STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G479	A. BUILDING 00 B. WING	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360

(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 the investigation of complaint #IN00411750. Complaint #IN00411750: State rule related to the allegation(s) is cited at W9999. Dates of Survey: August 7, 8, 9, 10, 11, and 14, 2023. Facility Number: 000993 Provider Number: 15G479 AIMS Number: 100244950 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/5/23.	W 0000		
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 observation, record review, and interview for 11 of 19 allegations of abuse and neglect reviewed for 3 of 3 sample clients (A, B, and C), plus 1 additional client (E), the facility failed to implement its written policy and procedure to prevent, report, and thoroughly investigate a fall with injury for client E, 4 injuries of unknown origin for client B, 2 incidents of peer to peer aggression for client B, 2 incidents of peer to peer aggression for client C, an incident of peer to peer aggression for client A, and an incident of evasion of supervision for client A.	W 0149	**W 149** Staff Treatment of Clients (Standard) – The facility failed to implement its written policy and procedure to prevent, report, and thoroughly investigate a fall with injury for client E, 4 injuries of unknown origin for client B, 2 incidents of peer to peer aggression for client B, 2 incidents of peer to peer aggression for client C, an incident of peer to peer aggression for client A, and an incident of evasion of	09/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Gichohi	Area Director	09/18/2023

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	Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports, incident reports, and related investigations were reviewed on 8/7/23 at 1:08 pm. 1a. A staff note dated 7/13/23 indicated the following: "[Client A] was sitting in the dining room when staff arrived. He was redirected from spitting on staff and individuals during pick ups. Pulling individuals hair and hitting individuals in the back of heads and hitting staff." The review did not indicate the incident was reported to BDDS. The review did not include an investigation for an allegation of physical abuse by client towards his peers. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/8/23 at 1:00 pm and stated, "I've never seen [client A] grab hair. The staff said they heard [client E] say, 'Stop, don't pull my hair.' The staff didn't see it happen. We don't know if he really did pull her hair." 1b. A staff note dated 7/27/23 indicated the following: "At 1:10 pm, staff gave [client A] an apple and big cup of water. He sat at the table and ate (sic) apple and drunk (sic) cup of water. Afterwards, he sat in the living room with his peers. Staff went to the bathroom and, when staff returned, [client A] was no longer in (sic) living room. Staff checked bedroom, kitchen, and bathroom. [Client A] was found outside going thru (sic) the trash. He we (sic) redirected, but he would not listened (sic) to staff. He finally stopped going thru (sic)		supervision for client A. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: · All facility staff retrained on Dungarvin policies regarding Incident Reporting. All incidents of falls with injury, injuries of unknown origin, and peer-to-peer aggression constitute high level GERs which require submission of an internal incident report (GER) and direct reporting to the nurse and supervisor. ·QIDP receiving retraining on the Dungarvin policy on Incident Reporting and the BDDS policy on Incident Reporting. ·QIDP is to review staff notes daily to ensure that no reportable incidents are in staff notes that were not reported to the Program Director or the PD on call. ·QIDP retrained on effective completion of Significant Incident Investigations, including the purpose of completing them thoroughly and promptly in order to prevent recurrence and identify any trends. 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.	

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	the trash. [Client A] then attempted to open staff's car doors. He was pulling on door handle and trying to put window down with his hands. Staff had to sound the alarm on (sic) car for him to stop. He went inside (sic) house. Staff assisted him with brushing his teeth and washing his hands. Staff gave [client A] a big cup of water afterwards. [Client A] still continued wandering about in the house. He is currently watching TV with his peers." The review did not indicate the incident was reported to BDDS. The review did not include an investigation of client A's evasion of supervision. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "Staff said [client A] went outside, and he was in our garbage. His supervision level is line of sight. Line of sight was not followed." Client A's record was reviewed on 8/8/23 at 2:00 pm. Client A's behavior support plan dated 4/22/23 indicated the following: "Target Behaviors Food/Drink Theft Pica (eating non-food items) Behaviors: [Client A] will take others' food, he will search the cabinets and refrigerator for food, he will search/rummage the garbage for food items, and when [client A] gains access to uncooked items, he will consume the item as it is uncooked or raw. [Client A] will also take staffs', housemates', and others' food/drinks when the items are not closely monitored. Although he does not eat inedible items, he will try to eat and drink items that are not his (in addition to inedible forms of food). Physical Aggression: Defined as any intentional act of causing or attempting to cause physical		Measures or systemic changes facility put in place to ensure no recurrence All new Program Director/QIDPs will be trained on Incident Reporting expectations. All new staff are trained on Incident Reporting during new staff orientation and then on an annual basis as a part of annual ANE training. Program Director is responsible to be aware of all reportable incidents and to report them according to state law. All significant incidents which could indicate abuse, neglect, exploitation, mistreatment and/or violation of individuals' rights will be investigated within 5 business days, including an analysis of any antecedents or triggers as well as any programmatic changes or staff trainings that are needed to prevent recurrence. -	

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	harm to others.... Elopement: Failure to remain within line of sight of family and staff.... Proactive Strategies: [Client A] will remain in line-of-sight (sic) staff during awake hours while at his residential placement for safety, security, and redirection. Staff will also work on stress reduction and communication activities as needed/tolerated by [client A]." 2a. A BDDS report dated 1/23/23 indicated the following: "PD (program director) received a call from staff that [client B] was in his room, Sunday night (1/22) when they heard a loud thump. When they entered the room, [client B] was found on the floor. It was determined that he had engaged in willful apnea (the client holds his breath until he loses consciousness) behavior which is not unusual for him. [Client B] is non-verbal and therefore we are not always able to determine when he is experiencing anxiety which triggers the behavior. [Client B] was given a head to toe (examination) and did not appear to have any visible injuries. Following this incident, staff followed his risk plan regarding techniques to use when he experiences this behavior to prevent him from furthering (sic) engaging in willful apnea. While completing his morning hygiene on Monday morning (1/23/23), staff noticed that his right foot was bluish in color. Staff was instructed to take him to urgent care. The x-ray revealed that he has three nondisplaced fractured toes. His foot was placed in a walking boot which will elevate the excess weight off your injured foot to promote the healing process. [Client B] was prescribed ibuprofen (pain reliever) to be administered every 4 hours or as needed for pain...."			

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	An investigation dated 1/23/23 indicated the following: "Were staff present following all Behavior Support Plans (BSPs)/High Risk Plan Interventions per the plans? If no, why? No, staff should have remained in [client B's] room until he was fully out of the behavior.... could the incident have been prevented? Staff could have possible (sic) prevented [client B] from falling to the floor if they remained in his room during the behavior....What actions should be taken to prevent future incidents? PD reviewed BSP with staff and reminded them to remain in close proximity whenever possible, especially when [client B] is in a behavior." QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "Staff reported they heard the loud thump. When they went in, [client B] was passed out. They didn't see it happen. Willful apnea is part of his plan. Staff are supposed to stay close by when he's in behavior. If they see him engage in that behavior, they need to sit him down right next to them. He will fall over." 2b. A staff note dated 4/25/23 indicated the following: "[Client B] was at day program when staff arrived. He grabbed a housemate by the hair and would not let go.... He was redirected multiple times for being inappropriate. He grabbed another housemate. Both staff had to pull him off." The review did not indicate the incident was reported to BDDS. The review did not include an investigation of peer to peer aggression by client B. 2c. A staff note dated 7/2/23 indicated the following:			

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	"While toileting [client B], staff noticed that his penis was red and irritated. May have been bleeding at one point, open scabs. Staff notified nurse and was told to apply antibiotic ointment on the area. Due to [client B's] history of masturbation, nurse suggested staff buys him [lubricating] jelly. At this time, [client B] doesn't appear to be in pain or any discomfort." The review did not indicate the incident was reported to BDDS. The review did not include an investigation of client B's unknown injury. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "That's an unknown injury. I would expect staff to report to me and the nurse. There should have been a GER (general event report), a BDDS report, and an investigation." 2d. A BDDS report dated 7/9/23 indicated the following: "[On 7/3/23] staff reports that during morning hygiene, he noticed that [client B's] right middle finger was red in color. [Client B] had slammed his finger in his bedroom door the previous night. Staff took photo of finger and submitted to nurse on-call. The nurse instructed staff to transport him to urgent care. An x-ray was performed showing that he had a hairline fracture...." The review indicated client B's injury was not reported to BDDS within 24 hours of knowledge. The review did not include an investigation of client B's broken finger. 2e. An observation was conducted in the group home on 8/8/23 from 3:45 pm to 5:30 pm. Client B was present throughout the observation period and had a blue bruise on his right arm below the			

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	elbow measuring 2 inches in length. Both of client B's knees were scraped and had scabs. Direct Support Professional (DSP) #1 was interviewed on 8/8/23 at 4:30 pm and stated, "That is a bruise on his arm. I didn't notice that. I did see the scrapes on his knees. He tripped over someone's shoes the other day and fell down." DSP #1 stated, "The say he bruises easily. He's clumsy and often has bruises." QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "I saw the bruises. A fall last week was not reported by staff. There is no BDDS report. I was not aware of that. There should have been a BDDS report. I don't know how or when the bruise happened. I noticed it yesterday." Client B's record was reviewed on 8/8/23 at 1:20 pm. Client B's fall risk plan dated 2/25/22 indicated the following: "Health Risk: Falls/injuries related to self-injurious behaviors; holding his breath and passing out, vision, medication, unsteady gait, moving too quickly, or not being aware of his surroundings.... Staff will assist with all ADLs (activities of daily living).... Staff will remove obstacles from the individual's path prior to ambulation. Staff will report falls to the PD/On-Call PD and any fall with injury to the nurse. Staff will have [client B] sit down if he is holding his breath. Staff will attempt to distract [client B] if he is holding his breath by blowing in his face, tickling him, or making a loud noise." Client B's Behavior Support Plan (BSP) dated 11/1/19 indicated the following:			

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	"Staff should always follow [client B's] safety plan that states he is to be within staff's supervision during all hours that he is awake." 3a. A staff note dated 3/28/23 indicated the following: "[Client C] was having a good afternoon. She was in a good mood and chilling most of the afternoon until she began trying to boss her housemate (client B) around. She pushed/shoved him and tries (sic) to tell him what to do. Staff advised her to stop it, and she continued. She attempts to overpower him everyday due to him being smaller and not speaking." The review did not indicate the incident was reported to BDDS. The review did not include an investigation of client C's physical aggression towards client B. 3b. A staff note dated 7/10/23 indicated the following: "[Client C] was on the van, and [client B] was being very intrusive and touching [client C]. Staff held [client B's] hands. Staff let go due to [client B] calming down. [Client B] put (his) head on [client C's] shoulder. [Client B] then proceeded to bite [client C] on her upper left arm. [Client C] has a bruise. No skin was broken." The review did not indicate the incident was reported to BDDS. The review did not include an investigation of client B's physical aggression towards client C. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "Peer to peer aggression should be reported to BDDS." 3c. An observation was conducted in the group			

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	home on 8/8/23 from 3:45 pm to 5:30 pm. Clients B and C were present throughout the observation period. On 8/8/23 at 4:19 pm, client B was standing in the doorway to the living room. Client C was pacing through the home. Client C walked up behind client B, looked around her, then pushed client B from behind. Client C stated, "Get over there and sit down." No staff were present in the area at the time and did not witness client C push client B. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "[Client C] is bossy, but she's not overly violent. She acts like she's [client B's] mother." QIDP #1 stated, "Staff should redirect [client C]. They should use verbal redirection." QIDP #1 stated, "I've never seen [client C] do that. We need to address it in a team meeting to ensure it doesn't happen again. Even when she's telling him what to do, we should redirect." Client C's record was reviewed on 8/8/23 at 2:00 pm. Client C's BSP dated 8/1/22 indicated the following: "If [client C] is aggressive, staff will ask her to stop and go to a quiet area to calm down. Staff should tell [client C] that she cannot earn her reinforcer if she is aggressive. Other peers and staff in the area may need to leave before [client C] is willing to go to a quiet area. She may continue to be aggressive if she feels cornered or physically blocked in any way...." 4a. A BDDS report dated 7/9/23 indicated the following: "Staff reports that [client E] sustained a superficial abrasion on her right knee when she lost her balance walking and fell in the hallway. Staff was instructed by on-call nurse to clean the area and			

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	apply triple antibiotic ointment on the area." The review did not include an investigation of client E's fall with injury. Client E's record was reviewed on 8/8/23 at 1:45 pm and did not include a high risk plan for falls. Area Director (AD) #1 was interviewed by phone on 8/10/23 at 2:00 pm and stated, "Staff report allegations of abuse and neglect to their supervisor. They need to make a phone call. If it's reportable, it's going to be in a GER as well as the [digital staff notes]. Staff should report as soon as they've made sure the individual is safe, by the end of their shift." AD #1 stated, "We report to BDDS within 24 hours of knowledge." AD #1 stated, "Peer to peer, falls with injury, and [client A] being out of sight should all be reported to BDDS. We investigate falls with injuries, peer to peer, and injuries of unknown origin." AD #1 stated, "The investigation should be completed within 5 business days. We should review any pertinent plans to the situation and should have recommendations to prevent recurrence." The facility's Policy and Procedure Concerning Abuse, Neglect, and Exploitation dated 5/21/21 was reviewed on 8/9/23 at 1:00 pm and indicated the following: "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; unnecessary restraint/confinement resulting from physical or chemical intervention.... Unnecessary restraint/confinement is defined as any physical intervention that limits the movement or mobility of an individual that is not			

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	outlined in an individuals' behavior support plan.... Neglect is defined as failure to provide appropriate care, supervision, or training.... Dungarvin responds promptly to actual and suspected abuse.... Dungarvin employees are required by law to report suspected or actual abuse, neglect, or exploitation.... The first step is to immediately contact the program supervisor for the individual, the on-call supervisor, or any area director or area manager if the supervisor cannot be reached or is the alleged perpetrator. The supervisor receiving the report shall inform the appropriate area director/manager or senior director. If the alleged perpetrator is the program supervisor, the area director/manager will be responsible for notifying authorities and conducting or delegating the investigation. Should the area director be the alleged perpetrator, the supervisor will notify the senior director, who is responsible for notifying authorities and conducting or delegating the investigation. Should a senior director be suspected, the supervisor will notify the regional director who will then be responsible for notifying authorities and conducting or delegating the investigation.... As appropriate, a description of the allegation or incident will be documented in a General Event Report (GER) in [digital record keeping system], or using an incident report form for sites not utilizing [digital record keeping system]. Within 24 hours of knowledge of the suspected or actual abuse, neglect, or exploitation, the program director/manager, area director/manager, senior director, or other designated administrator will report the incident to the Bureau of Developmental Disabilities Services using the on-line incident reporting process.... The program director/manager, area			

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	director/manager, senior director or his/her delegate will conduct a thorough investigation of any alleged, suspected or actual abuse, neglect, or exploitation. Within five business days, the results and/or status of the investigation will be reported to the administrator. A written investigation report including written witness statements, pertinent history, evidence, a summary of findings and conclusion, and recommendations for disciplinary action utilizing the format recommended by BDDS will be developed at the conclusion of the investigation. If allegations of abuse, neglect, or exploitation are substantiated, appropriate disciplinary action will be taken in consultation with the area director/manager, senior director and human resources director. Any conclusion of substantiated abuse, neglect, or exploitation by any employee is subject to disciplinary action up to and including immediate termination." 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS 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. Based on observation, record review, and interview for 8 of 17 allegations of abuse and neglect reviewed for 3 of 3 sample clients (A, B and C), the facility failed to report an allegation of peer to peer aggression by client A, an incident of evasion of supervision for client A, an allegation of peer to peer aggression for client B, 3 injuries of unknown origin for client B, and 2 allegations of	W 0153	**W 153** Staff Treatment of Clients (Standard) - The facility failed to report an allegation of peer to peer aggression by client A, an incident of evasion of supervision for client A, an allegation of peer to peer aggression for client B, 3 injuries of unknown origin for client B, and	09/14/2023

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	peer to peer aggression for client C to the supervisor immediately and to the appropriate state authority within 24 hours of knowledge in accordance with state law. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports, incident reports, and related investigations were reviewed on 8/7/23 at 1:08 pm. 1a. A staff note dated 7/13/23 indicated the following: "[Client A] was sitting in the dining room when staff arrived. He was redirected from spitting on staff and individuals during pick ups. Pulling individuals hair and hitting individuals in the back of heads and hitting staff." The review did not indicate the incident was reported to BDDS. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/8/23 at 1:00 pm and stated, "I've never seen [client A] grab hair. The staff said they heard [client E] say, 'Stop, don't pull my hair.' The staff didn't see it happen. We don't know if he really did pull her hair." 1b. A staff note dated 7/27/23 indicated the following: "At 1:10 pm, staff gave [client A] an apple and big cup of water. He sat at the table and ate (sic) apple and drunk (sic) cup of water. Afterwards, he sat in the living room with his peers. Staff went to the bathroom and, when staff returned, [client A] was no longer in (sic) living room. Staff checked bedroom, kitchen, and bathroom. [Client A] was found outside going thru (sic) the trash.		2 allegations of peer to peer aggression for client C to the supervisor immediately and to the appropriate state authority within 24 hours of knowledge in accordance with state law. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID6FRS11 will be fully implemented, including the following specifics: · All facility staff retrained on Dungarvin policies regarding Incident Reporting. All incidents of falls with injury, injuries of unknown origin, and peer-to-peer aggression constitute high level GERs which require submission of an internal incident report (GER) and direct reporting to the nurse and supervisor. ·QIDP receiving retraining on the Dungarvin policy on Incident Reporting and the BDDS policy on Incident Reporting. ·QIDP is to review staff notes daily to ensure that no reportable incidents are in staff notes that were not reported to the Program Director or the PD on call. 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.	

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	15G479	A. BUILDING 00 B. WING	08/14/2023

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	He we (sic) redirected, but he would not listened (sic) to staff. He finally stopped going thru (sic) the trash. [Client A] then attempted to open staff's car doors. He was pulling on door handle and trying to put window down with his hands. Staff had to sound the alarm on (sic) car for him to stop. He went inside (sic) house. Staff assisted him with brushing his teeth and washing his hands. Staff gave [client A] a big cup of water afterwards. [Client A] still continued wandering about in the house. He is currently watching TV with his peers." The review did not indicate the incident was reported to BDDS. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "Staff said [client A] went outside, and he was in our garbage. His supervision level is line of sight. Line of sight was not followed." 2a. A staff note dated 4/25/23 indicated the following: "[Client B] was at day program when staff arrived. He grabbed a housemate by the hair and would not let go.... He was redirected multiple times for being inappropriate. He grabbed another housemate. Both staff had to pull him off." The review did not indicate the incident was reported to BDDS. 2b. A staff note dated 7/2/23 indicated the following: "While toileting [client B], staff noticed that his penis was red and irritated. May have been bleeding at one point, open scabs. Staff notified nurse and was told to apply antibiotic ointment on the area. Due to [client B's] history of masturbation, nurse suggested staff buys him		Measures or systemic changes facility put in place to ensure no recurrence All new Program Director/QIDPs will be trained on Incident Reporting expectations. All new staff are trained on Incident Reporting during new staff orientation and then on an annual basis as a part of annual ANE training. Program Director is responsible to be aware of all reportable incidents and to report them according to state law.	

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	[lubricating] jelly. At this time, [client B] doesn't appear to be in pain or any discomfort." The review did not indicate the incident was reported to BDDS. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "That's an unknown injury. I would expect staff to report to me and the nurse. There should have been a GER (general event report), a BDDS report, and an investigation." 2c. A BDDS report dated 7/9/23 indicated the following: "[On 7/3/23] staff reports that during morning hygiene, he noticed that [client B's] right middle finger was red in color. [Client B] had slammed his finger in his bedroom door the previous night. Staff took photo of finger and submitted to nurse on-call. The nurse instructed staff to transport him to urgent care. An x-ray was performed showing that he had a hairline fracture...." The review indicated client B's injury was not reported to BDDS within 24 hours of knowledge. 2d. An observation was conducted in the group home on 8/8/23 from 3:45 pm to 5:30 pm. Client B was present throughout the observation period and had a blue bruise on his right arm below the elbow measuring 2 inches in length. Both of client B's knees were scraped and had scabs. Direct Support Professional (DSP) #1 was interviewed on 8/8/23 at 4:30 pm and stated, "That is a bruise on his arm. I didn't notice that. I did see the scrapes on his knees. He tripped over someone's shoes the other day and fell down." DSP #1 stated, "The say he bruises easily. He's clumsy and often has bruises."			

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	QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "I saw the bruises. A fall last week was not reported by staff. There is no BDDS report. I was not aware of that. There should have been a BDDS report. I don't know how or when the bruise happened. I noticed it yesterday." 3a. A staff note dated 3/28/23 indicated the following: "[Client C] was having a good afternoon. She was in a good mood and chilling most of the afternoon until she began trying to boss her housemate (client B) around. She pushed/shoved him and tries (sic) to tell him what to do. Staff advised her to stop it, and she continued. She attempts to overpower him everyday due to him being smaller and not speaking." The review did not indicate the incident was reported to BDDS. 3b. A staff note dated 7/10/23 indicated the following: "[Client C] was on the van, and [client B] was being very intrusive and touching [client C]. Staff held [client B's] hands. Staff let go due to [client B] calming down. [Client B] put (his) head on [client C's] shoulder. [Client B] then proceeded to bite [client C] on her upper left arm. [Client C] has a bruise. No skin was broken." The review did not indicate the incident was reported to BDDS. Area Director (AD) #1 was interviewed by phone on 8/10/23 at 2:00 pm and stated, "Staff report allegations of abuse and neglect to their supervisor. They need to make a phone call. If it's reportable, it's going to be in a GER as well as			

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	the [digital staff notes]. Staff should report as soon as they've made sure the individual is safe, by the end of their shift." AD #1 stated, "We report to BDDS within 24 hours of knowledge." AD #1 stated, "Peer to peer, falls with injury, and [client A] being out of sight should all be reported to BDDS." 9-3-2(a)			
W 0154 Bldg. 00	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 8 of 17 allegations of abuse and neglect reviewed for 3 of 3 sample clients (A, B, and C), the facility failed to thoroughly investigate a fall with injury for client E, 2 injuries of unknown origin for client B, an allegation of peer to peer aggression for client B, 2 allegations of peer to peer aggression for client C, an allegation of peer to peer aggression for client A , and an incident of evasion of supervision for client A. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports, incident reports, and related investigations were reviewed on 8/7/23 at 1:08 pm. 1a. A staff note dated 7/13/23 indicated the following: "[Client A] was sitting in the dining room when staff arrived. He was redirected from spitting on staff and individuals during pick ups. Pulling individuals hair and hitting individuals in the back of heads and hitting staff."	W 0154	**W 154** Staff Treatment of Clients (Standard) - The facility failed to thoroughly investigate a fall with injury for client E, 2 injuries of unknown origin for client B, an allegation of peer to peer aggression for client B, 2 allegations of peer to peer aggression for client C, an allegation of peer to peer aggression for client A, and an incident of evasion of supervision for client A. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID6FRS11 will be fully implemented, including the following specifics: · Program Director/QIDP is receiving re-training on the thorough and timely completion of investigations. Training to include	09/14/2023

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	The review did not include an investigation for an allegation of physical abuse by client towards his peers. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/8/23 at 1:00 pm and stated, "I've never seen [client A] grab hair. The staff said they heard [client E] say, 'Stop, don't pull my hair.' The staff didn't see it happen. We don't know if he really did pull her hair." 1b. A staff note dated 7/27/23 indicated the following: "At 1:10 pm, staff gave [client A] an apple and big cup of water. He sat at the table and ate (sic) apple and drunk (sic) cup of water. Afterwards, he sat in the living room with his peers. Staff went to the bathroom and, when staff returned, [client A] was no longer in (sic) living room. Staff checked bedroom, kitchen, and bathroom. [Client A] was found outside going thru (sic) the trash. He we (sic) redirected, but he would not listened (sic) to staff. He finally stopped going thru (sic) the trash. [Client A] then attempted to open staff's car doors. He was pulling on door handle and trying to put window down with his hands. Staff had to sound the alarm on (sic) car for him to stop. He went inside (sic) house. Staff assisted him with brushing his teeth and washing his hands. Staff gave [client A] a big cup of water afterwards. [Client A] still continued wandering about in the house. He is currently watching TV with his peers." The review did not include an investigation of client A's evasion of supervision. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "Staff said [client A] went outside, and he		a review of types of incidents that require investigations, including falls with injury, peer to peer aggression, and injuries of unknown origin. · Area Director will be responsible to ensure that all investigations are thorough by signing off on all investigations within 5 working days. <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> All Program Director/QIDPs are trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective.	

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	was in our garbage. His supervision level is line of sight. Line of sight was not followed." 2a. A staff note dated 4/25/23 indicated the following: "[Client B] was at day program when staff arrived. He grabbed a housemate by the hair and would not let go.... He was redirected multiple times for being inappropriate. He grabbed another housemate. Both staff had to pull him off." The review did not include an investigation of peer to peer aggression by client B. 2b. A staff note dated 7/2/23 indicated the following: "While toileting [client B], staff noticed that his penis was red and irritated. May have been bleeding at one point, open scabs. Staff notified nurse and was told to apply antibiotic ointment on the area. Due to [client B's] history of masturbation, nurse suggested staff buys him [lubricating] jelly. At this time, [client B] doesn't appear to be in pain or any discomfort." The review did not include an investigation of client B's unknown injury. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "That's an unknown injury. I would expect staff to report to me and the nurse. There should have been a GER (general event report), a BDDS report, and an investigation." 2c. A BDDS report dated 7/9/23 indicated the following: "[On 7/3/23] staff reports that during morning hygiene, he noticed that [client B's] right middle finger was red in color. [Client B] had slammed his finger in his bedroom door the previous night.			

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	Staff took photo of finger and submitted to nurse on-call. The nurse instructed staff to transport him to urgent care. An x-ray was performed showing that he had a hairline fracture...." The review did not include an investigation of client B's broken finger. 3a. A staff note dated 3/28/23 indicated the following: "[Client C] was having a good afternoon. She was in a good mood and chilling most of the afternoon until she began trying to boss her housemate (client B) around. She pushed/shoved him and tries (sic) to tell him what to do. Staff advised her to stop it, and she continued. She attempts to overpower him everyday due to him being smaller and not speaking." The review did not include an investigation of client C's physical aggression towards client B. 3b. A staff note dated 7/10/23 indicated the following: "[Client C] was on the van, and [client B] was being very intrusive and touching [client C]. Staff held [client B's] hands. Staff let go due to [client B] calming down. [Client B] put (his) head on [client C's] shoulder. [Client B] then proceeded to bite [client C] on her upper left arm. [Client C] has a bruise. No skin was broken." The review did not include an investigation of client B's physical aggression towards client C. QIDP #1 was interviewed on 8/8/23 at 1:00 pm and stated, "Peer to peer aggression should be investigated." 4a. A BDDS report dated 7/9/23 indicated the			

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	following: "Staff reports that [client E] sustained a superficial abrasion on her right knee when she lost her balance walking and fell in the hallway. Staff was instructed by on-call nurse to clean the area and apply triple antibiotic ointment on the area." The review did not include an investigation of client E's fall with injury. Client E's record was reviewed on 8/8/23 at 1:45 pm and did not include a high risk plan for falls. Area Director (AD) #1 was interviewed by phone on 8/10/23 at 2:00 pm and stated, "We investigate falls with injuries, peer to peer, and injuries of unknown origin." AD #1 stated, "The investigation should be completed within 5 business days. We should review any pertinent plans to the situation and should have recommendations to prevent recurrence." 9-3-2(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on record review and interview for 1 additional client (H), the facility failed to ensure staff working in the home were adequately trained to address client H's change in health status. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/7/23 at 1:08 pm.	W 0192	**W 192** Staff Training Program (Standard) - The facility failed to ensure staff working in the home were adequately trained to address client H's change in health status. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID6FRS11 will be fully	09/14/2023

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	A BDDS report dated 1/19/23 indicated client H was hospitalized on 1/18/23 due to high Dilantin (prevents seizures). A BDDS report dated 1/22/23 indicated client H was still hospitalized and removed his catheter on 1/21/23. Client H sustained an injury and required surgery. A BDDS report dated 1/30/23 indicated the following: "[Client H] was medically discharged from the hospital on Sunday, January 28, 2023 around 2:30 pm and (sic) transported to the Dungarvin group home by staff. Around 10:00 pm, as staff was emptying his catheter leg bag, they notice (sic) some spotting. Staff called the program director who instructed them to call the emergency room (ER) to determine is (sic) this was a medical emergency. The ER nurse informed staff that is it was normally (sic) to witness some spotting from the catheter if there was not visible blood in the catheter bag. On Sunday, January 29, 2023, around 11:50 am, staff called program director to report that [client H] had regurgitated his lunch. Staff called back around 1:00 pm saying that [client H's] gait was off, and he appeared to be in distress. Program director directed staff to call 911. Staff called back approximately 5 minutes (sic) reporting that [client H] was not breathing, and that they had begun CPR (cardio pulmonary resuscitations). Staff continued CPR until EMS (emergency medical services) arrived approximately 6 minutes later. EMS continued to provide CPR the AED (automated external defibrillator) was administered as [client H] was nonresponsive, not breathing, and had no pulse. Paramedics continued to administer CPR until he arrived at the hospital		implemented, including the following specifics: · All staff are being retrained on the agency policy on reporting changes in condition, including reporting all changes in health status to the nurse or nurse on call. · Program Director/QIDP also trained to redirect concerns brought to him to the nurse when the issue is a health status change that the nurse needs to be made aware of. 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 Going forward, all staff are trained upon hire on when to call a nurse and the agency policy on reporting changes in health status. They are then trained annually thereafter in the annual medication refresher course.	

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	where he was pronounced dead. The attending physician ruled his death as cardiac arrest due to the stress on his heart and lungs from the surgery and pneumonia." An investigation dated 2/6/23 indicated the following: "[Direct Support Professional (DSP) #3] has known [client H] since he moved in: States changes were noted around the beginning of January - he would use the walls to balance himself when walking. Said all staff were talking, trying to figure it out - [DSP #4] took him to urgent care to check for infections, then he went to ER. Was working in the house with [DSP #5] on 1/28 when [DSP #4] went to get him from the hospital. At first, he seemed to be himself - he came out for dinner and ate pretty well. Left at 8 that night. Came back in 1/29 at 10 am. [Client H] was in bed when she arrived. Checked on him about every 30 minutes. He came to the table at lunch time. Says [DSP #5] noted that he was staggering still. He ate a few crackers and then got up and went in to the bathroom and threw up in the toilet. She went with him and helped him to clean up. He climbed into bed then, and she didn't have him come back to eat again right then. No other symptoms noted at that time - at the time she thought he could have an upset stomach from the pneumonia or the meds (medications) he was taking unsettling his stomach. States around 30 minutes later, she went to check on him, and that is when she found him on the floor. She yelled for [DSP #5] to come. [DSP #5] was on the phone with the PD who told them to hang up and call 911. [DSP #5] called 911 and initiated CPR. After a few minutes, [DSP #3] took over CPR. Then they switched back after a few minutes. [DSP #3] went to open the door for the			

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	paramedics and take them to the room. [DSP #3] then went to help calm and reassure the other individuals while EMT (emergency medical technicians) took over in the bedroom. She thinks it was about 6 minutes that she and [DSP #5] did CPR.... [DSP #5] has known known [client H] since he moved in. Mostly works on the weekends - [client H] usually spent a lot of personal time in his room. She noted some changes in his over Christmas break when she worked more. Seemed a bit more unsteady. Said they took him to urgent care, and they didn't find anything. Felt he wasn't ready to be discharged from the hospital on 1/28. On the 28th itself, he got off the van ok and seemed ok, but on 1/29 in the morning, he seemed unsteady like before he went in when he got up for meds.... Sunday stated that [client H] had breakfast, and she did meds and a lot of laundry. Noted that his breathing when sleeping was kind of loud, but [DSP #3] thought that was just how he had been breathing lately. Ate a few bites of lunch and then went to throw up in the bathroom. [DSP #5] had been texting and talking with the PD since he seemed weak and had thrown up. Just when they had finished talking and [PD] had told her that they should take him back to the ER, she heard [DSP #3] cry out that [client H] was on the floor. He was breathing, but not responsive, and his breathing was shallow. She instinctively redialed [PD] and he said to hang up and call 911 immediately, and she did.... She and [DSP #3] positioned him for CPR and [DSP #5] started for the first couple of minutes. She stayed on the line with the dispatcher while the dispatcher walked her through everything.			

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	States she did about 2 minutes, then [DSP #3] gave her a break for a minute or so, and then she took back over until EMS arrived. She stayed in the room while the EMTs started working on him. She said they hooked up a machine that was doing the compressions and she heard the AED saying that electric shock was not recommended. States that when they got him to the ambulance, they were in the ambulance for about 15 minutes before they left.... [PD] has known [client H] since he moved in. States change in [client H's] gait was first noted around 1/3/23. Sent to urgent care on 1/9/23. No infection was found. Had [med DSP] reach out to PCP (primary care physician) to request blood work. States [day program provider] was also noting the changes with his balance. States when following up on the blood work on 1/17/23, med DSP was still waiting for the order from the PCP's office. States that on 1/18/23, [client H] was not looking well and was staggering, so PD had staff go straight to ER, where they ran multiple tests and identified the high Dilantin levels. He was then admitted. On 1/21/23, [client H] pulled his catheter our (sic) causing damage to the bladder and urethra. Emergency surgery completed. Hospital began using hand restraints to keep him from pulling it out again. On 1/25/23, PD went to the hospital to follow up. SW (social worker) stated PT (physical therapy) was working on [client H] using a walker. Now focus was on walking independently without a walker. Discharge on 1/28/23, PD went to the home to train on emptying the catheter. In contact with staff when spotting noted,			

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	neurologist called, then heard from staff that he seemed unsteady and had vomited at lunch. Wanted staff to call 911. Then staff called back and said he was having a medical emergency, and they were starting CPR. EMS arrived in about 6 minutes.... States doctor at the hospital stated that [client H] had cardiac arrest due to the stress on his heart and lungs from the surgery he had in the hospital as well as from fighting off pneumonia.... While it is evident that all staff were aware of the changes in [client H's] gait early in January, it seems staff were informing the Program Director. There is no evidence that staff were reaching out to the nursing department to discuss the concerns. The house did not have an assigned nurse at the time, but the on-call number can be used at any time. The PD and staff did make efforts to have [client H] seen at urgent care and then were pressing the PCP office for blood work to be done; however, it was still 1/18/23 when he was finally seen at the ER." The review indicated the PD and staff working with client H did not report their concerns of his change in health to their nurse in early January. The review indicated staff working with client H did not call the nurse to report his vomiting on 1/29/23. Nurse Manager #1 was interviewed on 8/8/23 at 12:45 pm and stated, "Staff should have called a nurse if [client H] was vomiting. That is our expectation regardless of a hospital stay. I would not send someone to bed after vomiting. They should sit up for a little bit. If they did need to go to bed, they should be raise." Nurse Manager #1 stated, "Staff should have called a nurse."			

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W 0249 Bldg. 00	9-3-3(a) 483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview for 2 of 3 sample clients (A and B), the facility failed to implement clients A and B's active treatment programs at all opportunities. Findings include: An observation was conducted in the group home on 8/7/23 from 3:45 pm to 5:30 pm. Clients A and B were present throughout the observation period. On 8/7/23 at 3:45 pm, clients A and B arrived to the group home in the facility's van. Clients A and B went inside the home. Client A paced from the dining room to the living room, his bedroom, the dining room, his bedroom, and back to the dining room. No staff were in the common living areas. Client B sat on a sofa in the living room. At 3:53 pm, client B went outside to stand on the front porch. DSP #1 followed him. At 3:56 pm, client B went inside the home with Direct Support Professional (DSP) #1. Client B sat down in the living room. At 4:00 pm, client B was sitting in the living room with his peers. The television was on. Client A was sitting in the dining room alone. Clients A and B were not offered an activity.	W 0249	**W 249** Program Implementation (Standard) – The facility failed to implement clients A and B's active treatment programs at all opportunities. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID6FRS11 will be fully implemented, including the following specifics: · All facility staff have been trained again the BSPs, ISPs, goals, and required supervision levels for clients A and B as well as all other individuals residing at the facility. · QIDP is reviewing and revising the posted active treatment and activity schedules to ensure they accurately reflect the planned activities and that activities are planned in sufficient number to engage all of the individuals and create opportunities for formal and	09/14/2023

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	At 4:07 pm, client A got up from the table and walked outside to the front porch. Client A returned to the dining room and sat down at the table. At 4:09 pm, client B walked outside and stood on the front porch. DSP #1 was passing medications in the medication room. DSP #4 was cooking in the kitchen. Clients A and B were not offered an activity. At 4:19 pm, client B went into the house and paced around the foyer. Client B was standing in the doorway to the living room. Client C walked up behind client B and pushed him from behind. Client C stated, "Get over there and sit down." Client A was sitting in the dining room alone. There were no staff in the area. DSP #1 was passing medications, and DSP #4 was cooking. At 4:30 pm, client A was sitting at the dining table alone. Client B was outside on the front porch alone. Clients A and B were not offered an activity and were not being supervised by their staff. At 4:45 pm, client A was sitting at the dining table alone. Client B was sitting in the living room with his peers. Client B got up from the sofa and went to stand on the front porch. DSP #1 followed client B outside. Clients A and B were not offered an activity. At 5:00 pm, client A was sitting at the dining table alone. Client B was sitting on the front porch with DSP #1. Client A and B were not offered an activity. DSP #3 was interviewed on 8/7/23 at 4:35 pm and stated, "I was trained on [client A's] BSP (behavior support plan). We watch out for pica.		informal active treatment. · Once retraining is complete, the QIDP, Nurse, Area Director or other qualified staff are responsible to conduct active treatment observations at varying times of the day to ensure that staff are competent in implementing the clients' programs during formal and informal opportunities. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. 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 Going forward, the QIDP is responsible to monitor active treatment implementation on an ongoing basis. The QIDP is expected to maintain a regular presence in the home through	

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	I'm not sure of his staffing level. We keep an eye on him, so he doesn't get into anything. There isn't an assigned staff, it's whoever is around." DSP #3 stated, "He gets into things. The kitchen most of the time. He'll get in the garbage." DSP #3 stated, "[Client B] also has pica, and he gets aggressive towards individuals. He grabs hair and glasses. DSP #3 stated, "We can't get [client B] to do anything. He will go for a ride in the golf cart, but he won't color or anything like that." DSP #3 stated, "[Client B's] goals are to rinse himself, exchange money, sign for his medication, and put laundry in his basket." DSP #4 was interviewed on 8/7/23 at 4:56 pm and stated, "[Client A's] plan says he steals food and drinks. He is supposed to be in eyesight." DSP #1 stated, "[Client A] likes to watch movies. We won't do coloring or crafts or go in the golf cart. There aren't many activities he will do." DSP #1 stated, "[Client B] will do some things if you do hand over hand." Client A's record was reviewed on 8/8/23 at 2:00 pm. Client A's Individual Support Plan (ISP) dated 2/17/23 indicated the following: "Needed Support: [Client A] is dependent on staff for medication management, educational, social, and independence skills. His guardian would like to see him independent in all modes of his Activities of Daily Living (ADLs). He does best with demonstration, modeling, and hand-over-hand assistance.... Behavior: [Client A] has Pica (eating inedible items) and must remain in line-of-sight. He will grab food and/or drinks that are left unattended.... Communication: [Client A] is non-verbal and uses sounds and pointing gestures to communicate. Additionally, he will grab you by the hand and		scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the program and in order to coach staff on active treatment implementation at all naturally occurring opportunities	

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	lead you to items that he wants. He can understand others and respond/follow direction appropriately.... Environmental and Living Arrangement Support: [Client A] requires 24-hour supervision with line-of-sight when during waking hours and when in the community for health and safety. He is fully depending on staff with most of his basic ADLs, money management, transportation. He can dress himself and put on his shoes independently. [Client A] can self-feed, take dirty clothes to washer and remove from dryer with prompting. He can make his bed and vacuum with demonstration and prompting. He cannot use the stove, operate a microwave, or kitchen appliances. He cannot differentiate between cooked or raw foods...." Client A's ISP dated 2/17/23 indicated goals in the areas of showering, laundry, medication, dental hygiene, dining, hand washing, and dressing. Client B's record was reviewed on 8/8/23 at 12:20 pm. Client B's ISP dated 6/19/23 indicated the following: "Needed Support: [Client B] is dependent on staff for medication management, educational, social, and independence skills. He will require long-term support. [Client B] is unable to perform the majority of the basic ADLs without assistance. He requires assistance, bathing, toileting, dressing, meal preparations, financial transactions, and medical management. Precautions and assistance must be given when eating any foods that are hot.... Communication: [Client B] is nonverbal with a flat affect and at times will make grunting sounds. He can hear others and respond/follow direction appropriately.... Environmental and Living Arrangement Support:			

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	At this time, [client B] receives 24 hour care with line-of-sight during awake hours. Individual requires 24 hour supervision for health and safety. Safety measures as well as additional assistance and monitoring to help prevent potential injury. Pay close attention to the kitchen and laundry room. Secure potentially dangerous items by placing safety locks or removing the items from the individual altogether. This can help keep staff and the individual served safe." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/7/23 at 12:08 pm and stated, "[Client A] is line of sight when he's in the group home. He tries to take food and drinks. He will outside and look for food in the garbage. Staff need to be able to see him at all times." QIDP #1 indicated staff should encourage all of the clients to be engaged in activities. QIDP #1 indicated clients should not be encouraged to sit without activity for long periods of time. 9-3-4(a)			
W 0310 Bldg. 00	483.450(e)(1) DRUG USAGE The facility must not use drugs in doses that interfere with the individual client's daily living activities. Based on observation, record review, and interview for 1 of 3 sample clients (B), the facility failed to ensure address client B's negative response to the use of his PRN (as needed) sedative. Findings include: An observation was conducted in the group home on 8/7/23 from 3:45 pm to 5:30 pm. Client B was	W 0310	**W 310** Drug Usage (Standard) - The facility failed to ensure address client B's negative response to the use of his PRN (as needed) sedative. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID6FRS11 will be fully	09/14/2023

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	present throughout the observation period. Client B walked through his home unassisted. Client B did not require assistance to open doors or to sit or stand. Client B fed himself with a spoon. Staff held a bowl of cut fruit under client B's face, so he would not spill juice on his shirt. The facility's Bureau of Developmental Disabilities Services (BDDS) reports, incident reports, and related investigations were reviewed on 8/7/23 at 1:08 pm. 1a. A staff note dated 7/9/23 indicated the following: "[Client B] was in his room when staff arrived at (sic) site. Staff assisted him with eating his breakfast. He immediately started his intrusive behavior with staff. He was grabbing on staff's clothing and touching staff inappropriately. Staff notified nurse due to this being on (sic) repeated behavior of yesterday. Nurse approved PRN Ativan (sedative). [Client B] received two tablets of Ativan. His intrusive behaviors continued up until 10:15 am. The medication kicked in, and [client B] went to bed. Staff woke him up to eat lunch. Staff had to assist him with eating due to drowsiness. Staff kept him up thirty minutes after lunch. Staff then assisted him back to bed. [Client B] slept until diner time. At dinner time, he was assisted with eating his food. Due to drowsiness, he did not get a shower. Another staff administered his evening meds (medications). [Client B] is currently getting toileted." A BDDS report dated 7/9/23 indicated the following: "Staff reported to nurse that [client B] was being extremely sexualized in behavior. He was exposing his penis in the common areas of his		implemented, including the following specifics: ·All facility staff retrained on the Adverse Side Effects to Medications risk plan for client B. ·The nurse consulted with the physician for client B and was able to obtain a revised prescription for his PRN that reduces the amount of the second dose of the medication when needed by half. ·The QIDP will investigate each use of the PRN medication and review any side effects seen with the use of the medication with that review. The medication has not yet been used again this month but any future use will be reviewed. 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 are required to successfully pass Med Core A&B before passing meds at the facility. They are also required to complete annual retraining on Medication Administration which covers possible side effects of psychotropic medications. All staff are to be trained in the High Risk	

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	housemates. Staff continued to redirect him back to his room for private time. [Client B] would return to the common area once again, exposing his genital (sic). While being redirected once again, he grabbed the female (staff) (sic) shirt and attempted to 'groped (sic) her' putting her shirt in his mouth. Per nurse approval, 1 mg (milligram) of Ativan was administered at 8:40 am. Nurse stated to wait an hour and see if second Ativan will be needed. During that hour, following a cool shower per his approved Behavior Support Plan (BSP), he continued to expose himself warranting a second 1 mg tablet of Ativan. The second dose was effective as [client B] stopped engaging in the inappropriate sexualized behavior." The staff note dated 7/9/23 indicated client B's physical abilities were diminished due to drowsiness following the second dose of his PRN medication. Client B's record was reviewed on 8/8/23 at 1:20 pm. Client B's Medication Administration Record (MAR) for July 2023 indicated the following: "Ativan 1 mg tablet, Take 1 - 2 tablets po (by mouth) every day as needed for agitation." "Administered 8:40 am on 7/9/23. Administered 9:50 am on 7/9/23." Client B's MAR for August 2023 indicated the following: "Ativan 1 mg tablet, Take 1 - 2 tablets po every day as needed for agitation. Administered 12:15 pm on 8/6/23. Administered 1:00 pm on 8/6/23." Direct Support Professional (DSP) #1 was interviewed on 8/7/23 at 5:07 pm and stated,		plans for the individuals including Adverse Side Effects of Medications and the agency policy on reporting all changes in health status.	

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	"[Client B's] behaviors are stomping, moaning, whining. He'll grab hair and glasses. He snatches food. He pulls on clothes. He can be aggressive to get attention. He pulls his penis out and pulls on it." DSP #1 stated, "Once he gets in the mood, we can redirect him, but he does it again 2 seconds later. We redirect him to his bedroom." DSP #1 stated, "I have not given the PRN, but I was here when it was given. It made him go to sleep. They gave the first, waited an hour, then gave another. He continued the behavior after the first one. After the second he went to sleep. He slept all day. He got up for his meds, and he ate, but he went back to sleep." DSP #1 stated, "It was yesterday. He could not walk on his own. We have to hold on to him and walk with him. He was too tired to eat. We had to feed him." Nurse Manager #1 was interviewed on 8/8/23 at 12:45 pm and stated, "There needs to be a discussion. It should be brought to the attention of the doctor. We should look at decreasing the second dose. If he's getting a second dose, there's a reason. He must be continuing the behavior. We need to find something that isn't as potent." Area Director (AD) #1 was interviewed by phone on 8/10/23 at 2:00 pm and stated, "Staff should report that concern. Any concerns with side effects of medications should be reported. If we let the nurse know, she would be on the phone with the doctor right away. We should talk about our protocol. We should review that closely. If he got that lethargic after a second dose, maybe he needs a smaller dose. We'd want to go to the doctor and discuss the effects of having that much." 9-3-5(a)			

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W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met: 1. 460 IAC 9-3-4 Active Treatment Services. (b) The provider shall obtain day services for each resident which: (1) meet the criteria and certification requirements established by the division of aging and rehabilitative services for all day service providers; (2) meet the resident's active treatment needs set forth in the resident's individual program plan as determined by the interdisciplinary team conference with preference for services in the least restrictive environment. This state rule was not met as evidenced by: Based on record review and interview for 1 of 3 sample clients (A), plus 1 additional client (D), the facility failed to meet clients A and D's active treatment needs for day programming. Findings include: Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/7/23 at 12:08 pm and stated, "[Client A] moved into the home 2 to 3 months ago. He is going to [outside provider] day program. They have issues with his behaviors. He was going 5 days a week, but now he goes 2 days a week. They wanted a 1 to 1 staff, but it is too expensive. They said he is a problem because he tries to take food and drink.	W 9999	**W 9999** Final Observations (State Findings) - The facility failed to meet clients A and D's active treatment needs for day programming. The facility failed to report the use of a PRN (as needed) medication used to control client B's behavior to the appropriate state authority within 24 hours of knowledge. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID6FRS11 will be fully implemented, including the following specifics: · All facility staff being retrained on this finding and on Dungarvin policies regarding Incident Reporting and Medication Administration. All medication errors, including missing medications, are high level incidents requiring submission of an internal incident report (GER) and direct reporting to the nurse and supervisor. ·All supervisory/QIDP level staff receiving retraining on the Dungarvin policy on Incident Reporting, including the requirement that missing medications/medications not available must be reported to BDDS in accordance with 460 IAC	09/14/2023

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	15G479	A. BUILDING 00 B. WING	08/14/2023

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	They said he would need to the 1 to 1 or he couldn't come anymore. With 1 to 1, he can only go two days a week because the cost is astronomical. The [outside provider] provides the 1 to 1 staff. At our site [client A's home], he is line of sight." QIDP #1 stated, "[Client D] refuses to go to day program. He always stays home." QIDP #1 stated, "We have a monthly activity schedule." When asked if clients participated in the activities scheduled, QIDP #1 indicated he did not know. QIDP #1 stated, "The schedule does not specify what [clients A and D] are doing at home during the day. We can create a schedule." Client A's guardian was interviewed by phone on 8/8/23 at 10:34 am and stated, "I had a meeting with Dungarvin. The residential staff are supposed to take him on an outing every day to do something with him. As long as they can fill that void, I'm comfortable with that. I don't want him sitting at home with nothing to do." Client A's record was reviewed on 8/8/23 at 2:00 pm and did not include an active treatment schedule for client A's community based day program. Client D's record was reviewed on 8/8/23 at 2:15 pm and did not include an active treatment schedule for client D's community based day program. Area Director (AD) #1 was interviewed by phone on 8/8/23 at 11:30 am and stated, "If he's at home, someone can take [client A] out. His mom wants him to be active. Staff need to take him out to do staff. He needs less time to sit at home and only focus on food." This state rule relates to complaint #IN00411750.		9-3-1. ·Nurse and QIDP hold a weekly nursing meeting which will include a review of the facility MARs to ensure that no medication errors have been missed by facility staff. 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 Program Director is responsible to be aware of all reportable incidents and to report them according to state law. Area Director and Program Director to do targeted review of Therap documentation on incidents during weekly supervision meetings to ensure that all incidents have been reported as required.	

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	9-3-4(b) 2. 460 IAC 9-3-1 Governing Body (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: 16) A medication error or medical treatment error as follows: c. missed medication - not given; and This state rule was not met as evidenced by: Based on record review and interview for 1 of 3 sample clients (B), on 4 occasions, the facility failed to report the use of a PRN (as needed) medication used to control client B's behavior to the appropriate state authority within 24 hours of knowledge. Findings include: 1. Client B's record was reviewed on 8/8/23 at 12:20 pm. Client B's Medication Administration Record (MAR) for April 2023 indicated the following: "Ativan 1 mg (milligram) tablet, Take 1 - 2 tablets po (by mouth) every day as needed for agitation. Administered 12:55 pm on 4/3/23." The review did not indicate the use of a PRN medication to control client B's behavior was reported to BDDS. 2. Client B's MAR for June 2023 indicated the following: "Ativan 1 mg tablet, Take 1 - 2 tablets po every day as needed for agitation. Administered 3:30 am 6/18/23."			

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	The review did not indicate the use of a PRN medication to control client B's behavior was reported to BDDS. 3. Client B's MAR for July 2023 indicated the following: "Ativan 1 mg tablet, Take 1 - 2 tablets po every day as needed for agitation. Administered 7:00 pm 7/18/23." The review did not indicate the use of a PRN medication to control client B's behavior was reported to BDDS. 4. Client B's MAR for August 2023 indicated the following: "Ativan 1 mg tablet, Take 1 - 2 tablets po every day as needed for agitation. Administered 12:15 pm 8/6/23. Administered 1:00 pm 8/6/23." The review did not indicate the use of a PRN medication to control client B's behavior was reported to BDDS. Area Director (AD) #1 was interviewed by phone on 8/10/23 at 2:00 pm and stated, "Use of a PRN should be reported to BDDS. There should be a review of the use as well. It is a chemical restraint." 9-3-1(b)			