed her, ensured her health and safety, and reported the incident to the supervisor. Area Director (AD) maintained frequent phone contact with staff and provided support. [Client B]'s</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>nurse provided the jail with all information needed. The jail was contacted today, 5/15/15 at 2:20 P.M., and we were informed she had not yet been processed and we should try again tomorrow. Facility will contact the jail tomorrow to obtain her hearing date, bail amount, charges, etc. The facility will bail [client B] out as soon as possible and QIDP will update when further info is obtained. Staff will continue to follow protocol and [client B]'s IDT (Interdisciplinary Team) will continue to review her BSP and revise as necessary to best assist her in controlling her aggressive behavior....[Client B] was released from jail on the afternoon of 5/14/15 (sic)...." Review of the record did not indicate staff attempted to physically escort her back to the home or implement an approved DCI (crisis intervention) technique as written in her 4/7/14 Behavior Support Plan.</p> <p>-BDDS report dated 5/23/15...Date of Knowledge: 5/24/15...Submitted Date: 5/25/15 involving client B indicated: "On 5/23/15 at approximately 4:03 P.M., [client B] was sitting at the dining room table talking with her birth mother on the telephone. Staff observed her crying and wiping the tears from her eyes. Later, staff then heard the back door slam, and staff ran down the hall, through the door</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>in the common area in the back and out the door outside calling out to [client B]. [Client B] continued to run, and staff was able to stop her at the fence. [Client B] turned around and staff noticed a large cut on her neck. Staff called to co-worker for assistance, applied pressure to the injury until EMT's (sic) (Emergency Medical Technician), and coworker called 911, Area Director and nurse. The police officer arrived first and asked [client B] what happened. [Client B] went into details about the mom telling her that her sister ran away and was placed back into foster care. The officer explained to [client B] that there are other ways to deal with anger. [Client B] said she understood. Plan to Resolve: Staff followed protocol, called 911, applied first aid and notified nurse and administrator. Staff stayed in contact with the Nurse the whole duration of the incident. EMTs transported [client B] to [Hospital] were (sic) she received 21 stitches from [Physician]. [Psych Hospital] was notified by hospital personnel due to suicide attempt. [Psych hospital] arrived and stated said (sic) that they had no facility for [client B] and that they told us this before and that her psych Doctor has a facility that he could admit her to in Indianapolis. [Client B] received a tetanus shot and blood was drawn (sic) the hospital served [client B]</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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(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>dinner. The ER (Emergency Room) Doctor refused to release [client B] to go home because of the fact that it was attempted suicide at 2:00 A.M. on 5/24/15. [Hospital] admitted [client B] to the hospital. AD/QIDP talked with staff on 5/25/15 and they stated they had been following protocol, and after the incident, they found a broken jar of Jalapeno's (sic) outside in the back of the house. AD/QIDP and [client B]'s IDT (Interdisciplinary Team) will evaluate this incident and develop further procedures to assist in ensuring [client B]'s health and safety at all times, before she returns to her home. Staff will continue to follow protocol and reporting procedure."</p> <p>A review of client B's record was conducted on 5/27/15 at 11:30 A.M.. Review of client B's Behavioral Support Plan (BSP) dated 4/7/14 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS): Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
(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>her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and scratching her lower forearms and face to the point of skin breakdown. [Client B] has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>3. Elopement: Intervention Steps: ...If [client B] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>Proactive Strategies:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home from any community outing. This strategy was discussed at a team meeting and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p> <p>...Staff should always be mindful of observing [client B]'s affect for moods that correlate with this target behavior....</p> <p>BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and yours, hugging along the person's natural waist. This may be combined with another staff</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>"All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness." Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client B at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious Behavior (SIB). The record did not indicate the behaviorist revisited the BSP after the documented incidents.</p> <p>A review of the facility's records was conducted on 5/29/15 at 3:00 P.M.. Review of the group home staff "House Sweeps" logs in which staff documented room sweeps were to be conducted daily on every staff scheduled working shift dated 4/29/15 to 5/29/15 indicated no room sweeps were conducted on: 5/4/15 for the 3P.M. to 11P.M. shift, 5/5/15 for the 3P.M. to 11 P.M. shift, 5/10/15 for the 11 P.M. to 7 A.M. shift, 5/18/15 for the 11 P.M. to 7 A.M. shift, 5/25/15 for the 11 P.M. to 7 A.M. shift, 5/27/15 for the 11 P.M. to 7 A.M. shift, and 5/28/15 for the 11 P.M. to 7 A.M. shift.</p> <p>Review of the "Room Sweeps" for client B's bedroom dated 5/16/15 to 5/29/15</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>indicated no bedroom sweeps were conducted on: 5/17/15 for the 11 P.M. to 7 A.M. shift, 5/19/15 for the 11 P.M. to 7 A.M. shift, No sweeps were conducted for any shift on 5/24/15, 5/25/15 for the 11 P.M. to 7 A.M. shift, 5/26/15 for the 11 P.M. to 7 A.M. shift, 5/27/15 for the 11 P.M. to 7 A.M. shift, and 5/28/15 for the 11 P.M. to 7 A.M. shift. No documentation was submitted for review to indicate the facility ensured home and bedroom searches for sharps were conducted on each shift daily by group home staff.</p> <p>2. -Investigation record dated 3/26/15-4/9/15 for an incident that occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 approximately 10:25 A.M....Persons involved: [Client A] and [Staff #13]. Dates of Investigation: 3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch [client A]. [Staff #13] stated that he did not harm the individual. [Client A] stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but there was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The nurse was called between 7 P.M. and 8 P.M. on 3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior</p>						

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due to an unsubstantiated allegation. I recommend all staff be retrained on properly documenting incidents. Date investigation was completed: 4/9/15."</p> <p>Review of the record failed to indicate all staff who worked at the group home were interviewed. Review of the record failed to indicate all clients who reside at the group home were interviewed. Review of the record failed to indicate the facility's nursing services assessed client A's foot after being notified of her complaining of pain on 3/23/15. The report failed to indicate the facility sought timely medical attention of client A's foot injury. The record failed to indicate the facility put measures in place to prevent reoccurrence. The record</p>			

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--	---	--	---

NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
---	---

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	<p>failed to indicate all staff who worked at the group home were retrained in regard to implementing client A's BSP. The record failed to indicate the administrator was notified of the findings of the investigation within 5 business days. Review of the record failed to indicate staff documented client A's SIB.</p> <p>-BDDS report dated 3/26/15 involving client A indicated: "On 3/26/15 [client A] told the QIDP that a staff bent her toe back breaking it after an incident in which she was agitated. The individual was seen by a doctor who told her to keep her leg elevated. Staff was suspended pending the out come (sic) of the investigation. Incident Follow-Up Report dated 4/10/15 indicated: "Was further treatment needed for the fractured foot? She is now wearing a boot prescribed by her podiatrist. What part of the foot is the fracture located? The front of the left foot between the upper foot and the toes. The result of the allegation is unsubstantiated."</p> <p>A review of client A's record was conducted on 5/28/15 at 12:30 P.M.. Review of client A's record indicated a "Medical Visit Summary" dated 3/24/15: "Reason for Visit: Foot injury. Possible foot fracture, sent for x-ray. 3/25/15: X-ray showed foot fracture, referring to</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
(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>Podiatry and ordering a boot to use." Further review failed to indicate the facility's nursing services assessed client A's foot after being notified of her complaining of pain on 3/23/15. Review of the record indicated the facility did not take client A for medical attention on 3/23/15. Review of the GER dated 3/23/15 indicated client A complained of foot pain.</p> <p>An interview with client A was conducted on 5/29/15 at 1:50 P.M. Client A was asked if she could tell this surveyor what happened during the documented incident on 3/23/15. Client A stated: "[Direct Support Professional (DSP) #13] grabbed my toes and bent them back and broke my toe." When asked if she could show me what happened, client A nodded her head indicating "yes" and grabbed her four fingers on her right hand, with her left hand, and pulled them backwards. When asked if there was any other staff present when the incident happened, client A shook her head indicating "no." When asked if she kicked her bedroom walls, client A shook her head indicating "no." When asked when her foot began to hurt, client A stated: "The same day." When asked if she told staff her foot hurt, client A nodded her head indicating "yes." When asked did she go to the doctor the</p>				

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
---	---

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	<p>same day, client A shook her head indicating "no."</p> <p>A review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation," dated 2/27/14 was conducted at the facility's administrative office on 5/27/15 at 6:30 P.M. and 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' (sic) served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a 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</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
---	---

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	<p>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:</p> <ol style="list-style-type: none"> 1. Review of witnesses. 2. Any evidence or previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the charge." <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The AD indicated all clients should be free of abuse and neglect. The AD indicated thorough investigations should be completed in regard to all incidents of alleged abuse and/or neglect. The AD indicated all incidents of alleged abuse and/or neglect should be immediately</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
---	---

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	<p>reported to the administrator and within 24 hours to BDDS. The AD indicated Staff #13 was terminated from employment due to an incident of client abuse at another group home. The AD indicated staff are to do room sweeps and house sweeps every shift for sharp items clients A and B may potentially harm themselves with. The AD indicated the glass jar should have been removed prior to client B's SIB. The AD indicated the facility's nursing staff should assess clients when they complain of pain. The AD indicated the nurse is to document in the client's record when they assess clients. When asked if any corrective measures were put in place by the IDT to prevent recurrence, the AD indicated staff implemented the clients' BSPs as written and will continue to follow them as written.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed for 2 of 2 sampled clients (clients A and B), to report allegations of staff abuse/neglect immediately to the administrator or to the Bureau of Developmental Disabilities Services (BDDS) according to state law.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation</p>	W 0153	<p>W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as</p>	07/01/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Name] that works at her home in the evening is the [Name] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact:</p>		<p>required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ul style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out</p>	

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	<p>[Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14." Review of the record failed to indicate this incident, that occurred on 11/10/14 of alleged staff abuse, was immediately reported to the administrator.</p> <p>2. -Investigation record dated 3/26/15-4/9/15 for an incident that occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 approximately 10:25 A.M....Persons involved: [Client A] and [Staff #13]. Dates of Investigation:</p>		<p>of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is</p>	

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	<p>3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated 12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch [client A]. [Staff #13] stated that he did not harm the individual. [Client A] stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but there was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The nurse was called between 7 P.M. and 8 P.M. on</p>		<p>completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p>				

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	<p>3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due to an unsubstantiated allegation. I recommend all staff be retrained on properly documenting incidents. Date investigation was completed: 4/9/15." Review of the record failed to indicate all staff who worked at the group home were interviewed. Review of the record failed to indicate all clients who reside at the group home were interviewed. Review of the record failed to indicate this</p>		<p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>		

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	<p>incident was reported to BDDS in a timely manner.</p> <p>-BDDS report dated 3/26/15 involving client A indicated: "On 3/26/15 [client A] told the QIDP that a staff bent her toe back breaking it after an incident in which she was agitated. The individual was seen by a doctor who told her to keep her leg elevated. Staff was suspended pending the out come (sic) of the investigation. Incident Follow-Up Report dated 4/10/15 indicated: "Was further treatment needed for the fractured foot? She is now wearing a boot prescribed by her podiatrist. What part of the foot is the fracture located? The front of the left foot between the upper foot and the toes. The result of the allegation is unsubstantiated." Review of this report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>BDDS report dated 5/23/15...Date of Knowledge: 5/24/15...Submitted Date: 5/25/15 involving client B indicated: "On 5/23/15 at approximately 4:03 P.M., [client B] was sitting at the dining room table talking with her birth mother on the telephone. Staff observed her crying and wiping the tears from her eyes. Later, staff then heard the back door slam, and staff ran down the hall, through the door in the common area in the back and out</p>			

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	<p>the door outside calling out to [client B]. [Client B] continued to run, and staff was able to stop her at the fence. [Client B] turned around and staff noticed a large cut on he neck. Staff called to co-worker for assistance, applied pressure to the injury until EMT's (sic) (Emergency Medical Technician), and coworker called 911, Area Director and nurse. The police officer arrived first and asked [client B] what happened. [Client B] went into details about the mom telling her that her sister ran away and was placed back into foster care. The officer explained to [client B] that there are other ways to deal with anger. [Client B] said she understood. Plan to Resolve: Staff followed protocol, called 911, applied first aid and notified nurse and administrator. Staff stayed in contact with the Nurse the whole duration of the incident. EMTs transported [client B] to [Hospital] were (sic) she received 21 stitches from [Physician]. [Psych Hospital] was notified by hospital personnel due to suicide attempt. [Psych hospital] arrived and stated said (sic) that they had no facility for [client B] and that they told us this before and that her psych Doctor has a facility that he could admit her to in Indianapolis. [Client B] received a tetanus shot and blood was drawn the hospital (sic) served [client B] dinner. The ER (Emergency Room)</p>			
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	<p>Doctor refused to release [client B] to go home because of the fact that it was attempted suicide at 2:00 A.M. on 5/24/15. [Hospital] admitted [client B] to the hospital. AD/QIDP talked with staff on 5/25/15 and they stated they had been following protocol, and after the incident, they found a broken jar of Jalapeno's (sic) outside in the back of the house. AD/QIDP and [client B]'s IDT (Interdisciplinary Team) will evaluate this incident and develop further procedures to assist in ensuring [client B]'s health and safety at all times, before she returns to her home. Staff will continue to follow protocol and reporting procedure." Review of the record indicated the administrator was not immediately notified of the incident. Further review of the report failed to indicate this incident was reported to BDDS in a timely manner.</p> <p>An interview with the Area Director/Qualified Intellectual Disabilities Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The AD/QIDP indicated the staff should have immediately reported the allegations of staff abuse/neglect to him. The AD/QIDP further indicated the staff did not immediately report the allegations of staff abuse/neglect to him.</p>			

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W 0154 Bldg. 00	<p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-1(b) 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 2 sampled clients (client B), the facility failed to provide written evidence a thorough investigation was conducted in regard to an allegation of staff physical abuse.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily</p>	W 0154	<p>W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing</p>	07/01/2015

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	<p>Progress Notes and an investigation record indicated:</p> <p>-Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead name] stated she was told by [client B] that she</p>		<p>services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ol style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. 				

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	<p>lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Name] that works at her home in the evening is the [Name] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14." Review of this record failed to indicate all staff who</p>		<p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure</p>	

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	<p>worked at the group home were interviewed. Review of the record failed to indicate all clients who reside at the group home were interviewed.</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The AD indicated the prior Qualified Intellectual Disabilities Professional (QIDP) should have conducted a thorough investigation in regard to alleged staff abuse. The AD indicated the QIDP did not conduct a thorough investigation in regard to this incident. No written documentation was submitted for review to indicate a thorough investigation was conducted in regard to this allegation of abuse.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-2(a)</p>		<p>the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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			<p>will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p>	

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W 0156 Bldg. 00	<p>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 report the results of 2 of 3 reviewed investigations of allegations of staff abuse, involving 2 of 2 sampled clients (clients A and B), to the administrator within five business days.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and investigation records indicated:</p> <p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event</p>			W 0156	<p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p> <p>W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect</p>		07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead Staff name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Male Group Home Staff Name] that works at her home in</p>		<p>through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ol style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be</p>		

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	<p>the evening is the [Staff #13] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14." Review of this record failed to indicate this investigation of alleged staff abuse was concluded, and the findings were reported to the administrator within 5 business days.</p> <p>2. -Investigation record dated 3/26/15-4/9/15 for an incident that</p>		<p>promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to</p>		

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	<p>occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 approximately 10:25 A.M....Persons involved: [Client A] and [Staff #13]. Dates of Investigation: 3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated 12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch [client A]. [Staff #13] stated that he did not harm the individual. [Client A]</p>		<p>each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p>		

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	<p>stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but there was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The nurse was called between 7 P.M. and 8 P.M. on 3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due to an unsubstantiated allegation. I recommend all staff be retrained on</p>		<p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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W 0157 Bldg. 00	<p>properly documenting incidents. Date investigation was completed: 4/9/15." The record failed to indicate the administrator was notified of the findings of the investigation within 5 business days.</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The AD/QIDP indicated the results of the investigations should have been reported to the administrator within 5 business days. The AD/QIDP further indicated the results of the investigations were not reported to the administrator within 5 business days.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for</p>	W 0157		07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>2 of 2 sampled clients (clients A and B), the facility failed to take sufficient/effective corrective measures in regard to preventing/addressing alleged staff neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and investigation records indicated:</p> <p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist]</p>		<p>W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead Staff name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Male Group Home Staff Name] that works at her home in the evening is the [Staff #13] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13]</p>		<p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation</p>	

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room.</p> <p>Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14." Review of this record failed to indicate the facility took sufficient/effective corrective action to prevent recurrence.</p> <p>2. -BDDS report dated 5/11/15 involving client B indicated: "On 5/11/15 at approximately 6:30 P.M. [client B] had just finished eating dinner. House mate asked staff could she talk to her. Staff went and sat with other house mate to see what she wanted. [Client B] then went outside. She was in the line of sight. Staff let her stay out there for 3-5 minutes before going to talk to her. When housemate talked to her she said she didn't want to come back into the house. When staff tried to talk to [client B], she was verbally aggressive. Staff then redirected [client B] and asked her did she want to get her jello. [Client B] then</p>		<p>and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>stated that she didn't want to be in this house any more because her house mate gets away with everything. This is when [client B] took off from staff. Staff yelled for other staff to come so that they could prevent her from leaving. She made it out of the sub-division. Staff followed her on foot, and other staff was driving behind us. [Client B] was picking up sticks and rocks a long (sic) the way throwing them at staff on foot and the van. AD (Area Director) coached staff and staff followed her behavior protocol and followed her to ensure her health and safety. [Client B] never got close to the neighbor or her property. She was being verbally and physically aggressive towards staff. At one point, [client B] picked up landscaping stone and threw it at the van, shattering the windshield. [Client B] refused to go back to the home, continued walking and ended up walking along a highway. Since it was becoming dark, and she was walking along a busy highway, to ensure her health and safety, the AD instructed staff to call the police for assistance. Before the police arrived, staff tried talking to [client B] again, telling her that she needed to calm down so that we can talk about what's going on and that they needed to get back to the house. She started yelling and saying that she hates this house and she doesn't want to go</p>		<p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	back. When the police arrived, they asked [client B] what was the problem, and she began being aggressive. They told her if she calms down she can go back to the house. When staff was explaining to her the same thing, she charged towards staff and that is when the police grabbed her and handcuffed her. While she was in handcuffs, the police officers were still trying to calm her down but she wasn't calming down, she charged at staff again, and that is when they put her in the car and stated they were taking her to jail. While in the car, [client B] was banging her head on the door. Plan to Resolve: Staff followed [client B's] HRC (Human Rights Committee) approved BSP protocol, followed her, ensured her health and safety, and reported the incident to the supervisor. Area Director (AD) maintained frequent phone contact with staff and provided support. [Client B]'s nurse provided the jail with all information needed. The jail was contacted today, 5/15/15 at 2:20 P.M., and we were informed she had not yet been processed and we should try again tomorrow. Facility will contact the jail tomorrow to obtain her hearing date, bail amount, charges, etc. The facility will bail [client B] out as soon as possible and QIDP will update when further info is obtained. Staff will continue to follow		Individuals served to Area Director. - C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served. Will be completed by: 7/1/15 Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist	

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	<p>protocol and [client B]'s IDT (Interdisciplinary Team) will continue to review her BSP and revise as necessary to best assist her in controlling her aggressive behavior....[Client B] was released from jail on the afternoon of 5/14/15 (sic)...." Review of the record did not indicate staff attempted to physically escort her back to the home or implement an approved DCI (crisis intervention) technique as written in her 4/7/14 Behavior Support Plan.</p> <p>3. -BDDS report dated 5/23/15...Date of Knowledge: 5/24/15...Submitted Date: 5/25/15 involving client B indicated: "On 5/23/15 at approximately 4:03 P.M., [client B] was sitting at the dining room table talking with her birth mother on the telephone. Staff observed her crying and wiping the tears from her eyes. Later, staff then heard the back door slam, and staff ran down the hall, through the door in the common area in the back and out the door outside calling out to [client B]. [Client B] continued to run, and staff was able to stop her at the fence. [Client B] turned around and staff noticed a large cut on her neck. Staff called to co-worker for assistance, applied pressure to the injury until EMT's (sic) (Emergency Medical Technician), and coworker called 911. Area Director and nurse. The police officer arrived first and</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>asked [client B] what happened. [Client B] went into details about the mom telling her that her sister ran away and was placed back into foster care. The officer explained to [client B] that there are other ways to deal with anger. [Client B] said she understood. Plan to Resolve: Staff followed protocol, called 911, applied first aid and notified nurse and administrator. Staff stayed in contact with the Nurse the whole duration of the incident. EMTs transported [client B] to [Hospital] were (sic) she received 21 stitches from [Physician]. [Psych Hospital] was notified by hospital personnel due to suicide attempt. [Psych hospital] arrived and stated said (sic) that they had no facility for [client B] and that they told us this before and that her psych Doctor has a facility that he could admit her to in Indianapolis. [Client B] received a tetanus shot and blood was drawn the hospital served [client B] dinner. The ER (Emergency Room) Doctor refused to release [client B] to go home because of the fact that it was attempted suicide at 2:00 A.M. on 5/24/15. [Hospital] admitted [client B] to the hospital. AD/QIDP talked with staff on 5/25/15 and they stated they had been following protocol, and after the incident, they found a broken jar of Jalapeno's (sic) outside in the back of the house. AD/QIDP and [client B]'s IDT</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>(Interdisciplinary Team) will evaluate this incident and develop further procedures to assist in ensuring [client B]'s health and safety at all times, before she returns to her home. Staff will continue to follow protocol and reporting procedure."</p> <p>4. -Investigation record dated 3/26/15-4/9/15 for an incident that occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 approximately 10:25 A.M....Persons involved: [Client A] and [Staff #13]. Dates of Investigation: 3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated 12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of</p>						

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	<p>the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch [client A]. [Staff #13] stated that he did not harm the individual. [Client A] stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but there was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The nurse was called between 7 P.M. and 8 P.M. on 3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated</p>			
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due to an unsubstantiated allegation. I recommend all staff be retrained on properly documenting incidents. Date investigation was completed: 4/9/15." The record failed to indicate the facility put measures in place to prevent reoccurrence. The record failed to indicate all staff who worked at the group home were retrained in regard to implementing client A's BSP.</p> <p>5. -BDDS report dated 3/26/15 involving client A indicated: "On 3/26/15 [client A] told the QIDP that a staff bent her toe back breaking it after an incident in which she was agitated. The individual was seen by a doctor who told her to keep her leg elevated. Staff was suspended pending the out come (sic) of the investigation. Incident Follow-Up Report dated 4/10/15 indicated: "Was further treatment needed for the fractured foot? She is now wearing a boot prescribed by her podiatrist. What part of the foot is the fracture located? The front of the left foot between the upper foot</p>						

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>and the toes. The result of the allegation is unsubstantiated."</p> <p>A review of client A's record was conducted on 5/28/15 at 12:30 P.M.. Review of client A's record indicated a "Medical Visit Summary" dated 3/24/15 which indicated: "Reason for Visit: Foot injury. Possible foot fracture, sent for x-ray. 3/25/15: X-ray showed foot fracture, referring to Podiatry and ordering a boot to use." Further review failed to indicate the facility's nursing services assessed client A's foot after being notified of her complaining of pain on 3/23/15. Review of the record indicated the facility did not take client A for medical attention on 3/23/15.</p> <p>No documentation was available for review to indicate the facility took sufficient/effective corrective action to prevent recurrence.</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The AD indicated staff still implements clients A and B's plans as written. When asked if any measures were put in place to prevent recurrence, the AD indicated staff were retrained on the clients' BSPs.</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0159 Bldg. 00	<p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the PD/Qualified Intellectual Disabilities Professional (PD/QIDP) failed for 2 of 2 sampled clients (clients A and B), to coordinate services and ensure measures were put in place to prevent alleged abuse/neglect.</p> <p>Findings include:</p> <p>Please refer to W120: The facility failed to ensure the contracted behaviorist provided sufficient staff training and oversight to meet the behavioral support</p>	W 0159	<p>W 159 483.430(a) QMRP</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times, to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals'</p>	07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
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	<p>needs of 2 of 2 sampled clients (clients A and B).</p> <p>Please refer to W189: The facility failed for 2 of 2 sampled clients (clients A and B), to ensure all staff who worked with clients A and B were sufficiently trained to assure competence in regard to the client's behavioral needs/plans.</p> <p>Please refer to W249: The facility failed for 2 of 2 sampled clients (clients A and B), to properly implement their Behavior Support Plans (BSP).</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-3(a)</p>		<p>behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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			<p>intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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(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>procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has</p>	

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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			<p>been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0189 Bldg. 00	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 2 of 2 sampled clients (clients A and B), the facility failed to ensure all staff who worked with clients A and B were sufficiently trained to assure competence in regard to the client's behavioral needs/plans.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event</p>	W 0189	<p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p> <p>W 189 483.430(e)(1) TRAINING PROGRAM</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy and Procedure is implemented at all times (Including providing sufficient staff at all times for the needs of the individuals), to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards</p>	07/01/2015
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Name] that works at her home in the evening is the [Name] that choked her</p>		<p>to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>v. Agency Policy and Procedure concerning reporting to supervisor when insufficient staff are on duty at any time.</p>				

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	<p>the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14."</p> <p>-BDDS report dated 5/23/15...Date of Knowledge: 5/24/15...Submitted Date: 5/25/15 involving client B indicated: "On 5/23/15 at approximately 4:03 P.M., [client B] was sitting at the dining room table talking with her birth mother on the telephone. Staff observed her crying and</p>		<p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>F. Area Director will work with HR Department and Agency Team to hire and retain sufficient staff, so that home will consistently have sufficient staff for client's needs.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various</p>	

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	<p>wiping the tears from her eyes. Later, staff then heard the back door slam, and staff ran down the hall, through the door in the common area in the back and out the door outside calling out to [client B]. [Client B] continued to run, and staff was able to stop her at the fence. [Client B] turned around and staff noticed a large cut on her neck. Staff called to co-worker for assistance, applied pressure to the injury until EMT's (sic) (Emergency Medical Technician), and coworker called 911, Area Director and nurse. The police officer arrived first and asked [client B] what happened. [Client B] went into details about the mom telling her that her sister ran away and was placed back into foster care. The officer explained to [client B] that there are other ways to deal with anger. [Client B] said she understood. Plan to Resolve: Staff followed protocol, called 911, applied first aid and notified nurse and administrator. Staff stayed in contact with the Nurse the whole duration of the incident. EMTs transported [client B] to [Hospital] were (sic) she received 21 stitches from [Physician]. [Psych Hospital] was notified by hospital personnel due to suicide attempt. [Psych hospital] arrived and stated said (sic) that they had no facility for [client B] and that they told us this before and that her psych Doctor has a facility that he could admit</p>		<p>and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and</p>	

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	<p>her to in Indianapolis. [Client B] received a tetanus shot and blood was drawn (sic) the hospital served [client B] dinner. The ER (Emergency Room) Doctor refused to release [client B] to go home because of the fact that it was attempted suicide at 2:00 A.M. on 5/24/15. [Hospital] admitted [client B] to the hospital. AD/QIDP talked with staff on 5/25/15 and they stated they had been following protocol, and after the incident, they found a broken jar of Jalapeno's (sic) outside in the back of the house. AD/QIDP and [client B]'s IDT (Interdisciplinary Team) will evaluate this incident and develop further procedures to assist in ensuring [client B]'s health and safety at all times, before she returns to her home. Staff will continue to follow protocol and reporting procedure."</p> <p>A review of the facility's records was conducted on 5/29/15 at 3:00 P.M.. Review of the group home staff "House Sweeps" logs in which staff documented room sweeps that were to be conducted daily on every staff scheduled working shift dated 4/29/15 to 5/29/15 indicated no room sweeps for client B were conducted on: 5/4/15 for the 3P.M. to 11P.M. shift, 5/5/15 for the 3P.M. to 11 P.M. shift, 5/10/15 for the 11 P.M. to 7 A.M. shift,</p>		<p>in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the</p>		

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>5/18/15 for the 11 P.M. to 7 A.M. shift, 5/25/15 for the 11 P.M. to 7 A.M. shift, 5/27/15 for the 11 P.M. to 7 A.M. shift, and 5/28/15 for the 11 P.M. to 7 A.M. shift.</p> <p>Review (5/29/15 at 3:00 P.M.) of the "Room Sweeps" for client A's bedroom dated 5/16/15 to 5/29/15 indicated no bedroom sweeps were conducted on: 5/17/15 for the 11 P.M. to 7 A.M. shift, 5/19/15 for the 11 P.M. to 7 A.M. shift, No sweeps were conducted for any shift on 5/24/15, 5/25/15 for the 11 P.M. to 7 A.M. shift, 5/26/15 for the 11 P.M. to 7 A.M. shift, 5/27/15 for the 11 P.M. to 7 A.M. shift, and 5/28/15 for the 11 P.M. to 7 A.M. shift.</p> <p>No documentation was submitted for review to indicate the facility ensured home and bedroom searches were conducted on each shift daily by group home staff.</p> <p>2. -Investigation record dated 3/26/15-4/9/15 for an incident that occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 approximately 10:25 A.M....Persons involved: [Client A] and</p>		<p>Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>	

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	<p>[Staff #13]. Dates of Investigation: 3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated 12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch [client A]. [Staff #13] stated that he did not harm the individual. [Client A] stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but the (sic) was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The</p>			
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	<p>nurse was called between 7 P.M. and 8 P.M. on 3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due to an unsubstantiated allegation. I recommend all staff be retrained on properly documenting incidents. Date investigation was completed: 4/9/15."</p> <p>-BDDS report dated 3/26/15 involving client A indicated: "On 3/26/15 [client A] told the QIDP that a staff bent her toe back breaking it after an incident in</p>			

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	<p>which she was agitated. The individual was seen by a doctor who told her to keep her leg elevated. Staff was suspended pending the out come (sic) of the investigation. Incident Follow-Up Report dated 4/10/15 indicated: "Was further treatment needed for the fractured foot? She is now wearing a boot prescribed by her podiatrist. What part of the foot is the fracture located? The front of the left foot between the upper foot and the toes. The result of the allegation is unsubstantiated."</p> <p>A review of client A's record was conducted on 5/27/15 at 10:50 A.M.. Review of client A's Behavioral Support Plan (BSP) dated 1/27/15 indicated: "BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS): Self Injurious Behavior (SIB), Verbal Aggression, Physical Aggression...Elopement...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques</p>				

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>"All of [client A]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client A]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client A]'s individual support team (IST) will review her BSP at least</p>			

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	<p>quarterly to evaluate its appropriateness." Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client A at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious Behavior (SIB). Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client A at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious Behavior (SIB).</p> <p>A review of client B's record was conducted on 5/27/15 at 11:30 A.M.. Review of client B's Behavioral Support Plan (BSP) dated 4/7/14 indicated: "BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS): Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p>			

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	<p>Less Restrictive</p> <p>Physical Redirection/Response</p> <p>Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and your,</p>			
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	<p>hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>"All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness." Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client B at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious Behavior (SIB). The record did not indicate the behaviorist revisited the BSP after the documented incidents.</p> <p>An interview with Direct Support Professional (DSP) #1 was conducted on 5/29/15 at 1:30 P.M.. DSP #1 indicated she had not been trained on clients A and B's BSPs by the behaviorist. DSP #1 indicated she has many questions and is confused in regard to how to implement the clients' BSPs because she gets different information from different people. When the AD asked DSP #1 if she received training before working at the group home, DSP #1 stated: "To be honest with you; no, I did not. I was given the clients' books and told to read through their books." When asked if the behaviorist trained her on each client's BSP, DSP #1 indicated she did not. DSP</p>			

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	<p>#1 further indicated when she has asked the behaviorist how to address the clients' aggressive behaviors and SIB, DSP #1 stated "The behaviorist told me to leave them alone until they calm down and then check on them. She told me we do not use physical intervention." When asked if she was trained on bedroom and house checks, DSP #1 stated: "I was told to do bedroom checks every shift but I was not told to do house checks every shift."</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The AD indicated staff were not able to handle client B's SIB. The AD indicated all staff who work at the group home with clients A and B should have been trained on their BSPs. The AD further indicated staff should have implemented their BSPs as written.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-3(a)</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0248 Bldg. 00	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview, the facility failed for 1 of 2 sampled clients (client B), by not ensuring the client's Behavior Support Plan (BSP) was available for all staff who worked with her at the group home.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and an investigation record indicated:</p> <p>-Investigation record dated</p>	W 0248	<p>W 248 483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure all current ISP, BSP, and Risk Plans are filed in each Individuals' permanent file at the home, for easy reference for all staff. AD will ensure Agency's abuse/neglect Policy and Procedure is implemented at all times (Including providing sufficient staff at all times for the needs of the individuals), to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing</p>	07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do it. [QIDP] talked with [client B] on</p>		<p>services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <ol style="list-style-type: none"> i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served. ii. Agency Policy and Procedure concerning Individual Rights. iii. Agency Policy and Procedure concerning reporting of incidents. iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>11/11/14 and [client B] told the QIDP that the [Name] that works at her home in the evening is the [Name] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14."</p> <p>-BDDS report dated 5/23/15...Date of Knowledge: 5/24/15...Submitted Date: 5/25/15 involving client B indicated: "On 5/23/15 at approximately 4:03 P.M.,</p>		<p>v. Agency Policy and Procedure concerning reporting to supervisor when insufficient staff are on duty at any time.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>F. Area Director will work with HR Department and Agency Team to hire and retain sufficient staff, so that home will consistently have sufficient staff for client's needs.</p>	

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	[client B] was sitting at the dining room table talking with her birth mother on the telephone. Staff observed her crying and wiping the tears from her eyes. Later, staff then heard the back door slam, and staff ran down the hall, through the door in the common area in the back and out the door outside calling out to [client B]. [Client B] continued to run, and staff was able to stop her at the fence. [Client B] turned around and staff noticed a large cut on he neck. Staff called to co-worker for assistance, applied pressure to the injury until EMT's (sic) (Emergency Medical Technician), and coworker called 911, Area Director and nurse. The police officer arrived first and asked [client B] what happened. [Client B] went into details about the mom telling her that her sister ran away and was placed back into foster care. The officer explained to [client B] that there are other ways to deal with anger. [Client B] said she understood. Plan to Resolve: Staff followed protocol, called 911, applied first aid and notified nurse and administrator. Staff stayed in contact with the Nurse the whole duration of the incident. EMTs transported [client B] to [Hospital] were (sic) she received 21 stitches from [Physician]. [Psych Hospital] was notified by hospital personnel due to suicide attempt. [Psych hospital] arrived and stated said (sic) that		A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect. This monitoring and supervision will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>they had no facility for [client B] and that they told us this before and that her psych Doctor has a facility that he could admit her to in Indianapolis. [Client B] received a tetanus shot and blood was drawn the hospital served [client B] dinner. The ER (Emergency Room) Doctor refused to release [client B] to go home because of the fact that it was attempted suicide at 2:00 A.M. on 5/24/1. [Hospital] admitted [client B] to the hospital. AD/QIDP talked with staff on 5/25/15 and they stated they had been following protocol, and after the incident, they found a broken jar of Jalapeno's (sic) outside in the back of the house."</p> <p>A review of client B's group home record was conducted on 5/27/15 at 11:30 A.M.. Review of the record indicated a BSP dated 4/7/14 for staff guidance. At 1:30 P.M., the AD was asked if the IDT revisited client B's BSP after the mentioned incidents, the AD said there is an updated BSP, and retrieved a BSP dated 2/23/15 from the computer. The updated BSP was not available for the group home staff for guidance.</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The PD indicated client B's BSP dated 2/23/15</p>		<p>continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p>		

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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W 0249 Bldg. 00	<p>should be at the group home for all staff.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on record review and interview the facility failed for 2 of 2 sampled clients (clients A and B), to properly implement their Behavior Support Plans (BSP).</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of</p>			W 0249	<p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p> <p>W 249 483.440(d)(1) INDIVIDUAL PROGRAM PLAN</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure all current ISP, BSP, and Risk Plans are</p>		07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385		
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	<p>Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and investigation records indicated:</p> <p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on</p>		<p>filed in each Individuals' permanent file at the home, for easy reference for all staff. AD will ensure Agency's abuse/neglect Policy and Procedure is implemented at all times (Including providing sufficient staff at all times for the needs of the individuals), to prevent staff physical abuse and neglect of Individuals served, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p>		

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead Staff name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't think he meant to do it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Male Group Home Staff Name] that works at her home in the evening is the [Staff #13] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not		<p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>v. Agency Policy and Procedure concerning reporting to supervisor when insufficient staff are on duty at any time.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director,</p>	

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	<p>happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14."</p> <p>2. -BDDS report dated 5/11/15 involving client B indicated: "On 5/11/15 at approximately 6:30 P.M. [client B] had just finished eating dinner. House mate asked staff could she talk to her. Staff went and sat with other house mate to see what she wanted. [Client B] then went outside. She was in the line of sight. Staff let her stay out there for 3-5 minutes before going to talk to her. When housemate talked to her she said she didn't want to come back into the house. When staff tried to talk to [client B], she was verbally aggressive. Staff then redirected [client B] and asked her did she want to get her jello. [Client B] then stated that she didn't want to be in this house any more because her house mate gets away with everything. This is when [client B] took off from staff. Staff yelled for other staff to come so that they could prevent her from leaving. She made it out of the sub-division. Staff followed her on foot, and other staff was driving behind us. [Client B] was picking up sticks and rocks a long (sic) the way throwing them at staff on foot and the van. AD (Area Director) coached staff and staff followed her behavior protocol and followed her to ensure her health and safety. [Client B] never got</p>		<p>QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>F. Area Director will work with HR Department and Agency Team to hire and retain sufficient staff, so that home will consistently have sufficient staff for client's needs.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	close to the neighbor or her property. She was being verbally and physically aggressive towards staff. At one point, [client B] picked up landscaping stone and threw it at the van, shattering the windshield. [Client B] refused to go back to the home, continued walking and ended up walking along a highway. Since it was becoming dark, and she was walking along a busy highway, to ensure her health and safety, the AD instructed staff to call the police for assistance. Before the police arrived, staff tried talking to [client B] again, telling her that she needed to calm down so that we can talk about what's going on and that they needed to get back to the house. She started yelling and saying that she hates this house and she doesn't want to go back. When the police arrived, they asked [client B] what was the problem, and she began being aggressive. They told her if she calms down she can go back to the house. When staff was explaining to her the same thing, she charged towards staff and that is when the police grabbed her and handcuffed her. While she was in handcuffs, the police officers were still trying to calm her down but she wasn't calming down, she charged at staff again, and that is when they put her in the car and stated they were taking her to jail. While in the car, [client B] was banging her head on		and thorough investigation is completed in regards to any allegation of abuse or neglect. This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan. A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing training and coaching to all staff working in the home.				

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>the door. Plan to Resolve: Staff followed [client B's] HRC (Human Rights Committee) approved BSP protocol, followed her, ensured her health and safety, and reported the incident to the supervisor. Area Director (AD) maintained frequent phone contact with staff and provided support. [Client B]'s nurse provided the jail with all information needed. The jail was contacted today, 5/15/15 at 2:20 P.M., and we were informed she had not yet been processed and we should try again tomorrow. Facility will contact the jail tomorrow to obtain her hearing date, bail amount, charges, etc. The facility will bail [client B] out as soon as possible and QIDP will update when further info is obtained. Staff will continue to follow protocol and [client B]'s IDT (Interdisciplinary Team) will continue to review her BSP and revise as necessary to best assist her in controlling her aggressive behavior....[Client B] was released from jail on the afternoon of 5/14/15 (sic)...." Review of the record did not indicate staff attempted to physically escort her back to the home or implement an approved DCI (crisis intervention) technique as written in her 4/7/14 Behavior Support Plan.</p> <p>3. -BDDS report dated 5/23/15...Date of Knowledge: 5/24/15...Submitted Date:</p>		<p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>5/25/15 involving client B indicated: "On 5/23/15 at approximately 4:03 P.M., [client B] was sitting at the dining room table talking with her birth mother on the telephone. Staff observed her crying and wiping the tears from her eyes. Later, staff then heard the back door slam, and staff ran down the hall, through the door in the common area in the back and out the door outside calling out to [client B]. [Client B] continued to run, and staff was able to stop her at the fence. [Client B] turned around and staff noticed a large cut on her neck. Staff called to co-worker for assistance, applied pressure to the injury until EMT's (sic) (Emergency Medical Technician), and coworker called 911, Area Director and nurse. The police officer arrived first and asked [client B] what happened. [Client B] went into details about the mom telling her that her sister ran away and was placed back into foster care. The officer explained to [client B] that there are other ways to deal with anger. [Client B] said she understood. Plan to Resolve: Staff followed protocol, called 911, applied first aid and notified nurse and administrator. Staff stayed in contact with the Nurse the whole duration of the incident. EMTs transported [client B] to [Hospital] were (sic) she received 21 stitches from [Physician]. [Psych Hospital] was notified by hospital</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>personnel due to suicide attempt. [Psych hospital] arrived and stated said (sic) that they had no facility for [client B] and that they told us this before and that her psych Doctor has a facility that he could admit her to in Indianapolis. [Client B] received a tetanus shot and blood was drawn (sic) the hospital served [client B] dinner. The ER (Emergency Room) Doctor refused to release [client B] to go home because of the fact that it was attempted suicide at 2:00 A.M. on 5/24/15. [Hospital] admitted [client B] to the hospital. AD/QIDP talked with staff on 5/25/15 and they stated they had been following protocol, and after the incident, they found a broken jar of Jalapeno's (sic) outside in the back of the house. AD/QIDP and [client B]'s IDT (Interdisciplinary Team) will evaluate this incident and develop further procedures to assist in ensuring [client B]'s health and safety at all times, before she returns to her home. Staff will continue to follow protocol and reporting procedure."</p> <p>A review of client B's record was conducted on 5/27/15 at 11:30 A.M.. Review of client B's Behavioral Support Plan (BSP) dated 4/7/14 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>BEHAVIORS/PROBLEM BEHAVIORS: Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and scratching her lower forearms and face to the point of skin breakdown. [Client B] has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision by staff after being declined permission to leave the area by staff.</p> <p>3. Elopement: Intervention Steps: ...If [client B] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI technique if an escort if (sic) not possible.</p>						

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>Proactive Strategies:</p> <p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home from any community outing. This strategy was discussed at a team meeting and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p> <p>...Staff should always be mindful of observing [client B]'s affect for moods that correlate with this target behavior....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS): Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and yours, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>FOLLOW-UP:</p> <p>"All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness." Review of the record did not indicate the contracted Behaviorist provided weekly behavior services to client B at the group home. The record did not indicate the Behaviorist provided staff training and guidance during incidents of physical aggression, elopement and Self Injurious Behavior (SIB). The record did not indicate the behaviorist revisited the BSP after the documented incidents.</p> <p>A review of the facility's records was conducted on 5/29/15 at 3:00 P.M.. Review of the group home staff "House Sweeps" logs in which staff documented room sweeps to be conducted daily on every staff scheduled working shift dated 4/29/15 to 5/29/15 indicated no house sweeps were conducted on: 5/4/15 for the 3P.M. to 11P.M. shift, 5/5/15 for the 3P.M. to 11 P.M. shift, 5/10/15 for the 11 P.M. to 7 A.M. shift,</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>5/18/15 for the 11 P.M. to 7 A.M. shift, 5/25/15 for the 11 P.M. to 7 A.M. shift, 5/27/15 for the 11 P.M. to 7 A.M. shift, and 5/28/15 for the 11 P.M. to 7 A.M. shift.</p> <p>Review of the "Room Sweeps" for client B's bedroom dated 5/16/15 to 5/29/15 indicated no bedroom sweeps were conducted on: 5/17/15 for the 11 P.M. to 7 A.M. shift, 5/19/15 for the 11 P.M. to 7 A.M. shift, No sweeps were conducted for any shift on 5/24/15, 5/25/15 for the 11 P.M. to 7 A.M. shift, 5/26/15 for the 11 P.M. to 7 A.M. shift, 5/27/15 for the 11 P.M. to 7 A.M. shift, and 5/28/15 for the 11 P.M. to 7 A.M. shift.</p> <p>No documentation was submitted for review to indicate the facility ensured home and bedroom searches were conducted on each shift daily by group home staff.</p> <p>4. -Investigation record dated 3/26/15-4/9/15 for an incident that occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 (sic) approximately 10:25 A.M....Persons involved: [Client A] and [Staff #13]. Dates of Investigation:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
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	<p>3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated 12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch [client A]. [Staff #13] stated that he did not harm the individual. [Client A] stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but there was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The nurse was called between 7 P.M. and 8</p>						

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>P.M. on 3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due to an unsubstantiated allegation. I recommend all staff be retrained on properly documenting incidents. Date investigation was completed: 4/9/15." Further review did not indicate the staff implemented DCI techniques to prevent client A from injury.</p> <p>A review of client A's record was conducted on 5/27/15 at 10:50 A.M..</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Review of client A's BSP dated 1/27/15 indicated: "BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS): Verbal Aggression, Self Injurious Behavior (SIB), Physical Aggression...Elopement...Due to a history of SIB, recent resurfacing of the behavior, as well as [client A]'s placement at a home with roommates who also have a history of self-injury, whole house sweeps of common areas each shift (sic). Items that can be used for self harm or weapons will be removed, such as magazines with staples, pencils, pens, plastic wrapping, string, beads, etc....If [client A] is physically aggressive with staff, the target staff should use DCI (crisis intervention techniques) to protect themselves from bodily harm:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p> <p>Walking with or accompanying/Escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and yours, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder. Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>Client A's BSP did not indicate staff should have "Taken down" client A. Further review of the record failed to indicate the contract behaviorist provided behavior services weekly at the group home for the client.</p> <p>FOLLOW-UP:</p> <p>"All of [client A]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client A]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client A]'s individual support team</p>			
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>(IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>A review of client B's record was conducted on 5/27/15 at 11:30 A.M.. Review of client B's Behavioral Support Plan (BSP) dated 4/7/14 indicated:</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS): Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal:</p> <p>Self-Injurious Behavior: Actions performed by [client B] in which she uses her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns, scrapes or rashes. [Client B] has a history of cutting her arms and scratching her lower forearms and face to the point of skin breakdown. [Client B] has recently begun to kick and hit walls, as well as banging her head on the wall up to three times in rapid succession.</p> <p>Elopement: Leaving the assigned area without (1) notifying staff or responsible person of her intention to leave supervision prior to departing and/or (2) leaving the assigned area or supervision</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>by staff after being declined permission to leave the area by staff.</p> <p>3. Elopement: Intervention Steps: ...If [client B] is showing signs of physical or verbal aggression of agitation and redirection is not working, staff will attempt to physically escort her back to the home or implement an approved DCI technique if an escort if (sic) not possible. As a last resort, staff should implement an approved DCI technique if an escort if (sic) not possible and safety becomes a concern. Agitation is described as yelling, crying, screaming, talking as if she is upset about something or someone.</p> <p>Proactive Strategies:</p> <p>1. Per the request of residential staff, [client B] will be searched for sharps (specifically paperclips, staples and other small sharp objects) upon arrival home from any community outing. This strategy was discussed at a team meeting and was proposed by residential staff and management as a means of prompting [client B] to identify when and if she plans to harm after being in the community, specifically after medical appointments.</p> <p>Re-Active Strategies:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>...Staff should always be mindful of observing [client B]'s affect for moods that correlate with this target behavior....</p> <p>"BEHAVIORS TO BE DECREASED (CHALLENGING BEHAVIORS/PROBLEM BEHAVIORS): Self Injurious Behavior (SIB), Physical Aggression...Elopement...Property Destruction...Refusal...Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques:</p> <p>Hierarchy of Physical Interaction of DCI (crisis intervention) Techniques</p> <p>Less Restrictive Physical Redirection/Response Blocking= to change course or direction of momentum. Redirection techniques are used to take advantage of a person's momentum to redirect without holding on to the person. Response blocking is the physical intervention to stop a person's momentum during events of physical aggression without holding on to the person.</p> <p>Releasing=Gaining release from a physical hold; this may involve briefly holding to the hand or the wrist of the person.</p>			

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>Walking with or accompanying/escorting: Walking with a person to give direction, guidance, and protection from harm. Staff may use light, occasional touch or may have to use a support walk with their hand on the upper shoulder and lower arm.</p> <p>Restrictive physical interaction should only be used for the protection from harm and should be terminated as soon as the need for protection is over.</p> <p>Side Body Hug=Standing beside/slightly behind the person holding one of the arms against the person's body and yours, hugging along the person's natural waist. This may be combined with another staff repeating this same hold on the other side of the person should a one-person hold prove to be ineffective.</p> <p>More restrictive:</p> <p>One arm Standing=Standing behind the person, holding one arm of the person in front of their body with both of your hands, hugging around the natural waistline from behind the person.</p> <p>Two Person Hold= Standing behind the person with hands in a 'c' formation at wrist with opposite arm to individual and arm closest to individual on the shoulder.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
(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>Inner leg should be behind client next to their inside foot for stability. Staff on other side with the same stance, bend the person over slightly for three count then raise back up. If client drops to the floor staff is to go with them while maintaining client safety. During this procedure staff should be giving short commands to calm down, take a breath, you are safe; to the individual."</p> <p>FOLLOW-UP:</p> <p>All of [client B]'s caregivers should be trained by his/her behavior consultant to consistently implement her behavior plan. After all staff are trained, [client B]'s behavior should be monitored by her behavior consultant on a weekly basis. [Client B]'s individual support team (IST) will review her BSP at least quarterly to evaluate its appropriateness."</p> <p>An interview with the Area Director (AD) was conducted on 5/29/15 at 4:15 P.M.. The AD indicated staff should always implement client's BSPs as written. The AD indicated staff should conduct thorough house and bedroom sweeps for sharp items and items clients may harm themselves with.</p> <p>This federal tag relates to complaint #IN000170468.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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W 0331 Bldg. 00	<p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 2 sampled clients (clients A and B), the facility failed to ensure timely medical treatment and provide assessments for clients A and B's injuries after alleged staff physical abuse/neglect.</p> <p>Findings include:</p> <p>A review of the facility's records was conducted on 5/21/15 at 2:30 P.M.. Review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, General Event Reports/Internal Reports (GER/IR), Daily Progress Notes and investigation records indicated:</p>	W 0331	<p>W 331 483.460(c) NURSING SERVICES</p> <p>In conjunction with the Plan of Corrections for all other citations in this survey, Area Director (AD) will review this Standard, and ensure Agency's abuse/neglect Policy is implemented at all times, that behavioral services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough</p>	07/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>1. -Investigation record dated 11/11/14-12/1/14 in regard to an incident that occurred on 11/10/14 involving client B indicated: "Nature of event under investigation: Allegation that staff [Staff #13] physically abused [client B] by choking [client B]....Date/Time of alleged incident: 11/10/14 during an evening at the group home....Dates of Investigation: 11/11/14-12/1/14....Investigation completed by [Qualified Intellectual Disabilities Professional (QIDP)]....Claims and Responses: On 11/11/14, [Behaviorist name], was pulled to the side and told by [client B] that staff [Staff #13] choked her. [Behaviorist] then called [QIDP] and told her what was said. [Staff #13] then was called and suspended pending an investigation....Witness/Evidence: [Staff #13] was interviewed on 11/17/14 and denies choking the individual served [client B]. [Staff #14] was interviewed on 11/17/14 and states that he did not see [Staff #13] choke [client B]. His statement does not match the allegation. [Behaviorist] was interviewed on 11/18/14 and was told by [client B] that [Staff #13] choked her. [Lead name] stated she was told by [client B] that she lied on [Staff #13]. [Client B] says [Staff #13] choked her for only a minute but that she don't (sic) think he meant to do</p>		<p>investigation is completed in regards to any allegation of abuse or neglect through the following:</p> <p>A. After investigation, it was determined that the QDDP, Nurse, and House Manager did not follow Agency Policy and Procedure as required by their job description concerning an incident of alleged abuse, and were terminated from employment accordingly.</p> <p>B. All current and new staff will be retrained on the following:</p> <p>i. Agency Policy and Procedure concerning abuse/neglect/exploitation of Individuals served.</p> <p>ii. Agency Policy and Procedure concerning Individual Rights.</p> <p>iii. Agency Policy and Procedure concerning reporting of incidents.</p> <p>iv. Refresher training on each Individual's BSP, including HRC approved/authorized physical intervention techniques.</p> <p>C. All nurses have been trained on consistently providing prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
(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>it. [QIDP] talked with [client B] on 11/11/14 and [client B] told the QIDP that the [Name] that works at her home in the evening is the [Name] that choked her the day before not the one that works at the boys (sic) home with the curly hair. The QIDP also talked with [client B] on 11/16/14 and was told by [client B] that 'maybe [Staff #13] didn't do it' and that 'maybe I should get to know him before I decide I don't like him.' Findings of Fact: [Client B] was agitated on the night of 11/10/14. [Staff #13] was in the doorway of [client B]'s room as witnessed by another staff. [Client B] was upset at her housemate. [Staff #17] told [Staff #13] to leave the room because he was a target. It took [Staff #17] a few seconds to leave from calming [client C] in her room to get to [client B]'s room. Conclusion Based on Facts: The investigation is unsubstantiated due to the fact that [client B] admitted to lying to staff about the incident and staff [Staff #17] witnessing [client B] standing on the far side of her bedroom behind her bed. Also [client B] indicating that the incident did not happen to the QIDP on 11/16/14. Date investigation was completed: 12/1/14." Review of this record failed to indicate the facility's nursing services assessed client B after the incident.</p>		<p>allegation of abuse/neglect. All assessments and medical care will be promptly documented in the Individual's permanent record.</p> <p>D. Behaviorist has been trained on ensuring behavioral services are provided at the home according to each Individuals' behavioral needs, and behaviorist will be signing in/out of a log book at the home as evidence of visits, training, etc.</p> <p>E. A Director will thoroughly train all new Program Director, QDDP, and House Managers upon employment on prompt notification to the administrator of any allegation and/or suspicion of abuse/neglect and on completing thorough and timely investigations into any allegation of abuse/neglect.</p> <p>A trained Area Director, Program Director/QDDP, Nurse, and/or Behaviorist, will be in the home each day throughout the week, at various and random times including shift changes and random overnight checks. These visits will be to ensure all Individuals' plans/protocol and all Agency policy and procedures are followed, to ensure the health and safety of all Individuals served, and to ensure Agency's abuse/neglect Policy, and reporting Policy/Procedures are implemented at all times. These visits will ensure that behavioral</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385
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	<p>2. -Investigation record dated 3/26/15-4/9/15 for an incident that occurred on 3/23/15 involving client A indicated: "Nature of event under investigation: Allegation by [client A] that [Staff #13] grabbed her toe and bent it back. Dated/Time of alleged incident: 3/26/15 approximately 10:25 A.M....Persons involved: [Client A] and [Staff #13]. Dates of Investigation: 3/26/15-4/9/15. Investigation completed by [QIDP]....History/Background: [Staff #13] is a Direct Support Professional (DSP). He has worked in the home since October 2014. [Staff #13] was suspended on 11/11/14 for an allegation of abuse that was not substantiated and his employment was reinstated 12/3/14....Claims and Responses: This investigation is being conducted due to a report from [client A] to the QIDP on 3/27/15 that a staff [Staff #13] member grabbed her toe on her left foot and bent it back breaking her foot. The QIDP notified [Area Director (AD)]. The staff was suspended and an investigation of the allegation was initiated.</p> <p>Witnesses/Evidence: [Staff #20] stated that she did not witness [Staff #13] bend [client A]'s toe or touch her in any inappropriate manner. She also stated in a written statement that [client A] was kicking walls that day. [Staff #21] stated that she did not see [Staff #13] touch</p>		<p>services by the behaviorist are provided at the home according to each Individuals' behavioral needs, that nursing services consistently provide prompt and thorough assessments and appropriate medical care in the event of any injury to an individual and/or allegation of abuse/neglect, and ensure a timely and thorough investigation is completed in regards to any allegation of abuse or neglect.</p> <p>This monitoring and supervision will continue until it is evident to each Individual's IDT, the Area Director, and State Director that all Individuals are free from abuse/neglect/exploitation, that all staff have demonstrated competency in all Individuals' Plans/Protocol and in Agency reporting and abuse/neglect/exploitation policies, and all Individuals are demonstrating that they are comfortable, and at ease, in their home. When this has been determined, the Area Director will revise the monitoring schedule as necessary to ensure sufficient observations in order to continue the continuity and effectiveness of this plan.</p> <p>A. While monitoring the home, Area Director, Program Director/QDDP, Nurse, and/or Behaviorist will provide ongoing</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 474 WHITEWOOD DR VALPARAISO, IN 46385			
(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>[client A]. [Staff #13] stated that he did not harm the individual. [Client A] stated that [Staff #13] grabbed her toe and bent it back breaking it....There is no mention of [client A] kicking a wall in the original GER for the behavior but there was a GER for the injury....The doctor diagnosed her with having a fractured foot not a broken toe. The nurse was called between 7 P.M. and 8 P.M. on 3/23/15 by [Staff #13] to report that [client A] was complaining of pain in her foot. The nurse told staff that [client A] could have some ibuprofen for pain and to have ice put on her foot while its (sic) kept elevated. The QIDP was called on 3/23/15 by [Staff #21] to report that [client A] was in an aggressive behavior that morning a little after 7 A.M. and again at around 8:20 A.M.. I asked staff if she had been restrained but was told that she had not. I then instructed them to continue following her plan, remove anything she could throw from the area and to call me when it was over.</p> <p>Findings of Fact: [Client A] was agitated on 3/23/15. [Staff #20] and [Staff #13] removed items from her room she could harm herself with. [Client A]'s foot is fractured....Conclusion Based on Facts: [Staff #13] was not alone with the individual in her room without a second staff being there. Recommendation: I recommend [Staff #13] be reinstated due</p>		<p>training and coaching to all staff working in the home.</p> <p>-</p> <p>B. Program Director/QDDP, Nurse, and/or Behaviorist will promptly communicate any issues, concerns, or signs of potential abuse/neglect/exploitation, or evidence of any anxiety or allegations, expressed by the Individuals served to Area Director.</p> <p>-</p> <p>C. The Area Director will promptly notify Senior Director of any issues that have been identified, that have not been addressed by the Individual's IDT, or any other significant issue that may negatively affect the health and safety of the Individuals served.</p> <p>Will be completed by: 7/1/15</p> <p>Persons Responsible: Area Director, Program Director/QDDP, Nurse, and Behaviorist</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/01/2015	
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	<p>to an unsubstantiated allegation. I recommend all staff be retrained on properly documenting incidents. Date investigation was completed: 4/9/15." Review of the record failed to indicate the facility's nursing services assessed client A's foot after being notified of her complaining of pain on 3/23/15. The report failed to indicate the facility sought timely medical attention of client A's foot injury.</p> <p>3. -BDDS report dated 3/26/15 involving client A indicated: "On 3/26/15 [client A] told the QIDP that a staff bent her toe back breaking it after an incident in which she was agitated. The individual was seen by a doctor who told her to keep her leg elevated. Staff was suspended pending the out come (sic) of the investigation. Incident Follow-Up Report dated 4/10/15 indicated: "Was further treatment needed for the fractured foot? She is now wearing a boot prescribed by her podiatrist. What part of the foot is the fracture located? The front of the left foot between the upper foot and the toes. The result of the allegation is unsubstantiated."</p> <p>A review of client A's record was conducted on 5/28/15 at 12:30 P.M.. Review of client A's record indicated a "Medical Visit Summary" dated 3/24/15</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G791	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/01/2015
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	<p>which indicated: "Reason for Visit: Foot injury. Possible foot fracture, sent for x-ray. 3/25/15: X-ray showed foot fracture, referring to Podiatry and ordering a boot to use." Further review failed to indicate the facility's nursing services assessed client A's foot after being notified of her complaining of pain on 3/23/15. Review of the record indicated the facility did not take client A for medical attention on 3/23/15. There was no evidence to indicate the facility nurse assessed client A on 3/23/15.</p> <p>An interview with the Area Director/Qualified Intellectual Disability Professional (AD/QIDP) was conducted on 5/29/15 at 4:15 P.M.. The AD indicated the GHN/Group Home Nurse should have gone to the group home to assess clients A and B when staff first contacted her and made her aware of physical aggression and complaints of pain. The AD indicated the GHN should have immediately sought medical attention for client A and further indicated she had not done so.</p> <p>This federal tag relates to complaint #IN000170468.</p> <p>9-3-6(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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