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	01/06/2025

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

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W 0000 Bldg. 00	This visit was for a post certification revisit (PCR) to the recertification and state licensure survey and the investigation of complaint #IN00441061 completed on 10/2/24. Complaint #IN00441061: Corrected. Dates of survey: 1/2, 1/3 and 1/6/2025. Facility Number: 000966 Provider Number: 15G452 Aims Number: 100244770 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/15/25.	W 0000		
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES Based on record review and interview for 1 of 3 sampled clients (B) and 1 additional client (F), the facility failed to ensure a complete accounting of client B and F's finances. Findings include: 1. Client B's record was reviewed on 1/2/25 at 4:47 pm. A review of client B's ledger at the house indicated: Client B's money credit card tracking ledger was dated November 2024. The ledger had an entry dated 12/28/24 for a deposit of $20.00 and spent $18.96 adding to the balance of $1.90 with a new balance of $4.11. Client B did not have a money ledger for January 2025.	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. This STANDARD is not met as evidenced by: {W 140} Based on record review and interview for 1 of 3 sampled clients (B) and 1 additional client (F), the facility failed to ensure a complete accounting of client B and F's finances.**	01/29/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Annmarie Fanning	Area Director	01/31/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	2. Client F's record was reviewed on 1/2/25 at 4:47 pm. A review of client F's ledger at the house indicated: Client F's money credit card tracking ledger was dated January 2025. The ledger did not have any entries on the ledger. Client F had a envelope marked $6.68 but when counted by Direct Support Professional (DSP) #1 there was $7.68. An interview with the DSP #1 was conducted on 1/2/25 at 4:50 pm. DSP #1 stated, "I don't know anything about the money. I don't deal with it." An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 1/3/25 at 1:36 pm. The QIDP stated, "The lead and all staff are responsible for writing all purchases on the ledgers. All of the clients should have a monthly ledger." An interview with the Area Director (AD) was conducted on 1/3/25 at 1:36 pm. The AD stated, "All clients should have ledgers for the month and the ledgers and receipts are turned in monthly. All staff have been trained on completing the ledgers." This deficiency was cited on 10/2/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)		**Corrective action for resident(s) found to have been affected** **All parts of the POC for the survey with event 6DPT12, will be fully implemented, including the following specifics:** **Facility staff were trained on 1/29/2025, 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. 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:** **QIDP and Lead DSP will**	

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			conduct a complete audit of client finances to ensure a complete accounting. Failure to maintain accurate records of client finances, will result in disciplinary action of the QIDP and Lead DSP, up to and including termination. Monthly financial packets are to be completed and submitted 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 0159 Bldg. 00	483.430(a) QIDP Based on record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure goal data was being reviewed monthly. Findings include: 1) Client A's record was reviewed on 1/2/25 at 11:37 am. There were not any Monthly Summaries completed since the annual survey was conducted on 10/2/24 completed for client A. 2) Client B's record was reviewed on 1/2/25 at 11:55 am. There were not any Monthly Summaries completed since the annual survey was conducted on 10/2/24 completed for client B. 3) Client C's record was reviewed on 1/2/25 at	W 0159	**W-159** **Governing Body (Standard) – Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who This STANDARD is not met as evidenced by: Based on record review and interview for 3 of 3 sampled clients (A, B and C), the QIDP (Qualified Intellectual Disabilities Professional) failed to ensure goal data was being reviewed monthly.** **Corrective action for resident(s) found to have been affected:**	01/27/2025

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	12:39 pm. There were not any Monthly Summaries completed since the annual survey was conducted on 10/2/24 completed for client C. An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 1/3/25 at 1:36 pm. The QIDP stated, "Every month I should be doing summaries on all of the clients. I have not done any of them." An interview with the Area Director (AD) was conducted on 1/3/25 at 1:36 pm. The AD stated, "The QIDP is responsible for completing the monthly summaries. We have not completed any monthly summaries since our annual survey. We have a training scheduled on how to complete them." This deficiency was cited on 10/2/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)		**All parts of the POC for the survey with event 6DPT12, will be fully implemented, including the following specifics:** **QIDP of facility received training, 01/27/2025, on the expectation of reviewing goals monthly of individual's active treatment programs.** **The Program Director/QIDP will ensure a monthly review of all goals are completed by the 15th of each month. The QIDP is auditing all ISPs in place to ensure that the goals listed in the ISP are in place correctly in the Therap documentation system, which would include the goals being measurable, having completion dates, having treatment schedules when needed and to include goal updates and requests from individuals.** **<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>**	

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			QIDP has been assigned monthly, the first Monday of the new month, to complete a monthly review of data gathered to assess progress on all goals and review that data gathered was sufficient per the parameters of each individual program and update accordingly based on the individual's needs. Failing to complete the monthly review of data, will result in disciplinary actions of the QIDP, up to and including termination. **All facility staff to be held accountable for expectations of documentation per the job description, including retraining and disciplinary action as needed.** **Area Manager and Area Director will randomly check monthly summaries throughout each quarter to ensure QIDP review and completion.** **Persons responsible: Program Director/QIDP, Area Manager, Area Director**	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE Based on observation and interview for 2 of 3	W 0488	**W 488**	01/29/2025

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	sampled clients (A and C) plus 4 additional clients (D, F, G and H), the facility failed to ensure the clients were prompted to assist with meal preparation. Findings include: Observations were conducted on 1/2/25 from 3:59 pm to 6:00 pm. Clients A, C, D, E, F, G and H were present throughout the observations. Client B was visiting with his family. Client E has a feeding tube and does not eat any food by mouth. On 1/2/25 at 3:59 pm Direct Support Professional (DSP) #3 was in the kitchen cooking sausage and rice. Clients E and G were sitting in the front living room watching television. Client A was sitting in the main living room and stated he had not been feeling well. Client H was sitting in the main living room and indicated he had not done anything today. An interview with client H was conducted on 1/2/25 at 4:11 pm. Client H stated, "If I am asked to cook, I do. I haven't been asked to cook since living in this home. Staff don't ask me to help cook. No residents are getting asked to cook." An interview with client A was conducted on 1/2/25 at 4:12 pm. Client A stated, "I never cook." At 4:14 pm clients F and C were in their bedroom. Client F was lying in his bed and client C was lying in his bed. At 4:16 pm client D was in his bedroom lying in his bed watching a television show. Client D stated, "They don't hardly ask me to help cook, I like to cook." At 4:18 pm DSP #3 was in the kitchen stirring the sausage in a gravy. DSP #2 assisted client G in		**Governing Body (Standard) –The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: {W 488} Based on observation and interview for 2 of 3 sampled clients (A and C) plus 4 additional clients (D, F, G and H), the facility failed to ensure the clients were prompted to assist with meal preparation.** **Corrective action for resident(s) found to have been affected:** **All parts of the POC for the survey with event 6DPT12, will be fully implemented, including the following specifics:** **Facility staff have received training on 1/29/2025, on this finding and on the expectations of family style dining. Training covered ways everyone 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**	

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	using the restroom. At 4:23 pm DSP #3 opened 3 cans of pears and then was stirring the rice. Clients A and H were sitting in the main living room. At 4:27 pm DSP #3 made juice. At 4:29 pm DSP #3 assisted client G into the front living room to sit in the recliner. Clients A, D and H were sitting in the main living room watching television. At 4:39 pm client F was brought into the kitchen in his wheelchair by DSP #2. Client F was positioned by the lower countertop in the kitchen and was listening to music. At 5:01 DSP #3 pureed client F's food. At 5:09 pm DSP #3 placed plates, cups and utensils on the table. At 5:05 pm DSP #3 placed bowls of food on the table and then the pitcher of juice and water. At 5:10 pm client A walked into the kitchen and indicated he wanted soup for dinner. DSP #3 asked client A if he wanted her to make it for him. Client A told DSP #3 she could make it for him. Clients A, C, D, E, F, G and H were not prompted to assist with preparing any of the meal. An interview with DSP #3 was conducted on 1/2/25 at 5:25 pm. The DSP #3 stated, "No, I didn't ask any clients to help me cook. We have not had a meeting since before COVID. We never have any house meetings. We just sign, and nobody trains us and then we fail again." An interview with the Qualified Intellectual Disability Professional (QIDP) was conducted on 1/3/25 at 1:36 pm. The QIDP stated, "The staff cook the meal with the help of individuals." An interview with the Area Director (AD) was conducted on 1/3/25 at 1:36 pm. The AD stated, "All individuals should be cooking to their abilities and making it a teachable moment. It might be hand over hand assistance, but anyone		**measures address the needs of all clients.** **<u>Measures or systemic changes facility put in place to ensure no recurrence:</u>** **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 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.** **Failing to ensure the clients are prompted to assist with meal preparation by the facility staff, will result in disciplinary actions of the QIDP, up to and including termination.** **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,**	

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	can help with making the meal." This deficiency was cited on 10/2/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-8(a)		**Area Director**	