

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G460	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 13, 14, 15, and 16, 2015.</p> <p>Facility number: 000974 Provider number: 15G460 AIM number: 100244830</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 10/26/2015.</p>	W 0000		
W 0137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, the facility failed to assure 2 of 4 sampled clients (clients #2 and #3) and 1 of 3 additional clients (client #5) wore a house coat or robe over their pajamas.</p> <p>Findings include:</p>	W 0137	The Program Director/QIDP and all facility staff will review this standard. All facility staff are being retrained on client rights and on the findings of this survey. This training will include the client right to privacy and the role of support staff in ensuring and prompting this privacy. The Lead DSP will ensure that clients #2,	11/15/2015

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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W 0227 Bldg. 00	<p>Clients #2, #3, and #5 were observed during the group home observation period on 10/14/15 from 5:50 A.M. until 8:00 A.M. Upon entering the group home, clients #2, #3, and #5 were wearing semi-revealing pajamas while sitting on the living room couch and walking around the living room, kitchen and dining room areas. Direct care staff #1 and #4 did not assist or prompt the clients in putting on house coats or robes.</p> <p>Program Director #1 was interviewed on 10/15/15 at 11:17 A.M. Program Director #1 stated, "Staff (direct care staff) should have prompted or assisted them (clients #2, #3, and #5) in putting something on while the surveyor was visiting."</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, the facility failed to address</p>	W 0227	<p>#5, & #3 all own a robe in good repair. The Lead DSP will also do a systemic check to ensure that all other clients at the facility also have a robe or other appropriate garments to ensure privacy. Any needed items will be purchased. Once the training is complete, for two weeks and then until compliance has been demonstrated, observations will be conducted 8 times per week to ensure that all individuals are dressed appropriately and that staff are prompting the clients as necessary to protect their privacy. Thereafter, the Lead DSP and/or Program Director will complete these checks at least weekly.</p> <p>The Program Director/QIDP and all facility staff will review this standard. Client #3 has been to</p>	11/15/2015			

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	<p>the crying episodes 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>Client #3 was observed at the group home during the 10/13/15 observation period from 3:58 P.M. until 5:50 P.M. During the observation, client #3 began crying on three occasions. When client #3 began crying, direct care staff #1 and #2 said to the client, "What's wrong? What are you crying about?" Client #3 eventually stopped crying and went on with watching television.</p> <p>Client #3 was observed at the group home during the 10/14/15 observation period from 5:50 A.M. until 8:00 A.M. During the observation, client #3 began crying on two occasions. When client #3 began crying, the client angrily pushed her walker away from her. Direct care staff #1 said to the client, "What's wrong? What are you crying about?" Client #3 eventually stopped crying and went on with watching television.</p> <p>Direct care staff #1 was interviewed on 10/14/15 at 7:50 A.M. Direct care staff #1 stated, "She (client #3) has been like this for a long time. Her (client #3's) crying has been getting worse in the last three months and I've never seen her push</p>		<p>see her primary physician to review the increase in crying and frustration witnessed by the support staff. The doctor ordered a medication change to try to assist the client in further managing her depression which is secondary to her diagnosis of Dementia. The QIDP in conjunction with the facility nurse is also developing a Dementia Risk Plan which will include strategies to support the client when she is exhibiting symptoms of her depression including crying or aggression (i.e. angrily pushing walker). All facility staff will be trained on this risk plan. Going forward, the QIDP is being re-trained on the expectation that the Individual Support Plan is to be updated on an ongoing basis to address changing needs of the clients as new support needs are identified.</p>		

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W 0368 Bldg. 00	<p>her walker like that. We think the crying is due to her dementia."</p> <p>Client #3's record was reviewed on 10/14/15 at 9:41 A.M. Review of client #3's 9/3/15 Individual Support Plan failed to indicate crying spells and any related aggression were being addressed by the facility.</p> <p>Program Director #1 was interviewed on 10/15/15 at 11:17 A.M. Program Director #1 stated, "[Client #3] is a very sensitive and social person. The crying may be because of that but, no, we have not addressed that (crying episodes and related aggression) yet."</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, interview, and record review, the facility failed to reconcile the administration instructions with the physician's orders for medications for 1 of 4 sampled clients (client #2) and 1 of 3 additional clients</p>	W 0368	The Program Director/QIDP, facility nurse, and all facility staff will review this standard. The facility nurse has completed an audit of all physician's orders for medications for all individuals residing at the facility and entered any revisions to the MAR as needed. Going forward, the facility	11/15/2015			

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	<p>(client #7).</p> <p>Findings include:</p> <p>Client #2 was observed receiving medications during the 10/13/15 observation period from 3:58 P.M. until 5:50 P.M. At 5:14 P.M., direct care staff #1 administered Warfarin (blood thinner medication) 5 mg (milligrams) tablet to client #2.</p> <p>Client #2's records were reviewed on 10/13/15 at 5:20 P.M. A review of client #2's medication packet indicated the following administration instructions for client #2's Warfarin 5 mg tablet: "1 tab (tablet) by mouth 5 days a week S. T. W. F. Sat. (Sunday, Tuesday, Wednesday, Friday, Saturday)." Review of the client's 10/15 MAR (Medication Administration Record) indicated the following administration instructions for client #2's Warfarin 5 mg tablet: "1- 5 mg tab on Tues (Tuesday)."</p> <p>Client #2's records were further reviewed on 10/14/15 at 9:07 A.M. A review of the client's 8/26/15 physician orders</p>		<p>nurse is responsible to ensure that all new medication orders are entered correctly and thoroughly. This is reviewed by the facility nurse and the med support DSP along with the Program Director/QIDP at a weekly meeting and documented on the weekly Med Support DSP/Nurse meeting agenda. This completed agenda is forwarded to the nursing services manager and the Area Director for review each week.</p>		

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	<p>indicated the following instructions for the administration of client #2's Warfarin 5 mg tablet: "Warfarin Sod (sodium) 5 mg tab, give 1 tablet by mouth 5 days per week on Tue, Thur, Sat, Sun." (4 days listed).</p> <p>Client #7 was observed receiving medications during the 10/14/15 observation period from 5:50 A.M. until 8:00 A.M. At 6:30 A.M., direct care staff #1 administered two Metformin (Diabetes medication) 500 mg (milligrams) tablets to client #2.</p> <p>Client #7's records were reviewed on 10/14/15 at 6:35 A.M. A review of client #7's medication packet indicated the following administration instructions for client #7's Metformin: "Metformin 500 mg tablet, 2 tabs twice daily with food." Review of the client's MAR indicated the following administration instructions for client #7's Metformin: "Metformin 500 mg tablet, 2 tabs twice daily."</p> <p>Client #7's records were further reviewed on 10/14/15 at 6:52 A.M. A review of the client's 8/26/15 physician orders</p>			

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W 0369 Bldg. 00	<p>indicated the following instructions for the administration of client #7's Metformin: "Metformin HCL (hydrochloride) 500 mg tablet 2 tabs {1000 mg} by mouth 2 x's (times) a day with meals."</p> <p>Nurse #1 was interviewed on 10/14/15 at 10:28 A.M. Nurse #1 stated, "All of these (medications) need to be reconciled so they all indicate the same administration information."</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed to assure 1 of 13 administered medications were administered according to physician's orders for 1 of 3 additional clients (client #5).</p>	W 0369	The Program Director/QIDP and all facility staff will review this standard. The DSP responsible for this failure to assure the medication was administered to client #5 according to the physician's order is receiving disciplinary action and re-training	11/15/2015			

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	<p>Findings include:</p> <p>Client #5 was observed during the group home observation period on 10/13/15 from 3:58 P.M. until 5:50 P.M. At 5:01 P.M., direct care staff #1 administered a Calcium 600 mg (milligram) tablet with 400 I.U. (International Units) of Vitamin D (vitamin supplement medication) to client #5. Client #5 swallowed the tablet without having any food and returned to sitting on the couch with other clients. Client #5 did not eat any food between 5:01 P.M. and the time all clients left the facility to go out to eat at 5:50 P.M.</p> <p>Client #5's record was reviewed on 10/14/15 at 6:47 A.M. Review of client #5's 8/26/15 physician's orders indicated the following orders: "Calcium 600 (mg) + Vit (vitamin) D 400 I.U., Give one tablet orally 2 times daily with food."</p> <p>Nurse #1 was interviewed on 10/14/15 at 10:28 A.M. Nurse #1 stated, "[Client #5's] Calcium (Calcium 600 mg + Vitamin D 400 I.U.) should have been administered according to the physician's orders."</p> <p>9-3-6(a)</p>		<p>according to Dungarvin policy & procedure. All facility staff are being retrained on the Organized System of Medication Administration, including the provision that staff are to follow the orders on the MAR exactly, including giving medications with food when indicated. Once the training is complete, for two weeks and then until compliance has been demonstrated, observations will be conducted 8 times per week to ensure that all medications are being passed according to the physician's orders. Thereafter, the facility nurse, Lead DSP and/or Program Director will complete these checks at least weekly.</p>				

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W 0382 Bldg. 00	<p>483.460(I)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 1 of 3 additional clients (clients #7).</p> <p>Findings include:</p> <p>Client #7 was observed during the group home observation period on 10/14/15 from 5:50 A.M. until 8:00 A.M. At 6:30 A.M., direct care staff #1 was preparing medications to administer to client #7. Direct care staff #1 had the client #7's medications on the medication room table when she left the medication room to retrieve some applesauce. The open medications were left on the table making them accessible to client #7 whom was sitting in the medication room waiting to take her medications.</p> <p>Nurse #1 was interviewed on 10/14/15 at 10:28 A.M. Nurse #1 stated, "Medications are to be locked when they aren't being administered."</p>	W 0382	The Program Director/QIDP, facility nurse, and all facility staff will review this standard. All facility staff are being retrained on the expectation that all medications are to remain locked except when being prepared for administration and that all needed supplies are to be accessible in the medication room before the medication area is unlocked and medications are prepared for passing. Once the training is complete, for two weeks and then until compliance has been demonstrated, observations will be conducted 8 times per week to ensure that all medications are locked except when being prepared for administration. Thereafter, the Lead DSP, Facility Nurse and/or Program Director/QIDP will complete these checks at least weekly.	11/15/2015

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W 0436 Bldg. 00	<p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, the facility failed to assure to 1 of 4 sampled clients (client #3), wore her dentures while eating her morning meal.</p> <p>Findings include:</p> <p>Client #3 was observed at the group home during the 10/14/15 observation period from 5:50 A.M. until 8:00 A.M. During the observation period, client #3 did not wear dentures as she ate a bowl of corn flakes and milk for her morning meal.</p> <p>Direct care staff #1 and #4 did not prompt or assist client #3 to wear her dentures.</p> <p>Client #3's record was reviewed on 10/14/15 at 9:41 A.M. A review of the client #3's 4/1/15 Dental exam indicated</p>	W 0436	<p>The Program Director/ QIDP and Lead DSP will review this Standard. All staff will be retrained on this Standard and Agency Policy and Procedure concerning an individual's adaptive equipment. Once the training is complete, for two weeks and then until compliance has been demonstrated, observations will be conducted 8 times per week to ensure that all ordered adaptive equipment is being used at the home, including the use of dentures at mealtimes. If the individual is not wearing their dentures or other adaptive equipment, documentation will be checked to see if there is a trend of refusals to utilize the ordered adaptive equipment and what prompting was utilized. If it is determined an individual is regularly refusing to utilize their adaptive equipment, the issue will</p>	11/15/2015

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W 0460 Bldg. 00	<p>client #3 was edentulous (had no natural teeth) and was to wear dentures.</p> <p>Program Director #1 was interviewed on 10/15/15 at 11:17 A.M. The Program Director stated, "[Client #3] should be wearing her dentures when she is eating."</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review, and interview, the facility failed to assure 4 of 4 sampled clients' (clients #1, #2, #3 and #4's) menu and diet recommendations were followed for the morning meal.</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed during the 10/14/15 group home observation period from 5:50 A.M. until 8:00 A.M. Direct care staff #4 prepared oatmeal as client #6 put assorted cold cereals on the dining room table for the morning meal. For their morning meals, client #1 had a bowl of cold cereal with a glass of milk. Client</p>	W 0460	<p>be presented to their IDT, by the Program Director/QIDP, in order to create a formal goal and address the refusals. Thereafter, Program Director, Lead DSP, and/or Facility Nurse will complete these visits at least weekly to ensure continued compliance.</p> <p>The Program Director/ QIDP and Lead DSP will review this Standard. All staff will be retrained on this Standard and Agency Policy and Procedure concerning following the menu and diet recommendations provided by the licensed dietician at all meals. All facility staff will receive retraining on the menu and diet recommendations currently in place for all individuals residing at the facility. Appropriate substitutions and the documentation of substitutions will also be reviewed at this training. The QIDP and nurse will also discuss strategies to use in the case of individuals refusing to follow the menu and the documentation to complete when</p>	11/15/2015	

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	<p>#2 had a bowl of oatmeal with a glass of milk. Client #3 had a bowl of cold cereal and a cup of coffee. Client #4 had a bowl of oatmeal and a glass of milk. Direct care staff #1 and #4 did not offer the clients assorted muffins, citrus sections, margarine, or jelly.</p> <p>The facility's menu for the 10/14/15 morning meal was reviewed on 10/14/15 at 7:51 A.M. Foods listed on the menu for clients #1, #2, #3, and #4's morning meal were: "Assorted hot and cold cereals, assorted muffins, citrus sections, margarine, jelly, milk, juice, coffee."</p> <p>Client #1's records were reviewed on 10/14/15 at 8:45 A.M. Review of the client's 4/7/15 Annual Physician's Physical Exam indicated client #1 was on a Regular diet with no double portions.</p> <p>Client #2's records were reviewed on 10/14/15 at 9:07 A.M. Review of the client's 6/17/15 Annual Physician's Physical Exam indicated client #2 was on a Regular low sodium diet with measured vegetables.</p> <p>Client #3's records were reviewed on 10/14/15 at 9:41 A.M. Review of the client's 2/7/15 Annual Physician's Physical Exam indicated client #3 was on a Regular diet.</p>		<p>this occurs. Once the training is complete, for two weeks and then until compliance has been demonstrated, observations will be conducted 8 times per week to ensure that the menus are being implemented as written and that the individuals are being offered the items and choices indicated on the menu. Going forward, the Program Director will be required to review the documentation completed by the staff regarding compliance with the menu and any substitutions made during weekly site visits. Any concerns noted will be reviewed at the weekly Nurse/Med Support meeting and relayed back to the Area Director and the dietician as needed for follow up training, program implementation, or disciplinary action as needed.</p>		

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NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 55693 ASH RD OSCEOLA, IN 46561		
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	<p>Client #4's records were reviewed on 10/14/15 at 10:21 A.M. Review of the client's 6/17/15 Annual Physician's Physical Exam indicated client #4 was on a Regular diet.</p> <p>Program Director #1 was interviewed on 10/15/15 at 11:17 A.M. Program Director #1 stated, "Staff (direct care staff) should have offered the items on the menu to [clients #1, #2, #3 and #4]."</p> <p>9-3-8(a)</p>				