| | TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING | | X3) DATE SURVEY COMPLETED 03/01/2022 | | |
|--------------------|--|--|--|---|-----------------|
| | PROVIDER OR SUPPLIER | | 422 MA | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |
| TAG W 0000 | REGULATORY OR | LSC IDENTIFYING INFORMATION | TAG | DEFICIENCE! | DATE |
| Bldg. 00 | #IN00369156. Complaint #IN0036 and state deficiencing are cited at W153, W382, W383, and W1011 Unrelated deficience | ies cited. | W 0000 | | |
| | March 1, 2022. Facility Number: 00 Provider Number: 100 These deficiencies a accordance with 460 Quality Review of ton 3/14/22. | 5G479 1244950 also reflect state findings in | | | |
| W 0129 Bldg. 00 | The facility must e clients. Therefore | CLIENTS RIGHTS Insure the rights of all Insure the facility must provide Insured the opportunity for personal | | | |
| | Based on observation interview for 2 of 3 additional clients to ensure the privace medical information. Findings include: | on, record review, and sample clients (A and B), plus (D, E and F), the facility failed y of clients A, B, D, E and F's h. | W 0129 | W 129 Protection of Clients Rights (Standard) – Failed to ensure to privacy of clients A, B, D, E and F's medical information. Corrective action for resident(standard) found to have been affected All parts of the POC for the sure with event ID BFLD11 will be fixed. | d s) rvey |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE | | |
|--|--|---|-------------------------|---------------------------------|---|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | A. BUILDING <u>00</u> COMPLETED | | | ETED |
| | | 15G479 | B. W | 'ING | | 03/01/ | 2022 |
| | | <u> </u> | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ARQUETTE TRAIL | | |
| DUNGAF | RVIN INDIANA LLC | | MICHIGAN CITY, IN 46360 | | | | |
| | | OTA TEMENT OF DEPOSITS OF | | | , | | OV.E. |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION 5 pm through 6:00 pm. Clients | + | TAG | | | DATE |
| | | rere present in the home | | | implemented, including the following specifics: | | |
| | | - | | | _ , | . n | |
| | throughout the observation period. | | | | All facility staff have been retrained on policies regarding | | |
| | Throughout the obs | ervation period, empty | | | Client Rights including the right | | |
| | _ | vere sitting out on the desk in | | | privacy regarding personal he | | |
| | | ng empty cards were on the | | | information. | aitii | |
| | desk: | | | | All facility staff retrainer | d on | |
| | Client A Lamotrigine 150 milligram (mg) (treats symptoms | | | | the procedure to follow when a | | |
| | | | | | med card or other med contain | | |
| | | | | | with protected health informati | | |
| | of epilepsy), the last pill was given on 2/14/22. | | | | printed on a label needs to be | | |
| | of ephepsy), the last pin was given on 2/1 1/22. | | | | discarded and what procedure | | |
| | Client B | | | | follow when new medications | | |
| | Sertraline 100 mg (treats symptoms of depression | | | | delivered and need to be store | | |
| | | oulsive disorder), the last pill | | | securely. | | |
| | was given on 2/13/2 | · · · · · · · · · · · · · · · · · · · | | | · Program Director/QIDP | and | |
| | <i>g</i> == == = 10, 2 | | | | nurse will be responsible to ve | | |
| | Client D | | | | that protected health informati | - | |
| | Vascepa 1 gram (g) | (treats symptoms to prevent | | | stored in a HIPAA compliant v | | |
| | | last administered 2/14/22. | | | during regular, frequent visits | - | |
| | | ts symptoms to prevent heart | | | the home. The facility nurse ha | | |
| | | administered 2/13/22. | | | added documentation of this to | | |
| | | treats symptoms of high | | | weekly written report to the QI | | |
| | cholesterol), last ad | ministered 2/13/22. | | | and Area Director. | | |
| | Gabapentin 300 mg | (treats symptoms of epilepsy), | | | · All occurrences of HIPA | A | |
| | last administered 2/ | 14/22. | | | violations discovered in the ho | me | |
| | Quetiapine 100 mg | (treats symptoms of | | | will be addressed immediately | , | |
| | schizophrenia), last | administered 2/14/22. | | | with responsible staff member | | |
| | | | | | through retraining and/or corre | ective | |
| | Client E | | | | action in accordance with | | |
| | | ymptoms to prevent bone loss) | | | Dungarvin policy and procedu | re. | |
| | last administered 2/ | 13/22. | | | How facility will identify other | | |
| | | | | | residents potentially affected & | <u> </u> | |
| | Client F | | | | what measures taken | | |
| | | ymptoms of vitamin | | | All residents potentially are | | |
| | deficiency), last adr | ministered 2/14/22. | | | affected, and corrective meas | | |
| | | | | | address the needs of all client | S. | |
| | | Sessional (DSP) #3 was | | | | | |
| | interviewed on 2/15 | 5/22 at 5:10 pm. DSP #3 | | | Measures or systemic change | S | |

| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X | | (X2) MULTIPLE CONSTRUCTION (X3) D. | | | (X3) DATE | SURVEY |
|-----------|--|---------------------------------|------------------------------------|----------------------------------|--|-----------|----------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETE | | | ETED | |
| | | 15G479 | B. WI | NG | | 03/01/ | /2022 |
| | | | <u> </u> | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | t | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | RQUETTE TRAIL | | |
| DUNGAF | RVIN INDIANA LLC | | | MICHIG | SAN CITY, IN 46360 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TC | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 16 | DATE |
| | indicated when a m | edication card is empty, staff | | | facility put in place to ensure n | 10 | |
| | put the top with the | client's name through the | | | recurrence | | |
| | shredder or black or | ut the name right away after | | | All new employees are trained | on | |
| | administering the la | st dose of the medication. | | | HIPAA and Client Rights upon | | |
| | | | | | and retrained annually thereaf | ter. | |
| | DSP #2 was interviewed on 2/15/22 at 5:15 pm. | | | | Program Director/QIDP is to | | |
| | DSP #2 stated, "Wh | nen a medication card is empty, | | | maintain a regular, frequent | | |
| | we rip off the top of | f the card and shred it. We | | | presence in the home and pro | vide | |
| | throw away the bott | tom of card." | | | direct coaching and redirectior | า to | |
| | | | | | any staff who violate policy an | d | |
| | Qualified Intellectu | al Disability Professional | | | procedure. Nurse will also rep | ort | |
| | (QIDP) #1 was interviewed on 2/15/22 at 6:00 pm. | | | | any violations to the PD/QIDP | for | |
| | QIDP #1 stated, "When a medication card is | | | | follow up. | | |
| | empty, staff should rip off the top of the card and | | | | | | |
| | shred it and throw a | way the bottom part." | | | | | |
| | D ' | 227. (4 | | | | ļ | |
| | - | RN) #1 was interviewed on | | | | | |
| | - | RN #1 indicated staff should | | | | | |
| | | edication card and shred it and | | | | | |
| | throw the bottom pa | art away. | | | | | |
| | Area Director (AD) | #1 was interviewed on 2/16/22 | | | | | |
| | , , | 1 indicated empty medication | | | | | |
| | | red in Health Insurance | | | | | |
| | | ountability Act (HIPAA) | | | | | |
| | | until they can be destroyed. | | | | | |
| | compilant focations | until they can be destroyed. | | | | | |
| | 9-3-2(a) | | | | | | |
| W 0149 | 483.420(d)(1) | | | | | | |
| - | STAFF TREATME | ENT OF CLIENTS | | | | | |
| Bldg. 00 | | levelop and implement | | | | | |
| ŭ | • | d procedures that prohibit | | | | | |
| | · · | lect or abuse of the client. | | | | ļ | |
| | | view and interview for 6 of 22 | W_0 | 149 | W 149 | | 04/01/2022 |
| | | and neglect reviewed, the | '' 0 | - 17 | Staff Treatment of Clients | | 0 1, 0 1, 2022 |
| | | ectively implement its policies | | | (Standard) – Failed to effective | ely | |
| | | revent 6 allegations of peer to | | | implement its policies and | , | |
| | peer abuse by client | - | | | procedures to prevent 6 | | |
| | · - | | | | allegations of peer-to-peer abo | use | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING 03/01/2022 15G479 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **422 MARQUETTE TRAIL** MICHIGAN CITY, IN 46360 **DUNGARVIN INDIANA LLC** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Findings include. by client B. Corrective action for resident(s) The facility's Bureau of Developmental Disabilities found to have been affected Services (BDDS) reports and related All parts of the POC for the survey investigations were reviewed on 2/16/22 at 11:50 with event ID BFLD11 will be fully implemented, including the following specifics: 1. A BDDS report dated 9/11/21 indicated the The Behavior Support Plan following: for client B is being updated to "While out in the community, staff was preparing ensure that the proactive and to leave. All the individuals were on the van, and reactive strategies in place are staff was speaking to one of the individual (sic) effectively preventing continuing when [client B] started hitting [client D] telling her peer to peer aggression by client to, 'Shut the f*** up.' [Client D] (sic) speaking to В. staff, so it's unclear why [client B] started striking Program Director/QIDP is her. When [client A] started crying, [client B] being retrained on the expectation then struck her as well as [client H]. Staff was that the investigation process into able to gain control without having to place [client peer-to-peer abuse allegations B] in a hold. Another staff sat with [client B] on must include a critical review of the van during the ride back to the site. [Client B] the current BSP strategies to was fine and no further incidents happened at the ensure measures are taken to prevent any recurrence of the - The BDDS report did not indicate the date the behavior and to protect all allegation occurred. individuals residing in the facility. All facility staff to receive An investigation dated 9/9/21 did not include a retraining on the BSP for client B. review of client B's Behavior Support Plan (BSP), Going forward, during interviews with staff and clients, a review of staff weekly supervision meetings with actions, or recommendations to prevent incidents. the Area Director, the Program Director/QIDP will review the 2. A BDDS report dated 10/13/21 indicated the status of every major incident following: currently under review, and the "[Client B] was in the dining area with his head on QIDP will be responsible to the table, when, all of a sudden, he jumps up and present the status of each starts flipping tables and chairs. Then he went investigation to ensure that the into the living room flipping chairs and lamps. investigations and resulting action One lamp was broken. Staff was able to talk him plans are timely, thorough, and down without having to put him in a hold. When effective, including any needed why (sic) he went into an explosive behavior (sic), revisions to support plans/BSPs. 'He smiled and said everything (sic) fine. I hate

BFLD11

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479 | | (X2) MULTIPLE (A. BUILDING B. WING | CONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 03/01/2022 | |
|--|---|---|---------------------|---|---------------------------|
| | PROVIDER OR SUPPLIER | | 422 M | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL IGAN CITY, IN 46360 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | Staff took [client B] about his behavior a housemates. [Clien housemates and fin further incidents." An additional BDD | It want to be here anymore.' I on a walk and talked with him and how he scared his apologized to his ished the evening with no S report dated 10/15/21 ustained a bruise during the | | How facility will identify other residents potentially affected what measures taken All residents potentially are affected, and corrective meas address the needs of all client Measures or systemic change facility put in place to ensure recurrence | ures ts. |
| | 3. A BDDS report of following: "[Client B] became got into the shower and pushed his house what he did. No injust this incident." - The BDDS report allegation occurred. An investigation da review of client B's | include an investigation. Idated 11/1/21 indicated the upset because his housemate before him. [Client B] went up semate then reported to staff juries was sustain (sic) from did not indicate the date the ted 10/30/21 did not include a BSP, interviews with staff and endations to prevent future | | All new Program Director/QID are being trained to complete thorough, timely investigations all significant incidents which could be indicative of abuse, neglect, or exploitation, include peer to peer abuse/aggressionew form which was piloted in 2021 has been finalized to streamline the process to revithese incidents critically and develop action plans to preverecurrence. | s of ling n. A n |
| | 4. A BDDS report of following: "[Client B] was withousemate came in him unprovoked. So verbally without sunot be redirect (sic) person hold with him B] immediately calin less than 5 minut | h staff in the kitchen when his and [client B] started slapping taff tried to redirect him coess. When [client B] could so staff placed him in a one s arms held to his side. [Client m (sic) down and staff released es. [Client B] was upset want to share his time with a | | | |

BFLD11

| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | X3) DATE SURVEY | |
|-----------|--|--------------------------------|--------|------------|--|------------|-----------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | | |
| | | 15G479 | B. W | NG | | 03/01/2022 | | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | | |
| NAME OF F | PROVIDER OR SUPPLIER | R | | | RQUETTE TRAIL | | | |
| DUNGAF | RVIN INDIANA LLC | | | | GAN CITY, IN 46360 | | | |
| D0110711 | | | | | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | • | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | • | did not indicate the date the | | | | | | |
| | allegation occurred. | | | | | | | |
| | | | | | | | | |
| | | ted 10/31/21 did not include a | | | | | | |
| | | BSP, interviews with staff and | | | | | | |
| | | endations to prevent future | | | | | | |
| | incidents. | | | | | | | |
| | 5 A DDDC | 1 . 111/11/01 : 1: . 1.1 | | | | | | |
| | • | lated 11/11/21 indicated the | | | | | | |
| | following: | . 1 1 1 1 1 1 1 | | | | | | |
| | | mpted and unknown [client B] | | | | | | |
| | came out (sic) the kitchen screaming, and ran to the living room, and threw his housemates walker | | | | | | | |
| | | | | | | | | |
| | down and threw his water at the television. Staff | | | | | | | |
| | | pproximately 10 minutes until | | | | | | |
| | he calmed down' | | | | | | | |
| | | did not indicate the date the | | | | | | |
| | allegation occurred. | • | | | | | | |
| | An investigation do | ted 11/10/21 did not include a | | | | | | |
| | | BSP, interviews with staff and | | | | | | |
| | | endations to prevent future | | | | | | |
| | incidents. | indations to prevent ruture | | | | | | |
| | meidents. | | | | | | | |
| | 6 A RDDS report of | lated 12/19/21 indicated the | | | | | | |
| | following: | atted 12/19/21 indicated the | | | | | | |
| | _ | to an unknown unprovoked | | | | | | |
| | | d his housemate, [client A] | | | | | | |
| | | ground. [Client A] did not | | | | | | |
| | _ | ons due to the fall; however, | | | | | | |
| | - | redness to her right knee." | | | | | | |
| | | did not indicate the date the | | | | | | |
| | allegation occurred | | | | | | | |
| | anoganon occurred. | • | | | | | | |
| | An investigation da | ted 12/17/21 did not include a | | | | | | |
| | | BSP, interviews with staff and | | | | | | |
| | | endations to prevent future | | | | | | |
| | incidents. | r r r | | | | | | |
| | | | | | | | | |
| | Qualified Intellectu | al Disabilities Professional | | | | | | |

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Event ID:

BFLD11 Facility ID: 000993

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| | VT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | (X2) MULTIPLE CC A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 03/01/2022 |
|--------------------------|---|--|--|--|---------------------------------------|
| | PROVIDER OR SUPPLIER | | 422 MA | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL BAN CITY, IN 46360 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | |
| | (QIDP #1) was inte 1:20 pm and stated, address [client B's] was going on with I anything that was trespect in December, medications. We have then." QIDP #1 ind BSP (Behavior Supdiscussed revisions client B's IDT (interespective) and the client B's 6 incident AD #1 indicated shat to prevent future aghis peers. The facility Policy and was reviewed on 2/the following: "Abuse, Neglect, and was reviewed on 2/the following: "Abuse, neglect, or served is strictly preservice delivery sett Physical abuse is deconstitutes a violation or criminal sexual contentionally touchi insolent, or angry many restraint that is or injury to the indinecessary in emergence instance" The program directed director/manager, setting that was the constituted in the con | rviewed by phone on 2/25/22 at "We did not have a meeting to behaviors. I don't know what him. We couldn't find iggering it. I took him to the hand they changed his haven't seen that problem since licated he oversaw client B's port Plan) and had not or retraining of staff with rdisciplinary team). #1 was interviewed by phone hom. AD #1 indicated she was group home at the time of s of peer to peer aggression. He was unaware of steps taken hand Procedure Concerning Hexploitation dated April 2011 He/22 at 4:15 pm and indicated exploitation of the individuals hibited in any Dungarvin hom of the assault, prostitution, honduct statues (sic) including hanner; infliction of injury hone to prevent serious harm havidual or others may be hercy situations; however, each hestigated as potential | | | |

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Event ID:

BFLD11

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|---|--|-------|--------|--|---|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479 | | A. BUILDING 00 COMPLETED B. WING 03/01/2022 | | | | | |
| | | 15G479 | B. W. | ING | | 03/01/ | 2022 |
| | PROVIDER OR SUPPLIER | 2 | | 422 MA | ADDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL GAN CITY, IN 46360 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| W 0153 Bldg. 00 | or exploitation. Wir results and/or status reported to the admi investigation report statements, pertinen summary of finding recommendations for the format recommendations for the facility must emistreatment, negginjuries of unknown immediately to the officials in accordates assed on record reversive allegations of abuse reviewed, the facility an allegation of explaneau of Developm (BDDS) with 24 hours law. Findings include: The facility's Bureau Services (BDDS) reinvestigations were am. A BDDS report data following: | ensure that all allegations of elect or abuse, as well as an source, are reported administrator or to other ance with State law through dures. Friew and interview for 1 of 22 | W | 0153 | W 153 Staff Treatment of Clients (Standard) – Failed to immedireport an allegation of exploitation of client A to the Bureau of Developmental Disabilities services (BDDS) within 24 hou accordance with state law. Corrective action for resident(stound to have been affected All parts of the POC for the sure with event ID BFLD11 will be stought following specifics: Program Director/QIDP reviewed this deficiency and be retrained on the expectation thall allegations of abuse, negle | ation urs in s) rvey fully has been bat | 04/01/2022 |
| | evening of Decemb | er 3, 2021. According to med | | | or exploitation must be reported | | |

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Event ID:

BFLD11 Facility ID: 000993

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PRINTED: 04/06/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE C | ONSTRUCTION | X3) DATE SURVEY | | |
|--|--|-----------------------------------|-------------|--|---------------|--|
| | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 15G479 | B. WING | | 03/01/2022 | |
| | | | | | 00/01/2022 | |
| NAME OF | PROVIDER OR SUPPLIEI | R | | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL | | |
| DUNGA | RVIN INDIANA LLC | | | GAN CITY, IN 46360 | | |
| DONOA | TOTAL INDIANA LLO | | | JAN 6111, IIV 40000 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE COMPLETION | |
| TAG | + | R LSC IDENTIFYING INFORMATION | TAG | | DATE | |
| | | lation, there are 29 Klonopin | | BDDS within 24 hours of | | |
| | | seizures, a controlled | | knowledge. | | |
| | substance) tablets n | missing." | | Program Director/QIDP | | |
| | Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed by phone on 2/25/22 at 1:20 pm and stated, "We were in a staff meeting on December 4th. One of the staff came out and said the medications were missing." QIDP #1 stated, "The way we were counting the | | | been retrained on reviewing al | 1 | |
| | | | | staff documentation on every | | |
| | | | | business day to ensure that no | | |
| | | | | reportable incidents are misse | d or | |
| | | | | reported late. | | |
| | | | | Going forward, during | | |
| | | - | | weekly supervision meetings v | | |
| | medications, the sheets weren't done correctly. When the incoming staff came in, they thought | | | the Area Director, the QIDP wi | | |
| | _ | | | report on any issues discovered | a l | |
| | the medications were missing. The staff told the nurse, the medications were found on the 5th. I | | | during daily review of staff | -11 | |
| | i i | | | documentation to ensure that | | |
| | December 13th." | and investigation on | | concerns have been reported | in a | |
| | December 15th. | | | timely fashion. | | |
| | Area Director (AD) |) #1 was interviewed by phone | | How facility will identify other | | |
| | on 2/25/22 at 1:00 j | pm and stated, "The | | residents potentially affected & | | |
| | medications went n | missing on December 4th." AD | | what measures taken | | |
| | #1 indicated QIDP | #1 was notified of the missing | | All residents potentially are | | |
| | medication on 12/4 | /21. AD #1 stated, "[QIDP #1] | | affected, and corrective measu | ures | |
| | | the medication was still missing. | | address the needs of all clients | S. | |
| | | he nurse knew about it, but | | | | |
| | | it was still missing." AD #1 | | Measures or systemic change | | |
| | _ | orted on 12/13/21." AD #1 | | facility put in place to ensure n | <u>10</u> | |
| | · · | ave been reported to BDDS | | <u>recurrence</u> | | |
| | within 24 hours of | knowledge." | | All new Program Director/QIDI | | |
| | | | | are being trained on this stand | | |
| | This federal tag rela | ates to complaint #IN00369156. | | and the Dungarvin policy rega | | |
| | 0.2.2() | | | Incident reporting as part of th | | |
| | 9-3-2(a) | | | new staff orientation process. | | |
| | | | | Area Director will review the st | | |
| | | | | of all investigations into signific | cant | |
| | | | | incidents during weekly | | |
| | | | | supervision meetings with the | | |
| | | | | Program Director/QIDP. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BFLD11 Facility ID: 000993 If continuation sheet Page 9 of 31

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | | |
|--|---|--|------|--|--|---|-----------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | A. BUILDING 00 | | | COMPLETED | |
| | | 15G479 | B. W | ING | | 03/01/2 | 2022 | |
| | PROVIDER OR SUPPLIER | | • | STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360 | | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| TAG W 0154 Bldg. 00 | 483.420(d)(3) STAFF TREATME The facility must h alleged violations Based on record rev allegations of abuse reviewed, the facilit investigations for 2 client C, 6 allegation by client B, 1 fall re and 1 allegation of 6 Findings include. The facility's Burear Services (BDDS) re investigations were am. 1. A BDDS report d following: "DSP (Direct Support completing night du noise. DSP went to found [client C] had the bathroom. Staff C] to bed and looke noticed he sustained DSP applied ice per swelling. [Client C] received any other i for his morning hyg scrape he received v swollen. DSP did n (sic) or appeared to went to day program An investigation dar review of client C's | eNT OF CLIENTS ave evidence that all are thoroughly investigated. riew and interview for 10 of 22 , neglect, and/or exploitation y failed to complete thorough falls resulting in injury for ns of peer to peer aggression resulting in injury for client A, exploitation of client A. | W | 1154 0154 | W 154 Staff Treatment of Clients (Standard) - Facility failed to complete thorough investigation for 3 falls resulting in injury, 6 allegations of peer-to-peer aggression, and 1 allegation of exploitation. Corrective action for resident() found to have been affected. All parts of the POC for the survive with event ID BFLD11 will be a implemented, including the following specifics: Program Director/QIDP reviewed this deficiency and be retrained on the expectation the all allegations of abuse, negle and exploitation, including incidences of falls resulting in injury, peer to peer aggression and alleged exploitation, requit thorough investigation to be completed within 5 business of the Area Director, the Program Director/QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigations and resulting act plans are timely, thorough, an | ons of s) rvey fully has been hat ct, r, ire a lays. with n e | DATE 04/01/2022 | |

PRINTED: 04/06/2022 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 15G479 | A. BUILDI B. WING | ING 00 | COMPLETER 03/01/202 | D |
|--------------------------|---|---|----------------------|---|---|---------------------------|
| | PROVIDER OR SUPPLIER | | 42 | REET ADDRESS, CITY, STATE, ZIP COD 22 MARQUETTE TRAIL ICHIGAN CITY, IN 46360 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREF TA | FIX CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY) | N SE RIATE | (X5) OMPLETION DATE |
| | following: "On 7/30/21, this w [client C] had multi (holding his breath) med pass, staff wen medication. He got head. He had a bur between his right ey nurse and was (sic) emergency room (E completed a head C scan, a complete ble Results were norma from ER." An investigation da review of client C's staff and clients, or future injuries. 3. A BDDS report of following: "While out in the co to leave. All the ine staff was speaking t when [client B] star to, 'Shut the f*** u staff, so it's unclear her. When [client A then struck her as w able to gain control B] in a hold. Anoth the van during the r was find and no fur site" | riter was notified from staff that ple 'willful' apnea attacks throughout the evening. At it to administer [client C's] up then fell over and hit his inp that formed instantly we and ear. Staff contacted the instructed to take him to (sic) (R) due to head injury. ER (T) (computerized tomography) and panel, and urine analysis. It, and he was discharged home ted 8/2/21 did not include a high risk plans, interviews with recommendations to prevent dated 9/11/21 indicated the formunity, staff was preparing dividuals were on the van, and so one of the individual (sic) ted hitting [client D] telling her one of the individual (sic) ted hitting [client D] telling her one of the individual (sic) ted hitting [client B] started crying, [client B] vell as [client H]. Staff was without having to place [client her staff sat with [client B] on ide back to the site. [Client B] ther incidents happened at the | | How facility will identify otheresidents potentially affected what measures taken All residents potentially are affected, and corrective meaddress the needs of all click. Measures or systemic characteristic facility put in place to ensure recurrence All new Program Director/Coare being trained to complet thorough, timely investigative all significant incidents whice could be indicative of abuse neglect, or exploitation, inclails with injury, missing meds/controlled medication alleged exploitation, and pepeer aggression. A new for which was piloted in 2021 been finalized to streamline process to review these incoritically and develop action to prevent recurrence. | asures ents. ges e no IDPs te ons of h e, uding s, er to m as the dents | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BFLD11

Facility ID: 000993

If continuation sheet

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| AND PLAN OF CORRECTION IDE | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | A. BUILDING <u>00</u> | | (X3) DATE SURVEY COMPLETED 03/01/2022 |
|----------------------------|---|---|-----------------------|---|---|
| | PROVIDER OR SUPPLIED | | 422 M | ARQUETTE TRAIL IGAN CITY, IN 46360 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) | DBE COMPLETION OPRIATE |
| TAG | An investigation dareview of client B's interviews with staractions, or recomm 4. A BDDS report of following: "[Client B] was in the table, when, all starts flipping table into the living room One lamp was brok down without having why (sic) he went in 'He smiled and said Dungarvin and don Staff took [client B about his behavior housemates. [Client housemates and fin further incidents." An additional BDE indicated client H sincident. The review did not 5. A BDDS report of following: "[Client B] became got into the shower and pushed his hou what he did. No in this incident." - The BDDS report allegation occurred | ated 9/9/21 did not include a Behavior Support Plan (BSP), and clients, a review of staff endations to prevent incidents. Idated 10/13/21 indicated the standard and chairs. Then he went an flipping chairs and lamps. Items. Staff was able to talk him and to put him in a hold. When an explosive behavior (sic), a everything (sic) fine. I hate the want to be here anymore. I on a walk and talked with him and how he scared his and how he scared his in the Benefit and a bruise during the standard a bruise during the supset because his housemate to before him. [Client B] went up semate then reported to staff juries was sustain (sic) from a did not indicate the date the cated 10/30/21 did not include a staff include an investigation. | TAG | | DATE |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BFLD11

Facility ID: 000993

If continuation sheet

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PRINTED: 04/06/2022 FORM APPROVED OMB NO. 0938-039

| | OF CORRECTION | IDENTIFICATION NUMBER 15G479 | A. BUIL B. WINC | DING | 00 | COMPL 03/01/ | ETED |
|--------------------------|--|--|--------------------|--------------------|--|-----------------|----------------------------|
| | ROVIDER OR SUPPLIER | | | 422 MAF | DDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL AN CITY, IN 46360 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PF | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | E | (X5) COMPLETION DATE |
| PREFIX | review of client B's clients, or recomme incidents. 6. A BDDS report of following: "[Client B] was with housemate came in, him unprovoked. S verbally without such not be redirect (sic) person hold with his B] immediately calmin less than 5 minute because he did not whousemate" - The BDDS report allegation occurred. An investigation darreview of client B's clients, or recomme incidents. 7. A BDDS report of following: "For reason unprome came out (sic) the key clients are review of client B's clients, or recomme incidents. | BSP, interviews with staff and endations to prevent future dated 11/1/21 indicated the th staff in the kitchen when he and client B] started slapping staff tried to redirect him access. When [client B] could so staff placed him in a one is arms held to his side. [Client in (sic) down and staff released ites. [Client B] was upset want to share his time with a did not indicate the date the | PF | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | E | COMPLETION |
| | down and threw his restrained him for a he calmed down" | water at the television. Staff approximately 10 minutes until did not indicate the date the | | | | | |
| | review of client B's | ted 11/10/21 did not include a BSP, interviews with staff and endations to prevent future | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BFLD11 Facility ID: 000993

If continuation sheet Page 13 of 31

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | | |
|--|---|---|-------------|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 15G479 | B. WING | | 03/01/2022 | |
| | PROVIDER OR SUPPLIER | | 422 N | T ADDRESS, CITY, STATE, ZIP COD MARQUETTE TRAIL IGAN CITY, IN 46360 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | DECLUDED ON AN OF CORDUCTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | 8. A BDDS report of | lated 12/19/21 indicated the | | | | |
| | following: | | | | | |
| | | an unknown unprovoked | | | | |
| | | s housemate, [client A] | | | | |
| | _ | ground. [Client A] did not | | | | |
| | | ons due to the fall; however, redness to her right knee." | | | | |
| | | did not indicate the date the | | | | |
| | allegation occurred | | | | | |
| | | | | | | |
| | An investigation da | ted 12/17/21 did not include a | | | | |
| | review of client B's BSP, interviews with staff and | | | | | |
| clients, or recommendations to prevent future | | | | | | |
| | incidents. | | | | | |
| | 9. A BDDS report dated 12/13/21 indicated the following: "[Client A's] medications were not counted on the evening of December 3, 2021. According to med (medication) calculation, there are 29 Klonopin (treats anxiety and seizures, a controlled substance) tablets missing." | | | | | |
| | An investigation da | ted 12/13/21 did not include a | | | | |
| | | y's policies and procedures | | | | |
| | | of medications or a review of | | | | |
| | | The investigation did not | | | | |
| | indicate recommend incidents. | dations to prevent future | | | | |
| | meidents. | | | | | |
| | 10. A BDDS report | dated 2/11/22 indicated the | | | | |
| | following: | | | | | |
| | | eturned to the facility, she | | | | |
| | | knee hurt.' Program Director | | | | |
| | | ic) her pants leg and noticed | | | | |
| | |) mild abrasion under her right what happened, she | | | | |
| | | what happened, she Fell Down, fell down.' [Client | | | | |
| | | iculate exactly what happened | | | | |
| | _ | n.' PD called [day service | | | | |

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Event ID:

BFLD11 Facility ID: 000993

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-----------------------|-----------------------------------|----------------------------|----------|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | |
| | | 15G479 | B. W | ING | | 03/01 | /2022 |
| N | NOVEMBER OF STATE | | - | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIEF | C | | | RQUETTE TRAIL | | |
| DUNGAF | RVIN INDIANA LLC | | | MICHIG | GAN CITY, IN 46360 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY) | | DATE |
| | | mpt to gather additional | | | | | |
| | | aff was able to provide any | | | | | |
| | additional informat | ion." | | | | | |
| | An investigation da | ted 2/13/22 did not include | | | | | |
| | interviews with staf | If providing care at the time of | | | | | |
| | the injury or a revie | ew of client A's high risk plans. | | | | | |
| | Area Director (AD) | #1 was interviewed by phone | | | | | |
| | | om and stated, "Investigations | | | | | |
| | | rviews with staff and clients. | | | | | |
| | For falls, the invest | igation should look at a | | | | | |
| | pattern. Were staff | following the plans. Should | | | | | |
| | there be revisions to | o risk plans or training to | | | | | |
| | prevent recurrence. | The investigator should look | | | | | |
| | for underlying med | ical issues that need to be | | | | | |
| | discussed." AD #1 | stated, "For peer to peer | | | | | |
| | incidents, the invest | tigator should find out the | | | | | |
| | | rgeting certain people, are | | | | | |
| | | to the support plans, is | | | | | |
| | _ | prevent recurrence, were staff | | | | | |
| | | SSP (Behavior Support Plan)." | | | | | |
| | | en medication goes missing, | | | | | |
| | | what happened, interview staff | | | | | |
| | | being done to prevent | | | | | |
| | recurrence, training | for staff." | | | | | |
| | This federal tag rela | ates to complaint #IN00369156. | | | | | |
| | 9-3-2(a) | | | | | | |
| W 0156 | 483.420(d)(4) | | | | | | |
| | STAFF TREATME | ENT OF CLIENTS | | | | | |
| Bldg. 00 | | nvestigations must be | | | | | |
| | 1 - | ministrator or designated | | | | | |
| | 1 - | to other officials in | | | | | |
| | | State law within five working | | | | | |
| | days of the incide | | | | | | |
| | | view and interview for 1 of 22 | W (|)156 | <u>W 156</u> | | 04/01/2022 |
| | allegations of abuse | e, neglect, and mistreatment | | | Staff Treatment of Clients | | 1 |

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Event ID:

BFLD11

Facility ID: 000993

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) I | | | (X3) DATE | SURVEY | |
|--|----------------------------------|-----------------------------------|-------|---------|---|--------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 15G479 | B. W | ING | | 03/01/ | /2022 |
| | | <u> </u> | 1 | CTDEET | ADDRESS, CITY, STATE, ZIP COD | I | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL | | |
| DUNCAR | | | | | | | |
| DUNGAF | RVIN INDIANA LLC | | | MICHIC | GAN CITY, IN 46360 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | reviewed, the facilit | ty failed to conduct an | | | (Standard) - Facility failed to | | |
| | investigation of one | allegation of exploitation for | | | conduct an investigation of on | е | |
| | client A within 5 business days. | | | | allegation of exploitation for cl | ient | |
| | | | | | A within 5 business days. | | |
| | Findings include: | | | | | | |
| | | | | | Corrective action for resident(s | <u>s)</u> | |
| | _ | u of Developmental Disabilities | | | found to have been affected | | |
| | Services (BDDS) re | - | | | All parts of the POC for the su | ırvey | |
| | investigations were | reviewed on 2/16/22 at 11:50 | | | with event ID BFLD11 will be | fully | |
| | am. | | | | implemented, including the | | |
| | | | | | following specifics: | | |
| | A BDDS report dat | ed 12/13/21 indicated the | | | · Program Director/QIDP | has | |
| | following: | | | | reviewed this deficiency and b | een | |
| | "[Client A's] medic | ations were not counted on the | | | retrained on the expectation th | nat | |
| | evening of Decemb | er 3, 2021. According to med | | | all allegations of exploitation | | |
| | (medication) calcul | ation, there are 29 Klonopin | | | require a thorough investigation | on to | |
| | (treats anxiety and s | seizures, a controlled | | | be completed within 5 busines | ss | |
| | substance) tablets n | nissing." | | | days. | | |
| | | | | | · Going forward, during | | |
| | An investigation da | ted 12/13/21 did not include a | | | weekly supervision meetings v | with | |
| | review of the facilit | y's policies and procedures | | | the Area Director, the Progran | n | |
| | concerning storage | of medications or a review of | | | Director/QIDP will review the | | |
| | medication counts. | The investigation did not | | | status of every major incident | | |
| | indicate recommend | dations to prevent future | | | currently under review, and th | е | |
| | incidents. | | | | QIDP will be responsible to | | |
| | | | | | present the status of each | | |
| | - | al Disabilities Professional | | | investigation to ensure that the | е | |
| | (QIDP) #1 was inte | rviewed by phone on 2/25/22 at | | | investigations and resulting ac | ction | |
| | 1:20 pm and stated, | "We were in a staff meeting | | | plans are timely, thorough, an | d | |
| | on December 4th. | One of the staff came out and | | | effective. | | |
| | said the medication | s were missing." QIDP #1 | | | | | |
| | stated, "The way we | e were counting the | | | How facility will identify other | | |
| | medications, the she | eets weren't done correctly. | | | residents potentially affected & | <u>&</u> | |
| | | staff came in, they thought | | | what measures taken | | |
| | the medications we | re missing. The staff told the | | | All residents potentially are | | |
| | nurse, the medication | ons were found on the 5th. I | | | affected, and corrective meas | ures | |
| | turned in the report | and investigation on | | | address the needs of all client | | |
| | December 13th." | | | | | | |
| | | | | | Measures or systemic change | <u>s</u> | |
| | Area Director (AD) | #1 was interviewed by phone | | | facility put in place to ensure r | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
|--|--|--|------------------------|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 15G479 | A. BUILDING B. WING | 00 | COMPLETED 03/01/2022 |
| | | | | TADDRECC CITY CTATE 7ID COD | 00/01/2022 |
| NAME OF P | ROVIDER OR SUPPLIEF | R | | FADDRESS, CITY, STATE, ZIP COD | |
| DUNGAR | RVIN INDIANA LLC | | MICH | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | R LSC IDENTIFYING INFORMATION om and stated, "The | TAG | | DATE |
| | - | nissing on December 4th." AD | | recurrence All new Program Director/QID | iPs |
| | | #1 was notified of the missing | | are being trained to complete | |
| | | /21. AD #1 stated, "[QIDP #1] | | thorough, timely investigations | |
| | | he medication was still missing. | | all significant incidents which | |
| | | ne nurse knew about it, but | | could be indicative of abuse, | |
| | | it was still missing." AD #1 | | neglect, or exploitation, include | ling |
| | stated, "It was repor | rted on 12/13/21." AD #1 | | missing medications/missing | |
| | stated, "Investigation | ons should be completed | | controlled medications. A new | ı |
| | within 5 business da | ays." | | form which was piloted in 202 | .1 |
| | | | | has been finalized to streamli | ne |
| | This federal tag rela | ates to complaint #IN00369156. | | the process to review these | |
| | | | | incidents critically and develo | • |
| | 9-3-2(a) | | | action plans to prevent recurr | ence. |
| W 0192 Bldg. 00 | For employees wh must focus on skil directed toward cl Based on observation interview for 3 of 3 the facility failed to were adequately trapolicies for medical for clients A, B, C, The facility failed to home were adequate for clients A, B, D, to ensure clients A, medications were stensure the keys to to cabinet were kept in A, B, C, D, E, F, G, | A83.430(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 observation, record review, and interview for 3 of 3 sample clients (A, B, and C), the facility failed to ensure staff working the home were adequately trained to implement plans and policies for medication storage and record keeping for clients A, B, C, D, E, F, G, and H. The facility failed to ensure staff working the home were adequately trained to provide privacy for clients A, B, D, E, and F's medical information, to ensure clients A, B, C, D, E, F, G, and H's medications were stored in a secure manner, to ensure the keys to the office and medication cabinet were kept in a secure location for clients A, B, C, D, E, F, G, and H, and to accurately account for clients A, B, E, and G's controlled | | W 192 Staff Training Program (Stand Facility failed to ensure staff working in the home were adequately trained to impleme plans and policies regarding medication storage and reconkeeping. Also failed to ensure working were adequately train provide privacy for individuals medical information, to ensure meds were stored in a secure manner, to ensure the keys to office and med cabinet were kin a secure location, and to accurately account for clients' controlled medications. | ent d e staff ned to s' e to the kept |
| | Findings include: | | | Corrective action for resident(| <u>s)</u> |

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Event ID:

BFLD11 Facility ID: 000993

If continuation sheet Page 17 of 31

| DEPARTMENT OF HEALTH | I AND HUMAN SERVICES |
|----------------------|----------------------|
| CENTERS FOR MEDICARE | & MEDICAID SERVICES |

| STATEMEN | IT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | SURVEY | | |
|-----------|------------------------|----------------------------------|--|----------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | ETED |
| | | 15G479 | B. WI | NG | | 03/01/ | 2022 |
| | | | <u> </u> | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | RQUETTE TRAIL | | |
| DUNCAE | | | | | | | |
| DUNGAR | RVIN INDIANA LLC | | | MICHIG | GAN CITY, IN 46360 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | found to have been affected | | |
| | 1. The facility failed | d to ensure staff working in the | | | All parts of the POC for the su | rvev | |
| | | ely trained to ensure privacy | | | with event ID BFLD11 will be f | - | |
| | | E and F's medical information. | | | implemented, including the | , | |
| | Please see W129. | | | | following specifics: | | |
| | | | | | · All facility staff have bee | en | |
| | 2. The facility failed | d to ensure staff working in the | | | retrained on the expectation th | | |
| | | ely trained to ensure clients A, | | | all medications must be secure | | |
| | - | d H's medications were stored in | | | in a locked cabinet at all times | | |
| | a secure manner. P | | | | · Program Director/QIDP | | |
| | | | | | Facility nurse have been retrai | | |
| | 3. The facility failed | d to ensure staff working in the | | | on their responsibility to ensur | | |
| | | ely trained to ensure the keys | | | that staff working in the home | | |
| | | edication cabinet were kept in a | | | adequately trained in plans an | | |
| | | clients A, B, C, D, E, F, G, and | | | policies regarding medication | _ | |
| | H. Please see W383 | | | | storage and record keeping, | | |
| | | | | | locking medications, protecting | ני | |
| | 4. The facility failed | d to ensure staff working in the | | | the privacy of health information | | |
| | - | ely trained to accurately | | | securing the med room, and | , | |
| | - | A, B, E, and G's controlled | | | accounting of all controlled | | |
| | medications. Please | | | | medications. | | |
| | | | | | · Program Director/QIDP | and | |
| | This federal tag rela | ites to complaint #IN00369156. | | | Facility Nurse held an all-staff | ana | |
| | | | | | mandatory meeting to retrain o | n | |
| | 9-3-3(a) | | | | all of these policies and | ,,, | |
| |) | | | | procedures in place at the faci | litv | |
| | | | | | to ensure medications are stor | - | |
| | | | | | and accounted for safely and | | |
| | | | | | health information privacy is | | |
| | | | | | maintained at all times. | | |
| | | | | | manianos at an unios. | | |
| | | | | | How facility will identify other | | |
| | | | | | residents potentially affected & | , | |
| | | | | | what measures taken | <u>-</u> | |
| | | | | | All residents potentially are | | |
| | | | | | affected, and corrective measu | ires | |
| | | | | | address the needs of all clients | | |
| | | | | | agained the fields of all ollers | | |
| | | | | | Measures or systemic change | s | |
| | | | | | facility put in place to ensure n | | |
| | | | | | issuity pat in place to cliquie in | <u>-</u> | |

PRINTED: 04/06/2022 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 03/01/2022 |
|--------------------------|---|--|--|---|--|
| | PROVIDER OR SUPPLIER | | 422 M | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| W 0331 Bldg. 00 | services in accord Based on observation interview for 3 of 3 plus 5 additional clifacility's nursing services adequate oversight record keeping for of the H's medications. The facility's nursing privacy of clients A information, to ensure and H's medications manner, to ensure the medication cabinet for clients A, B, C, | ance with their needs. on, record review, and sample clients (A, B, and C), ents (D, E, F, G, and H), the rvices failed to provide to ensure proper storage and clients A, B, C, D, E, F, G, and g services failed to ensure the clients A, B, C, D, E, F, G, and are clients A, B, C, D, E, F, G, to were stored in a secure the key to the office and were kept in a secure locations to D, E, F, G, and H, and to the cord clients A, B, E, and G's | W 0331 | All new employees are trained the policy on drug storage and transference as part of new storientation. All staff are require complete annual retraining on Medication Administration who covers med storage. QIDP is maintain a regular, frequent presence in the home and prodirect coaching and redirection any staff who violate policy ar procedure. Nurse will also repany violations to the PD/QIDF follow up. W 331 Nursing Services (Standard) - Facility nursing services failed provide adequate oversight to ensure proper storage and rekeeping for medications, to enprivacy for clients' medical information, to ensure medical were stored in a secure manner to ensure the key to the office med cabinet were stored in a secure manner, and to accurate account for controlled medications. Corrective action for resident found to have been affected. All parts of the POC for the survite with event ID BFLD11 will be implemented, including the | d taff ed to lich to lovide in to loor loor loor loor loor loor loor l |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BFLD11

Facility ID: 000993

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|-------------------------------|----------------------------------|-------|-------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 15G479 | B. W | ING | | 03/01/ | /2022 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIE | R | | | RQUETTE TRAIL | | |
| DUNGAF | RVIN INDIANA LLC | | | MICHIO | GAN CITY, IN 46360 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | • | rsing services failed to ensure | | | following specifics: | | |
| | | A, B, D, E and F's medical | | | · Facility nurse reviewed | this | |
| | information. Please see W129. | | | | finding and the related | | |
| | | | | | deficiencies. Facility nurse the | | |
| | - | rsing services failed to ensure | | | provided retraining to all facili | - | |
| | | E, F, G, and H's medications | | | staff regarding the proper stor | rage | |
| | were stored in a sec | cure manner. Please see W382. | | | and record keeping for | | |
| | 0.771 0.111.1 | | | | medications, the privacy of cli | ients' | |
| | | rsing services failed to ensure | | | medical information, the safe | | |
| | | ce and medication cabinet were | | | storage of the office and med | | |
| | _ | ation for clients A, B, C, D, E, | | | cabinet keys, and proper | | |
| | F, G, and H. Pleas | e see w 383. | | | accounting of controlled | | |
| | 4 Th - f:1:4! | | | | medications. | | |
| | - | rsing services failed to | | | · Facility nurse provides | а | |
| | - | for clients A, B, E, and G's | | | weekly, written report to the | | |
| | controlled medicati | ions. Please see W385. | | | Program Director/QIDP, Area | | |
| | This fodoral too rol | ates to complaint #IN00369156. | | | Director, and Nursing Service | | |
| | This federal tag fer | ates to complaint #1100309130. | | | Director. Facility nurse has ac | | |
| | 9-3-6(a) | | | | a section to her report where reports her observations of th | | |
| | 9-3-0(a) | | | | proper storage and record ke | | |
| | | | | | for medications, the privacy o | | |
| | | | | | medical information, proper k | | |
| | | | | | storage, and the counts of the | - | |
| | | | | | controlled medications. | • | |
| | | | | | Program Director/QIDF |) | |
| | | | | | Facility Nurse, and Area Direction | | |
| | | | | | week meetly to review these | | |
| | | | | | observations and other nursing | na | |
| | | | | | review items for the week. | .5 | |
| | | | | | | | |
| | | | | | | | |
| | | | | | How facility will identify other | _, | |
| | | | | | residents potentially affected | | |
| | | | | | what measures taken | | |
| | | | | | All residents potentially are | | |
| | | | | | affected, and corrective meas | sures | |
| | | | | | address the needs of all clien | ts. | |
| | | | | | | | |
| | | | | | Measures or systemic change | es_ | |

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 03/01/2022 |
|--------------------------|--|--|--|--|---------------------------------------|
| | RVIN INDIANA LLC | | 422 MA | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 5.112 |
| | | | | facility put in place to ensure in recurrence Facility nurses will maintain regular presence in the home. Nurses provide all initial training Med Core and agency policies regarding Medication storage record keeping for medications locking medications, double locking controlled medications counting of controlled medications. Nurses also provide annual training where this reviewed. Facility nurse will observe for ongoing staff competence in these areas downweekly site visits and report a concerns to the Program Director/QIDP and Area Director the home. | s. ng on s and s, s and vide is |
| W 0382 Bldg. 00 | The facility must k biologicals locked prepared for admi Based on observation sample clients (A, E clients (D, E, F, G, | except when being | W 0382 | W 382 Drug Storage and Recordkee (Standard) - Facility failed to ensure medications were stor | |
| | medications were st Findings include: Observations were on 2/15/22 from 3:4 A, B, C, D, E, F, G, throughout the observations | conducted in the group home 5 pm through 6:00 pm. Clients and H were present in the home | | a secure manner. Corrective action for resident(found to have been affected All parts of the POC for the su with event ID BFLD11 will be implemented, including the following specifics: All facility staff will be retrained on the expectation to | s <u>)</u> ırvey fully |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BFLD11 Facility ID: 000993

If continuation sheet Page 21 of 31

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | (X2) MULTIPLE C A. BUILDING B. WING | OO | (X3) DATE SURVEY COMPLETED 03/01/2022 |
|--------------------------|--|---|-------------------------------------|---|---|
| | PROVIDER OR SUPPLIER | | 422 M | CADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | TION (X5) .D BE IOPRIATE COMPLETION DATE |
| | a half door, and the throughout the obse the observation per the outside of the do Throughout the obs | ervation period, there were | | all medications must be so in a locked cabinet at all to . QIDP and nurse will responsible to verify that medication is stored in a locabinet during regular, free visits in the home. | imes. Il be ocked |
| | paper bags on a desk in the office containing the following medications: Client A SMZ-TMP 800- 160 (treats symptoms of bacterial infections). Calcium 600 (used to prevent or treat low blood calcium levels). | | | Staff who were respect to have locked the med cannot the date of the observation received employee couns addition to the retraining for staff. Similarly, any staff for have left the medications | abinet on n have eling in or all |
| | · · · · · · · · · · · · · · · · · · · | | | unsecured during an obse will receive corrective acti retraining in accordance v Dungarvin policy. | on and/or vith |
| | Vitamin D 5000 un disorders). Loratadine 10 mg (conjunctivitis). | tereats and prevents bone treats symptoms of hay fever/ | | How facility will identify ot residents potentially affect what measures taken All residents potentially ar affected, and corrective maddress the needs of all of | re neasures |
| | Lamotrigine 150 mg | g (treats symptoms of epilepsy). n)(treats symptoms of heart | | Measures or systemic characteristics of the facility put in place to ensure recurrence. All new employees are training the policy on drug storage transference as part of ne | ure no ained on e and |
| | Lamotrigine 200 m, Lamotrigine 100 m, Clonazepam .5 mg disorder) | reats symptoms of allergies). g (treats symptoms of seizures). g (treats symptoms of epilepsy). (treats symptoms of panic | | orientation. All staff are recomplete annual retraining Medication Administration covers med storage. QIDI maintain a regular, freque presence in the home and direct coaching and redirect | equired to g on which is to ent d provide ection to |
| | Client C | | 1 | any staff who leave the m | ed closet |

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | ľ | UILDING | onstruction 00 | (X3) DATE COMPL 03/01/ | ETED |
|--------------------------|--|---|---|---------------------|---|------------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | R | | 422 MA | ADDRESS, CITY, STATE, ZIP COD RQUETTE TRAIL GAN CITY, IN 46360 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | REGULATORY OF Fenofibrate 145 mg cholesterol). Metformin 1000 mg Jardiance 25 mg (tr Docusate SOD 100 constipation). Atorvastatin 20 mg cholesterol). Amlodipine 5 mg (trough fenome of the stroke). Pantoprazole 20 mg gastroesophageal re Vitamin D 5000 un disorders). Vascepa 1 mg (treastroke). Propranolol 60 mg pressure). Divalproex 500 mg Trazodone 100 mg depression, anxiety depression and anxiety depression and anxiety depression for the schizophrenia. Quetiapine 200 mg depression/bi-polar Sertraline 50 mg (treastroke) mg (treastroke). The medication stor (as needed) medicathroughout the observer stored in a rol | R LSC IDENTIFYING INFORMATION (treats symptoms of high g (treats symptoms of Diabetes), eats symptoms of Diabetes), mg (treats symptoms of (treats symptoms of high treats symptoms of high blood to prevent or treat low blood g (treats symptoms of efflux disease). it (treat and prevents bone tts symptoms of heart attack/ (treats symptoms of high blood (treats symptoms of seizures). (treats symptoms of g, or a combination of iety). reats symptoms of (treats symptoms of compulsive disorder). | | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) unsecured. Nurse will also repany violations to the PD/QIDP follow up. | ort | |
| | medications. Throu the keys for the me | uble lock controlled aghout the observation period, dication cart were lying on top dication cart and the narcotics | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

BFLD11

Facility ID: 000993

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| | OF CORRECTION | IDENTIFICATION NUMBER 15G479 | A. BUILDING B. WING | 00 | | LETED 1/2022 |
|--------------------------|--|---|---------------------|--|----|----------------------------|
| | PROVIDER OR SUPPLIER RVIN INDIANA LLC | | 422 MA | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | At 4:04 pm Direct S was in the office. Co office door to unlook walked into the office. On the proof of the p | Support Professional (DSP) #2 Client D used the key in the k and open the door and ce. DSP #2 walked her out. Ce and went into the living not lock the medication cart, im, or secure the office door #2 brought client A from the ministered her 4 pm medication. Clication room and did not lock for narcotics box. The key was the medication room door. At sed the key on the outside of foor and walked inside. Staff ication room. Evened on 2/15/22 at 4:17 pm and not pass medications. DSP #2 ten trained to pass 2 indicated all medications | | | | |

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Event ID:

BFLD11

Facility ID: 000993

If continuation sheet

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|---|---|-----------------------------|--|------|--|---|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | a. building <u>00</u> | | | COMPLETED | |
| 15G479 | | B. WING 03/01/2022 | | | 2022 | | |
| NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC | | | STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | ID | | PROVIDED'S BLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | DEFICIENCY) | | DATE |
| TAG W 0383 Bldg. 00 | until they are logged in." Area Director (AD) #1 was interviewed by phone on 2/16/22 at 11:08 am and stated, "The medication room should be secured. The cabinet should be locked anytime staff aren't in the room. The policy is to have a lock between the individuals and the medications. There should be two locks between individuals and narcotics." This federal tag relates to complaint #IN00369156. 9-3-6(a) 483.460(I)(2) DRUG STORAGE AND RECORDKEEPING | | | TAG | DEFICIENCY | | DATE |
| | the keys to the drug storage area. Based on observation, record review, and interview for 3 of 3 sample clients (A, B, and C), plus 5 additional clients (D, E, F, G, and H), the facility failed to ensure the keys to the office and medication cabinet were kept in a secure location. Findings include: Observations were conducted in the group home on 2/15/22 from 3:45 pm through 6:00 pm. Clients A, B, C, D, E, F, G, and H were present in the home throughout the observation period. Throughout the observation period, the medication storage cabinet containing PRN (as needed) medications was unlocked. Medications were stored in a rolling cart with drawers and a box with a lock was built into one of the drawers and was used to double lock controlled medications. Throughout the observation period, the keys for the medication cart were lying on top | | W | 0383 | W 383 Drug Storage and Recordkeep (Standard) - Facility failed to ensure the keys to the office a medication cabinet were kept secure location. Corrective action for resident(standard) found to have been affected. All parts of the POC for the su with event ID BFLD11 will be fimplemented, including the following specifics: All facility staff have been retrained on how they are to ensure the keys to the office a medication cabinet are to be exarried by staff or placed in a secure location only accessible staff members at all times. QIDP and nurse have be verifying the location of the medication of | nd in a s) rvey fully en ind either e to een | 04/01/2022 |

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Event ID:

BFLD11 Facility ID: 000993

If continuation sheet Page 25 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/01/2022 15G479 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **422 MARQUETTE TRAIL** MICHIGAN CITY, IN 46360 DUNGARVIN INDIANA LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of the cart. The cart and the narcotics box were room and med closet keys during unlocked. all scheduled and unscheduled visits/observations several times At 4:04 pm Direct Support Professional (DSP) #2 per week to verify staff was in the office. Client D used the key in the competence after the retraining. office door to unlock and open the door and walked into the office. DSP #2 walked her out. How facility will identify other DSP #2 left the office and went into the living residents potentially affected & room. DSP #2 did not lock the medication cart, what measures taken take the keys with him, or secure the office door All residents potentially are when he left. DSP #2 brought client A from the affected, and corrective measures living room and administered her 4 pm medication. address the needs of all clients. DSP #2 left the room with client A. The medication cart was unlocked, and the key to the Measures or systemic changes medication room was left in the door handle. At facility put in place to ensure no 4:55 pm, Client D, used the key on the outside of recurrence medication room door and walked inside. Staff All new employees are trained on were not in the medication room. the policy on drug storage and transference as part of new staff Qualified Intellectual Disabilities Professional orientation. Part of the onsite staff (QIDP) #1 was interviewed on 2/15/22 at 5:02 pm orientation process involves and stated, "The key for the medication room training staff on how the keys to should be hanging on the handle inside the the med room, closet, and medication room. The clients here cannot use the controlled medication box are to key to open the door." QIDP #1 indicated the be maintained safely at all times. clients in the home would not reach over the half All staff are required to complete door to unlock the door or to get the key. QIDP annual retraining on Medication #1 stated, "When staff leave the medication room, Administration which covers med they should close and lock the door." storage. QIDP is to maintain a regular, frequent presence in the Registered Nurse (RN) #1 was interviewed on home and provide direct coaching 2/16/22 at 1:37 pm. RN #1 stated "The medication and redirection to any staff who room should be locked with the key on the staff at leave the med closet unsecured. all times." Nurse will also report any violations to the PD/QIDP for Area Director (AD) #1 was interviewed by phone follow up. on 2/16/22 at 11:08 am and stated, "The staff should carry the key to the medication room with them."

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Event ID:

BFLD11

Facility ID: 000993

If continuation sheet

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|--|--|----------------------------|-------------------------|---|---------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | | COMPL | MPLETED | |
| 15G479 | | B. WING 03/01/2022 | | | /2022 | | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | RQUETTE TRAIL | | |
| DUNGARVIN INDIANA LLC | | | MICHIGAN CITY, IN 46360 | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | TAG | | DEFICIENCY) | | DATE |
| | This federal tag rela | ites to complaint #IN00369156. | | | | | |
| | 9-3-6(a) | | | | | | |
| W 0385 | 483.460(I)(3) | | | | | | |
| | | AND RECORDKEEPING | | | | | |
| Bldg. 00 | The facility must n | naintain records of the | | | | | |
| | receipt and dispos | sition of all controlled drugs. | | | | | |
| | | view and interview for 2 of 3 | W_0 | 385 | W 385 Drug Storage and Recordkeeping | | 04/01/2022 |
| | | nd B), plus 2 additional clients | | | | | |
| | , , | ty failed to accurately account | | | (Standard) - Facility failed to | | |
| | for clients A, B, E, | and G's controlled medications. | | | accurately account for clients' | | |
| | | | | | controlled medications. | | |
| | Findings include: | | | | Corrective action for resident(s | s) | |
| | The facility's medic | ation count sheets were | | | found to have been affected | <u></u> | |
| | reviewed on 2/15/22 at 5:40 pm. | | | | All parts of the POC for the su | rvey | |
| | | • | | | with event ID BFLD11 will be t | - | |
| | 1. Client A's undate | ed Narcotic Record indicated | | | implemented, including the | • | |
| | the following: | | | | following specifics: | | |
| | "Clonazepam (treats | s seizures and anxiety), 1 mg | | | All facility staff have bee | en | |
| | (milligram). | | | | retrained on Dungarvin proced | lure | |
| | | t on hand 11, Amount given -1, | | | for storage of and documentat | ion | |
| | Amount left 10. | | | | of controlled medications. | | |
| | - | t on hand 10, Amount given -1, | | | · The employee responsi | | |
| | Amount left 9. | | | | for documenting the 8pm narc | | |
| | | t on hand 9, Amount given -1, | | | counts before the 8pm med pa | ass | |
| | Amount left 8." | | | | has received retraining and | | |
| | Client Al. Cl | | | | disciplinary action in accordan | | |
| | | oam medication card contained The record indicated staff | | | with Dungarvin policy & proce | | |
| | • • | count before the 8 pm | | | QIDP and nurse have be auditing the percent about the percent and the percent about the percent and the p | | |
| | medication pass too | - | | | auditing the narcotic count she | ะยเร | |
| | medication pass too | k piace. | | | during all scheduled and unscheduled site visits severa | ı | |
| | 2 Client B's undate | d Narcotic Record indicated | | | times per week to ensure that | | |
| | the following: | a randone recent indicated | | | counts are accurate, and that | | |
| | "Clonazepam, 0.5 n | ng. | | | demonstrate competency | Cuii | |
| | | t on hand 10, Amount Given -1, | | | regarding completing the cour | ıts | |
| | Amount Left 9. | | | | and documenting their audits. | | |
| 2/15, 3 pm. Amount on hand 9. Amount given -1. | | | | Any staff found to have | | | |

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Event ID:

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|------------------------------|--|-----------------------------------|----------------------------|---------|--|------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BUILDING 00 | | COMPLETED | | |
| | | 15G479 | | B. WING | | 03/01/2022 | |
| | | | | | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | RQUETTE TRAIL | | |
| DUNGAF | RVIN INDIANA LLC | | | MICHIG | GAN CITY, IN 46360 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | .16 | DATE |
| | Amount left 8. | | | | improperly documented contro | olled | |
| | 2/15, 8 pm, Amoun | t on hand 8, Amount given -1, | | | medication counts during an | | |
| | Amount left 7." | , 3 | | | observation will receive correct | tive | |
| | | | | | action and/or retraining in | | |
| | Client B's Clonazer | oam medication card contained | | | accordance with Dungarvin po | | |
| | | The record indicated staff | | | | | |
| | | count before the 8 pm | | | How facility will identify other | | |
| | medication pass too | - | | | residents potentially affected & | ર | |
| | 1 | 1 | | | what measures taken | <u>~</u> | |
| | 3. Client E's Narcot | ic Record dated 1/24/22 | | | All residents potentially are | | |
| | indicated the follow | | | | affected, and corrective measures | | |
| | | reats seizures), 10 mg. | | | address the needs of all client | | |
| | 2/15, 8 pm, Amount on hand 8, Amount given -1, | | | | | | |
| | Amount left 7." | | | | Measures or systemic change | s | |
| | Timosiit tett /. | | | | facility put in place to ensure no | | |
| | Client E's Clobazan | n medication card contained 8 | | | recurrence | | |
| | | he record indicated staff | | | All new employees are trained | lon | |
| | 1 | count before the 8 pm | | | the procedures to follow for | | |
| | medication pass too | - | | | counting controlled medications | | |
| | · | • | | | on every shift and every time a | | |
| | Client E's Narcotic | Record dated 2/15/22 indicated | | | controlled medication is | - | |
| | the following: | | | | administered. All staff are requ | uired | |
| | "Vimpat (anticonvu | ılsant), 200 mg. | | | to complete annual retraining | | |
| | | t on hand 7, Amount given -1, | | | Medication Administration whi | | |
| | Amount left 6. | , , | | | covers controlled medication | | |
| | 2/15, 8 pm, Amoun | t on hand 6, Amount given -1, | | | storage and counting. QIDP is | to | |
| | Amount left 5." | , 6 | | | maintain a regular, frequent | | |
| | | | | | presence in the home and pro | vide | |
| | Client E's Vimpat n | nedication card contained 6 pills | | | direct coaching and redirection | | |
| | _ | cord indicated staff completed | | | any staff who fail to follow this | | |
| | _ | ore the 8 pm medication pass | | | training. Nurse will also report | | |
| | took place. | | | | violations to the PD/QIDP for | , | |
| | 1 | | | | supervisory follow up. | | |
| | 4. Client G's Narcotic Record dated 2/15/22 | | | | ' ' ' | | |
| | indicated the following: | | | | | | |
| | "Klonopin, 0.75 mg. | | | | | | |
| | 2/15, 7 am, Amount on hand 4.5, Amount given | | | | | | |
| | 1.5, Amount left 3. | | | | | | |
| | | t on hand 3, Amount given 1.5, | | | | | |
| | Amount left 1.5." | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G479 | | (X2) MULTIPLE CO A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 03/01/2022 | | | | | | |
|--|---|--|---------------------------------------|---|----------------------|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC | | | 422 MA | STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | (X5) COMPLETION DATE | | | | |
| | 3 pills at 5:40 pm. | pam medication card contained The record indicated staff a count before the 8 pm k place. | | | | | | | |
| | interviewed on 2/16 "Medication counts shift. If a medicatio staff should never s swallowed or admin | Nurse (LPN) #1 was 6/22 at 12:37 pm and stated, should be done once per on is being administered, the ign before the medication is nistered. The person passing in should not sign for the 8 pm | | | | | | | |
| | on 2/25/22 at 1:00 p documentation shot schedule. It cannot Medications that ne counted every shift passed. Every shift | ald be done ahead of be accurate that way. ed to be counted should be and every time they are makes sure we have the right pass the medication, they | | | | | | | |
| | _ | ates to complaint #IN00369156. | | | | | | | |
| W 0455 | 9-3-6(a) 483.470(I)(1) INFECTION CON | TROL | | | | | | | |
| Bldg. 00 | prevention, control infection and com Based on observation interview for 3 of 3 plus 5 additional clifacility failed to ensimplemented proact | active program for the II, and investigation of municable diseases. on, record review, and sample clients (A, B, and C), ents (D, E, F, G, and H), the sure staff working in the home tive/preventative infection uring a world wide pandemic of | W 0455 | W 455 Infection Control (Standard) - Facility failed to ensure staff working in the home implement proactive/preventative infection control measures during a | | | | | |

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Event ID:

BFLD11 Facility ID: 000993

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 03/01/2022 | |
|---|--|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC | | 422 MA | ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | COMPLETION | |
| TAG | | | TAG | DEFICIENCY) | DATE | |
| | COVID-19. | | | worldwide pandemic of COVID | -19 . | |
| | on 2/15/22 from 3:4 A, B, C, D, E, F, G throughout the obso opened the door an #2. Direct Support up to client D and t did not address the temperatures, ask a or ask the surveyor. The facility's COVI dated 2/1/22 were r and indicated the fo "6. Visitors must ta visit 7. All visitors must document upon arri their best contact pl in case we need to notification" Licensed Practical 1 interviewed on 2/10 "Staff need to take" | ke their temperature prior to the complete a health screening living for the visit and provide thone number or email address follow-up with a contact Nurse (LPN) #1 was 6/22 at 12:37 pm and stated, visitors' temperature and have | | Corrective action for resident(s found to have been affected All parts of the POC for the sur with event ID BFLD11 will be for implemented, including the following specifics: All facility staff have been retrained on the facility's COVID-19 Pandemic Guideline including the requirement for a visitors to be screened by taking their temperature and completing the health screening document visitors. QIDP and nurse are monitoring staff compliance with the retraining during all scheduled and unscheduled site visits each week. Staff who fail to screen visitors or otherwise fail to follo the COVID-19 Pandemic Guidelines during an observating will receive corrective action ar retraining in accordance with Dungarvin policy. | rvey ully en es, II ng ing t for th uled ch | |
| | go any further." 9-3-7(a) | ID sign in form before they can | | How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measured address the needs of all clients Measures or systemic changes facility put in place to ensure no recurrence | ıres 5. | |

All new employees are trained on

PRINTED: 04/06/2022 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION (| (X3) DATE SURVEY COMPLETED 03/01/2022 | |
|---|---|---|--|---|---------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER DUNGARVIN INDIANA LLC | | | STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360 | | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| | REGULATION ON ESC IDENTIFY THAT HAVE BUT ON MANAGEMENT. | | | the Infection control policies including Dungarvin's COVID-1 Pandemic guidelines as part of new staff orientation. All staff ar required to complete annual retraining on Medication Administration which covers infection control policies and procedures. QIDP is to maintain regular, frequent presence in the home and provide direct coach and redirection to any staff who to follow Dungarvin's COVID-19 Pandemic guidelines and other measures in place to prevent the spread of infection and communicable diseases. Nurse will also report any violations to the PD/QIDP for follow up. | n a ne ing o fail o | |

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