STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G452	A. BUILDING 00 B. WING	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	52812 HIGHLAND DR SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaints #IN00441061 and #IN00442051. Complaint #IN00441061- Federal/state deficiencies related to the allegation(s) are cited at W153 and W154. Complaint #IN00442051-No deficiencies related to the allegation(s) are cited. Dates of Survey: 9/24, 9/25, 9/26, 9/27 and 10/2/24. Facility Number: 000966 Provider Number: 15G452 AIMS Number: 100244770 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 10/18/24.	W 0000		
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES Based on record review and interview for 1 additional client (F), the facility failed to ensure a complete accounting of client F's finances to the penny. Findings include: On 9/24/24 at 5:00 PM, a review of client F's petty cash ledgers from the group home indicated: Client F's money pouch included 2 gift cards. One	W 0140	**W 140** **Governing Body (Standard):** **The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.** Corrective action for resident(s) found to have been affected **All parts of the POC for the**	10/30/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annmarie Fanning	Area Director	10/31/2024

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	gift card was for [name] Donuts and the other was for a restaurant. DSP (Direct Support Professional) #1 was unable to locate a ledger to determine the balance of each gift card. DSP #1 was able to call the toll free number on the back of the donuts card and determined the balance of the card was $10.00. The toll free number for the restaurant was no longer in service therefore the balance of the card was unknown. An interview was conducted on 9/24/24 at 5:15 PM with DSP #1. DSP #1 stated, "ledgers are supposed to be kept for gift cards, but the new HM (Home Manager) does not do this." An interview was conducted on 9/28/24 at 1:15 PM with the PD (Program Director). The PD stated, "cash and gift cards are to be tracked on a ledger." 9-3-2(a)		**survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **All facility staff were trained on 10/30/2024, on the proper documentation expected when assisting individuals in spending their personal funds, including gift cards. All individual spending is to be track on ledgers for each month, including tracking of gift cards. Program Director/ QIDP, Lead DSP and staff were trained on the expectation that monthly ledgers are to be turned in monthly and that new ledgers are to be started each month. New ledgers are in place for October 2024 and will be turned over on the 1st of the month. Copy of staff training uploaded for reference.** How facility will identify other residents potentially affected & what measures taken: All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence:** **Monthly financial packets are to be completed and submitted**	

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			to the office for auditing by the Client Finance Coordinator by the 15th of each month. Persons responsible: Program Director/QIDP, Lead DSP, Quality Assurance Manager, Area Manager, Area Director and Client Finance Coordinator	
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 3 sampled clients (A) and 1 former client (H), the facility failed to report an incident of peer to peer aggression and an injury of unknown origin to BDS (Bureau of Disability Services) within 24 hours in accordance with state law. Findings include: The facility's BDS (Bureau of Disability Services) reports were reviewed on 9/25/24 at 12:15 PM. The review indicated the following: 1. An 8/1/24 BDS incident report indicated "On 7/29/24 staff overheard a fight between [client A] and former [client H]. [Client A] punched [client H] on the back and [client H] hit him back." The incident report was not filed with BDS timely in accordance with state law. 2. An 8/14/24 BDS incident report indicated, "08/06/2024, the emergency (sic) was called by the nurse's instruction to pick up [client H] to the ER (emergency room), as he had a swollen leg and had difficulty getting up. He was diagnosed with a fracture of the shaft of the right fibula. The nurse contacted his PCP (Primary Care Physician) and	W 0153	**W153** **Governing Body (Standard) – The facility must ensure that all allegations 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.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **Program Director/QIDP and Area Manager received training, 10/25/2024, on the thorough and timely completion of reporting**	10/25/2024

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	made an appointment with an orthopedist. The staff followed all the doctors' instructions, and [client H] remained home and returned to his daily routine. On 08/09/2024, due to the exacerbating (sic) health of [client H], the Area Manager and the Nurse contacted staff to take him to the ER, and he was admitted." The incident report was not filed timely with BDS in accordance with state law. An interview was conducted with the PD (Program Director) on 9/26/24 at 1:15 PM. The PD stated,"I got overwhelmed with a lot of things to do, and didn't get the incident reports filed timely." An interview was conducted with the AD (Area Director) on 9/26/24 at 1:56 PM. The AD stated, "I was just made aware of this. It has been discussed with the PD about our requirements of reporting within 24 hours of knowledge." This federal tag relates to complaint #IN00441061. 9-3-2(a)		**incidents to BDS within 24 hours of knowledge, by reviewing Policy and Procedure A-07, regarding Documentation of Incidents and General Events. Copy of staff training uploaded for reference.** **Quality Assurance Manager is tracking the timeliness of initial filed reports and their follow ups, to assist the Program Director/QIDP to meet expectations.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS Based on record review and interview for former client H, the facility failed to ensure a thorough investigation was completed regarding an injury	W 0154	**W 154** **Governing Body (Standard) – The facility must have**	10/25/2024

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	of unknown origin. Findings include: The facility's BDS (Bureau of Disability Services) reports were reviewed on 9/25/24 at 12:15 PM. The review indicated the following: An 8/14/24 BDS incident report indicated, "08/06/2024, the emergency (sic) was called by the nurse's instruction to pick up [client H] to the ER, as he had a swollen leg and had difficulty getting up. He was diagnosed with a fracture of the shaft of the right fibula. The nurse contacted his PCP (Primary Care Physician) and made an appointment with an orthopedist. The staff followed all the doctors' instructions, and [client H] remained home and returned to his daily routine. On 08/09/2024, due to the exacerbating (sic) health of [client H], the Area Manager and the Nurse contacted staff to take him to the ER, and he was admitted." The review did not indicate documentation of a thorough investigation regarding injury of unknown origin. An interview was conducted on 9/24/24 at 1:54 PM with the AD (Area Director). The AD stated, "injuries of unknown origin are to be investigated." This federal tag relates to complaint #IN00441061. 9-3-2(a)		**evidence that all alleged violations are thoroughly investigated.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **Program Director/QIDP and Area Manager received training, 10/25/2024, on the thorough and timely completion of investigations of significant incidents. Training included a review of types of significant incidents that require investigations, including elopement, peer to peer aggression, hold/restraint, police involvement, property destruction, fall, choking, injury of unknown origin and medication error and that the investigation must be reviewed by an Administrator within 5 business days. Copy of staff training uploaded for reference.** **Quality Assurance Manager is tracking the timeliness of initial filed reports and their follow ups, to assist the Program Director/QIDP to meet**	

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			expectations. **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS Based on record review and interview for 2 of 3 sampled clients (A and C), 1 additional client (E) and 1 former client (H), the facility failed to ensure the results of 5 investigations were reported to the administrator within 5 working days. Findings include: The facility's BDS (Bureau of Disability Services) reports and investigations were reviewed on 9/25/24 at 12:15 PM. The review indicated the following: 1) A BDS report dated 6/30/24 indicated, "Staff heard a crash from [client E's] room and saw that [client E] had fallen on her buttocks alongside a	W 0156	**W-156** **Governing Body (Standard) – 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.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11,**	10/25/2024

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	bin of coloring materials. Staff checked her and found no immediate apparent injuries." The investigation summary dated 7/3/24 did not include the date when the administration reviewed the results of the investigation. 2) A BDS report dated 6/30/24 indicated, "The staff was taking [client E's] blood pressure and noticed two bruises on her arm (sic) the other one is less than 3 cm (centimeters) and the second bruise is about 5 cm the length. She was asked if she knew what happened but does not remember. [Client E] stated that it did not hurt. Nurse was notified and she said if she reports any pain, staff will call and assist her right away." The investigation summary dated 7/3/24 did not include the date when the administration reviewed the results of the investigation. 3) A BDS report dated 8/1/24 indicated, "[Client A] was in the living room folding his laundry when his housemate [client H] came out of his room, staff overheard a fight between them. Staff redirected them, [client A] continued to pursue [client H] and punched him on the back, but his housemate turned and punched him back. Staff separated them. There were no injuries." The investigation summary dated 8/1/24 did not include the date when the administration reviewed the results of the investigation. 4) A BDS report dated 9/9/24 indicated, "[Client C] stated to staff that he was changing his brief and fell on his bottom area. On-site staff then assisted [client C] and completed a health wellness check for any injuries. [Client C] did not obtain any injuries from the fall."		**will be fully implemented, including the following specifics:** **Program Director/QIDP and Area Manager received training, 10/25/2024, on the thorough and timely completion of investigations of significant incidents. Training included a review of types of significant incidents that require investigations, including elopement, peer to peer aggression, hold/restraint, police involvement, property destruction, fall, choking, injury of unknown origin and medication error and that the investigation must be reviewed by an Administrator within 5 business days. Copy of staff training uploaded for reference.** **Quality Assurance Manager is tracking the timeliness of initial filed reports and their follow ups, to assist the Program Director/QIDP to meet expectations.** **<u>How facility will identify other residents potentially affected & what measures taken:</u>** **All residents potentially are affected, and corrective measures address the needs of all clients.**	

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	The investigation summary dated 9/10/24 did not include the date when the administration reviewed the results of the investigation. 5) A BDS report dated 9/16/24 indicated, "[Client E] fell at the church playing a game with her peers. While walking under the parachute, she bumped into another person and fell on the floor. She fell on her left side. She was able to get off the floor with staff assistance. [Client E] complained of pain in her knees, especially the left knee. She was unable to ambulate and had to use a wheelchair to get around throughout the shift. [Client E] had no type of injury at the time of the incident." The investigation summary dated 9/16/24 did not include the date when the administration reviewed the results of the investigation. An interview was conducted on 9/26/24 at 1:15 PM with the PD (Program Director). The PD stated, "the AD (Area Director) is who should review the investigations after they are completed. I should have sent them to her first." An interview was conducted on 9/26/24 at 1:51 PM with the AD. The AD stated, "I was not aware until I saw the email the PD was not sending me the investigations to review as administrator." 9-3-2(a)		**Measures or systemic changes facility put in place to ensure no recurrence:** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	
W 0159 Bldg. 00	483.430(a) QIDP Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities	W 0159	**W-159** **Governing Body (Standard) – Each client's active treatment**	10/25/2024

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	Professional) failed to ensure: 1) clients A, B and C's goal data was being reviewed monthly, 2) clients A, B and C or their guardians participated in the development of their ISPs (Individual Support Plans), 3) client B's functional ability was assessed related to his sensorimotor skills by establishing a baseline, 4) client B's plan for elopement and safety included specific instructions for staff to implement, 5) clients A and C's CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed, and 6) client C's ISP (Individual Support Plan) was revised annually. Findings include: 1) Client A's record was reviewed on 9/26/24 at 12:30 PM. There were no Monthly Summaries for the last six months available to review for client A. Client B's record was reviewed on 9/26/24 at 11:45 AM. There were no Monthly Summaries for the last six months available to review for client B. Client C's record was reviewed on 9/25/24 at 2:16 PM. There were no Monthly Summaries for the last six months available to review for client C. Am interview was conducted on 9/26/24 at 1:15 PM with the QIDP. The QIDP stated, "Monthly Summaries should be completed to determine of the goal has been completed and revise if needed." 2) The QIDP failed to ensure clients A, B and C or their guardians participated in the development of their ISPs. Please see W209. 3) The QIDP failed to ensure client B's functional ability was assessed related to his sensorimotor		**program must be integrated, coordinated, and monitored by a qualified intellectual disability professional.<u>Corrective action for resident(s) found to have been affected:</u>All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics: (1) There were no client Monthly Summaries for the last six months available to review for client A, B and c. The Program Director/QIDP and Area Manager received training, 10/25/2024, on the expectation of reviewing goals monthly, of individual's active treatment programs. All monthly summaries will be placed in the individuals document storage, for review in Therap, upon completion, by the 15th of the following month. Copy of staff training uploaded for reference. (2) The QIDP failed to ensure clients A, B and C or their guardians participated in the development of their ISPs. Please see W209.(3) The QIDP failed to ensure client B's functional ability was assessed related to his sensorimotor skills by establishing a baseline. Please see W218.(4) The QIDP failed to ensure client B's plan for elopement**	

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	skills by establishing a baseline. Please see W218. 4) The QIDP failed to ensure client B's plan for elopement and safety included specific instructions for staff to implement. Please see W240. 5) The QIDP failed to ensure CFAs were reviewed annually and updated as needed for clients A and C. Please see W259. 6) The QIDP failed to ensure client C's ISP was revised annually. Please see W260. 9-3-3(a)		**and safety included specific instructions for staff to implement. Please see W240.** **(5) The QIDP failed to ensure CFAs were reviewed annually and updated as needed for clients A and C. Please see W259.(6) The QIDP failed to ensure client C's ISP was revised annually. Please W260<u>How facility will identify other residents potentially affected & what measures taken:</u>** **All residents potentially are affected, and corrective measures address the needs of all clients.<u>Measures or systemic changes facility put in place to ensure no recurrence:</u>The QIDP is required to complete a monthly summary of data gathered by the 15th of the month to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program.All staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed.Area Manager, Quality Assurance Managerand Area Director will randomly check monthly summaries throughout each quarter to ensure QIDP completion.Persons responsible: Program**	

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W 0209 Bldg. 00	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure clients A, B and C or their guardians participated in the development of their ISPs (Individual Support Plans). Findings include: 1. Client A's record was reviewed on 9/25/24 at 11:41 AM. Client A's ISP (Individual Support Plan) dated 3/8/24 indicated he had a legal guardian. Client A's ISP was not signed by client A's guardian. Client A's record did not indicate documentation of client A's guardian's participation in the development of client A's ISP. 2. Client B's record was reviewed on 9/26/24 at 11:45 AM. Client B's ISP dated 11/17/23 indicated he had a legal guardian. Client B's ISP was not signed by client B's guardian. Client B's record did not indicate documentation of client B's guardian's participation in the development of client B's ISP. 3. Client C's record was reviewed on 9/25/24 at 2:16 PM. Client C's ISP dated 7/13/23 indicated he was emancipated. Client C's record did not indicate documentation of client C's signature/participation in the development of his ISP. An interview was conducted on 9/26/24 at 1:15 PM with the QIDP (Qualified Intellectual	W 0209	**Director/QIDP, Area Manager, Quality Assurance Manager and Area Director** **W-209** **Governing Body (Standard) – Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. This standard is not met as evidenced by based on record review and interview for 3 of 3 sampled client, the facility failed to ensure clients A, B and C ore their guardians participated in the development of their ISPs.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **Currently, on our finalized ISPs we do notate the participants. However, we haven't included the IDT signature page, from the client's annual ISP meetings. Going forward, when ISPs are**	10/30/2024

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	Disabilities Professional). The QIDP stated, "ISPs should be signed by the individual or guardians." An interview was conducted on 9/26/24 at 2:34 PM with the PM (Program Manager). The PM stated, "the ISPs should be signed. We do a verbal agreement during the meeting." 9-3-4(a)		**uploaded to Therap, Program Directors/QIDP will also include their IDT meeting notes, that has the team's signatures listed. The IDT signature page will then be added as an attachment onto the ISP in Therap, as proof of participant participation.** **In the event of a virtual meeting, the IDT form will be emailed to each virtual attendee via Adobe, and they electronically sign the form and email it back. Their electronic signatures can then be uploaded as an attachment onto the ISP, listing the virtual participants.** **All Program Directors/QIDPs were notified of this expectation on 10/30/2024.** **<u>How facility will identify other residents potentially affected & what measures taken:</u>** **All residents potentially are affected, and corrective measures address the needs of all clients.** **<u>Measures or systemic changes facility put in place to ensure no recurrence:</u>** **Persons responsible: Program Director/QIDP, Area Manager, Area Director**	

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	15G452	A. BUILDING 00 B. WING	10/02/2024

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W 0218 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN Based on observation, record review, and interview for 1 of 3 sampled clients (B), the facility failed to assess client B's functional ability related to his OT (Occupational Therapy)/PT (Physical Therapy) skills by establishing a baseline. Findings include: Observations were conducted at the group home on 9/24/24 from 3:10 PM until 6:30 PM and on 9/25/24 from 6:50 AM until 8:30 AM. During the observation period client B utilized a rolling walker for all of his ambulatory needs. Client B's record was reviewed on 9/26/24 at 11:45 AM. Client B's nursing quarterly dated 7/19/24 indicated client B used a walker. Client B was admitted to the group home on 10/27/23. Client B's ISP (Individual Support Plan) dated 11/17/23 indicated, "[Client B] uses adaptive equipment, has mobility concerns, needs occupational therapy or physical therapy." Client B's Fall High Risk plan dated 3/7/24 indicated, "Falls/Injuries related to diagnosis of medications, unsteady gait (wheelchair), transferring or not being aware of surroundings. Goal(s) To prevent falls and injuries related to non-ambulatory status and needing assistance with transferring from the wheel chair." Client B's record did not indicate completion of a sensorimotor assessment to establish a baseline of client B's strengths and needs.	W 0218	**W-218** **Governing Body (Standard) – The comprehensive functional assessment must include sensorimotor development. The facility failed to assess client B's functional ability related to his OT/PT skills by establishing a baseline.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **A baseline was not established for client B, in relation to his ability related to his OT and PT skills, strengths and needs, when he transitioned into the facility.** **10/25/2024, Dungarvin's nurse reached out to client's doctor. The doctor's nurse put an order in for a referral for OT/PT evaluation, to establish a baseline of client B's strengths and needs. Staff will transport**	10/25/2024

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	An interview was conducted on 9/24/24 at 5:50 PM with DSP (Direct Support Professional) #6. DSP #6 stated, "[Client B] uses a rolling walker. He is able to get around the house independently with the use of the walker." An interview was conducted on 9/26/24 at 3:14 PM with the LPN (Licensed Practical Nurse). The LPN stated, "a baseline should have been established concerning [client B]." The LPN stated, "nursing is responsible for setting up all the appointments for new clients." 9-3-4(a)		**client B to his appointment for evaluation and any further recommendations as needed.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Persons responsible: Program Director/QIDP, Nurse, Area Manager, Area Director**	
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure client B's plan for elopement and safety included specific instructions for staff to implement. Findings include: Client B's record was reviewed on 9/26/24 at 11:45 AM. Client B's Individual Care Plan dated 3/7/24 indicated, "Staff will assure that the individual is within line of sight when exhibiting increased anxiety, cussing, threatening to elope, voicing displeasure of something or someone or some	W 0240	**W240** **Governing Body (Standard) – The individual program plan must describe relevant interventions to support the individual toward independence. The facility failed to ensure client B's plan for elopement and safety included specific instructions for staff to implement.** **Corrective action for resident(s) found to have been affected:**	10/30/2024

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	place or while out in the community. Staff will attempt to speak slowly to the individual and make sure he understands what you are saying to him. Call 911 if: Individual appears gravely ill or you are concerned about their immediate health and safety, such as when the individual is no longer in eye sight." An interview was conducted on 9/26/24 at 1:15 PM with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated, "the plan should be detailed giving staff instructions on what they should do if he elopes." An interview was conducted on 9/26/24 at 1:56 PM with the AD (Area Director). The AD stated, "the elopement plan should provide specific instructions. It should not jump to calling 911 first." 9-3-4(a)		**All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **The Program Director/QIDP and Area Manager received training, 10/25/2024, on the expectation of reviewing individual's plans to ensure specific instructions are available for staff to implement.** **The nurse has updated client B's plan for elopement and safety, on 10/30/2024, to include specific instructions for staff to implement.** **Copy of staff training uploaded for reference.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **All staff to be held accountable for expectations and knowledge of client**	

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			specific plans. **Persons responsible: Program Director/QIDP, Nurse, Area Manager, Area Director**	
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE Based on record review and interview for 2 of 3 sampled clients (A and C), the facility failed to ensure the CFAs (Comprehensive Functional Assessments) were reviewed annually and updated as needed for clients A and C. Findings include: 1) Client A's record was reviewed on 9/26/24 at 12:30 PM. Client A's record indicated his CFA was completed on 3/6/23. Client A's record did not indicate documentation of an annual review of the CFA since 3/6/23. 2) Client C's record was reviewed on 9/25/24 at 2:16 PM. Client C's record indicated his CFA was completed on 3/6/23. Client C's record did not indicate documentation of an annual review of the CFA since 3/6/23. An interview was conducted on 9/26/24 at 1:15 PM with the PD (Program Director). The PD stated, "CFAs are to be reviewed annually with the ISP (Individualized Support Plan)." An interview was conducted on 9/26/24 at 1:56 PM with the AD (Area Director). The AD stated, "CFAs are to be reviewed annually by the PD (Program Director)."	W 0259	**W-259** **Governing Body (Standard) – At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **Program Director/QIDP and Area Manager received training, 10/25/2024, on the thorough and timely completion of the comprehensive functional assessments of each client at this facility and the expectation**	10/25/2024

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	9-3-4(a)		**that the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed at least annually.** **Copy of staff training uploaded for reference.** **<u>How facility will identify other residents potentially affected & what measures taken:</u>** **All residents potentially are affected, and corrective measures address the needs of all clients.** **<u>Measures or systemic changes facility put in place to ensure no recurrence:</u>** **It is the expectations for ensuring the comprehensive functional assessments of each individual will be reviewed and updated annually by the Program Director/QIDP.** **The Area Manager and Area Director will be monitor this quarterly to ensure compliance.** **Persons responsible: Program Director/QIDP, Area Manager, Area Director**	
W 0260	483.440(f)(2) PROGRAM MONITORING & CHANGE			

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Bldg. 00	Based on record review and interview for 1 of 3 sampled clients (C) the facility failed to ensure client C's ISP (Individual Support Plan) was revised annually. Findings include: Client C's record was reviewed on 9/25/24 at 2:16 PM. Client C's record indicated his ISP was dated 7/13/23. Client C's record did not indicate documentation of an annual review of the ISP since 7/13/23. An interview was conducted on 9/26/24 at 1:15 PM with the PD (Program Director). The PD stated, "ISPs are to be done annually. The PD stated, "[Client C's] ISP is done but has not been implemented, it is laying on my desk." An interview was conducted on 9/26/24 at 1:56 PM with the AD (Area Director). The AD stated, "the ISP should be updated annually." 9-3-4(a)	W 0260	**W 260** **Governing Body (Standard): At least annually, the individual program plan must be revised, as appropriate. The facility failed to ensure client C's ISP was revised annually.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **Program Director/QIDP receiving training on 10/25/2024 on the expectations of entering the ISP and related programs into the Therap documentation system. QIDP receiving additional training on how to run monthly and quarterly progress reports from the Therap system in order to ensure that the ISP is always current and progress on all programs is being aggressively monitored.** **Client C's ISP annual meeting was completed on 07/19/2024, and the updated ISP was uploaded onto Therap, on 10/31/2024. PD/QIDP was reminded of the necessary**	10/25/2024

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			prompt updating of ISPs after annual meetings, so that individual's new plans will be in place. **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **All QIDPs are to be trained that they are responsible to ensure that the ISP is developed and implemented in a timely fashion after admission and annually thereafter.** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE Based on observation and interview for 5 of 8 clients living in the group home (B, C, D, F and G), the facility failed to ensure the clients were prompted to assist with meal preparation and serving themselves. Findings include:	W 0488	**W 488** **Governing Body (Standard) – The facility must assure that each client eats in a manner consistent with his or her developmental level.**	10/30/2024

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	An observation was conducted at the group home on 9/24/24 from 3:10 PM until 6:30 PM. At 3:30 PM DSP (Direct Support Professional) #6 stated, "it is Taco Tuesday, we will be having tacos for dinner." At 3:44 PM DSP #6 was standing at the kitchen counter cutting up an onion for dinner. Client C was sitting in his wheelchair near the table looking out of the window. Client B was sitting in the recliner in the large living room and client D was lying in bed watching a movie. Client G was sitting in a rocking chair watching a cartoon in the small living room off the kitchen. Client F was lying in bed in his bedroom. Client A was visiting with his family and client E was in the hospital. At 5:25 PM DSP #6 indicated the clients usually don't eat until 5:45 PM or 6:00 PM, but dinner was ready so they would be eating early. At 5:30 PM DSP #6 put plates with hard shell tacos containing meat and cheese and mixed vegetables in front of clients B, C, D and G. At 5:35 PM DSP #6 put food into a food processor for a pureed diet for client F. Clients B, C, D, F and G were not prompted to assist with meal preparation or serving themselves. An observation was conducted at the group home on 9/25/24 from 6:50 AM until 8:30 AM. At 6:55 AM a pot was on the stove with a clear lid containing hot cereal. At 7:30 AM clients B, C, D, F and G sat down at the table with bowls of hot cereal and cups of juice and milk. Clients B, C, D, F and G were not prompted to assist with meal preparation or serving themselves. An interview was conducted on 9/24/24 at 3:50 PM with client B. Client B stated, "I never help with dinner or breakfast, the staff cook it." An interview was conducted on 9/26/24 with the		**Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **All facility staff have received training on 10/30/2024, on this finding and on the expectations of family style dining. Training covered ways each individual could participate in the preparation, serving, and cleanup of meals according to their individual strengths and needs. Copy of staff training uploaded for reference.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **All new employees are trained on active treatment and family style dining expectations in the ICF-IDD setting. QIDP is to maintain a regular, frequent**	

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	AD (Area Director). The AD stated, "all individuals should participate in meal preparation. It is their right." 9-3-8(a)		**presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the PD/QIDP for follow up.** **The QIDP, Nurse, Area Manager, Area Director, or other qualified supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on promoting independence for all individuals while dining.** **Persons responsible: Program Director/QIDP, Area Manager, Area Director**	
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met: 460 IAC 9-3-1 Governing body Authority: IC 12-28-5-19 Affected: IC 4-21.5:12-10-3; IC 12-28-5-12; IC 22-12	W 9999	**W-9999** **Governing Body (Standard) – The facility shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. An emergency intervention for the individual resulting from: a.**	10/25/2024

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	Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division. 11) An emergency intervention for the individual resulting from: a. a physical symptom; b. a medical or psychiatric condition; c. any other event. This State rule is not met as evidenced by: Based on record review and interview for 1 of 3 sampled clients (B) and 1 former client (H), the facility failed to report emergency room visits for client B and former client H to BDS (Bureau of Disabilities Services) within 24 hours. Findings include: The facility's BDS (Bureau of Disability Services) reports were reviewed on 9/25/24 at 12:15 PM. The review indicated the following: 1) A 6/30/24 BDS incident report indicated, "On 6/27/24 former [client H] had 3 seizures in the morning, and 3 more in the afternoon. 911 was contacted and took [client H] to the ER (Emergency Room). Labs were drawn at the ER and were fine. Discharge instructions to continue taking prescribed medications." The incident report was not filed with BDS within 24 hours. 2) A 7/23/24 BDS incident report indicated, "On 7/20/24 former [client H] suffered a seizure lasting approximately 10 minutes. Staff immediately called 911 after 5 minutes and the VNS (Vagus Nerve Stimulator) yielded no improvement in		**a physical symptom, b. a medical or psychiatric condition; c. and other event. The facility failed to report emergency room visits for client B and former client H to BDS within 24 hours.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event ID 6DPT11, will be fully implemented, including the following specifics:** **Program Director/QIDP and Area Manager received training, 10/25/2024, on the thorough and timely completion of reporting incidents to BDS within 24 hours of knowledge, by reviewing Policy and Procedure A-07, regarding Documentation of Incidents and General Events. This includes when clients go to the emergency room. Copy of staff training uploaded for reference.** **Quality Assurance Manager is tracking the timeliness of initial filed reports and their follow ups, to assist the Program**	

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	responsiveness. Client H was taken to the ER. All tests results came back with a normal reading. Bloodwork indicated seizure medication was at therapeutic levels. Discharged without further treatment." The incident report was not filed with BDS within 24 hours. 3) A 9/26/24 BDS incident report indicated, "On 8/27/24 [client B] was taken to urgent care for having a temperature of 100 degrees and emesis. [Client B] was diagnosed with having a UTI (Urinary Tract Infection). The incident report was not filed with BDS within 24 hours. An interview was conducted with the PD (Program Director) on 9/26/24 at 1:15 PM. The PD stated,"I got overwhelmed with a lot of things to do, and didn't get the incident reports filed timely." An interview was conducted with the AD (Area Director) on 9/26/24 at 1:56 PM. The AD stated, "I was just made aware of this. It has been discussed with the PD about our requirements of reporting within 24 hours of knowledge." 9-3-1(b)		**Director/QIDP to meet expectations.** **How facility will identify other residents potentially affected & what measures taken:** **All residents potentially are affected, and corrective measures address the needs of all clients.** **Measures or systemic changes facility put in place to ensure no recurrence:** **Persons responsible: Program Director/QIDP, Quality Assurance Manager, Area Manager, Area Director**	