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	03/01/2022

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 #IN00369156. Complaint #IN00369156: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W153, W154, W156, W192, W331, W382, W383, and W385. Unrelated deficiencies cited. Dates of Survey: February 15, 16, 24, 25, and March 1, 2022. Facility Number: 000993 Provider Number: 15G479 AIMS Number: 100244950 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/14/22.	W 0000		
W 0129 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. Based on observation, record review, and interview for 2 of 3 sample clients (A and B), plus 3 additional clients (D, E and F), the facility failed to ensure the privacy of clients A, B, D, E and F's medical information. Findings include: Observations were conducted in the group home	W 0129	**W 129** Protection of Clients Rights (Standard) – Failed to ensure the privacy of clients A, B, D, E and F's medical information. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully	04/01/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	03/01/2022

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
	on 2/15/22 from 3:45 pm through 6:00 pm. Clients A, B, D, E, and F were present in the home throughout the observation period. Throughout the observation period, empty medications cards were sitting out on the desk in office. The following empty cards were on the desk: Client A Lamotrigine 150 milligram (mg) (treats symptoms of epilepsy), the last pill was given on 2/14/22. Client B Sertraline 100 mg (treats symptoms of depression and obsessive compulsive disorder), the last pill was given on 2/13/22. Client D Vascepa 1 gram (g) (treats symptoms to prevent heart attack/stroke), last administered 2/14/22. Aspirin 81 mg (treats symptoms to prevent heart attack/stroke), last administered 2/13/22. Fenofibrate 48 mg (treats symptoms of high cholesterol), last administered 2/13/22. Gabapentin 300 mg (treats symptoms of epilepsy), last administered 2/14/22. Quetiapine 100 mg (treats symptoms of schizophrenia), last administered 2/14/22. Client E Calcium D (treats symptoms to prevent bone loss) last administered 2/13/22. Client F B-complex (treats symptoms of vitamin deficiency), last administered 2/14/22. Direct Support Professional (DSP) #3 was interviewed on 2/15/22 at 5:10 pm. DSP #3		implemented, including the following specifics: · All facility staff have been retrained on policies regarding Client Rights including the right to privacy regarding personal health information. · All facility staff retrained on the procedure to follow when a med card or other med container with protected health information printed on a label needs to be discarded and what procedure to follow when new medications are delivered and need to be stored securely. · Program Director/QIDP and nurse will be responsible to verify that protected health information is stored in a HIPAA compliant way during regular, frequent visits in the home. The facility nurse has added documentation of this to her weekly written report to the QIDP and Area Director. · All occurrences of HIPAA violations discovered in the home will be addressed immediately with responsible staff members through retraining and/or corrective action in accordance with Dungarvin policy and procedure. 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	

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	03/01/2022

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
	indicated when a medication card is empty, staff put the top with the client's name through the shredder or black out the name right away after administering the last dose of the medication. DSP #2 was interviewed on 2/15/22 at 5:15 pm. DSP #2 stated, "When a medication card is empty, we rip off the top of the card and shred it. We throw away the bottom of card." Qualified Intellectual Disability Professional (QIDP) #1 was interviewed on 2/15/22 at 6:00 pm. QIDP #1 stated, "When a medication card is empty, staff should rip off the top of the card and shred it and throw away the bottom part." Registered Nurse (RN) #1 was interviewed on 2/16/22 at 1:37 pm. RN #1 indicated staff should rip off the top of medication card and shred it and throw the bottom part away. Area Director (AD) #1 was interviewed on 2/16/22 at 11:08 am. AD #1 indicated empty medication cards should be stored in Health Insurance Portability and Accountability Act (HIPAA) compliant locations until they can be destroyed. 9-3-2(a)		facility put in place to ensure no recurrence All new employees are trained on HIPAA and Client Rights upon hire and retrained annually thereafter. Program Director/QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who violate policy and procedure. Nurse will also report any violations to the PD/QIDP for follow up.	
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 record review and interview for 6 of 22 allegations of abuse and neglect reviewed, the facility failed to effectively implement its policies and procedures to prevent 6 allegations of peer to peer abuse by client B.	W 0149	**W 149** Staff Treatment of Clients (Standard) – Failed to effectively implement its policies and procedures to prevent 6 allegations of peer-to-peer abuse	04/01/2022

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	03/01/2022

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
	Findings include. The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/16/22 at 11:50 am. 1. A BDDS report dated 9/11/21 indicated the following: "While out in the community, staff was preparing to leave. All the individuals were on the van, and staff was speaking to one of the individual (sic) when [client B] started hitting [client D] telling her to, 'Shut the f*** up.' [Client D] (sic) speaking to staff, so it's unclear why [client B] started striking her. When [client A] started crying, [client B] then struck her as well as [client H]. Staff was able to gain control without having to place [client B] in a hold. Another staff sat with [client B] on the van during the ride back to the site. [Client B] was fine and no further incidents happened at the site...." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 9/9/21 did not include a review of client B's Behavior Support Plan (BSP), interviews with staff and clients, a review of staff actions, or recommendations to prevent incidents. 2. A BDDS report dated 10/13/21 indicated the following: "[Client B] was in the dining area with his head on the table, when, all of a sudden, he jumps up and starts flipping tables and chairs. Then he went into the living room flipping chairs and lamps. One lamp was broken. Staff was able to talk him down without having to put him in a hold. When why (sic) he went into an explosive behavior (sic), 'He smiled and said everything (sic) fine. I hate		by client B. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · The Behavior Support Plan for client B is being updated to ensure that the proactive and reactive strategies in place are effectively preventing continuing peer to peer aggression by client B. · Program Director/QIDP is being retrained on the expectation that the investigation process into peer-to-peer abuse allegations must include a critical review of the current BSP strategies to ensure measures are taken to prevent any recurrence of the behavior and to protect all individuals residing in the facility. · All facility staff to receive retraining on the BSP for client B. · Going forward, during weekly supervision meetings with 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 investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective, including any needed revisions to support plans/BSPs.	

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	03/01/2022

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
	Dungarvin and don't want to be here anymore.' Staff took [client B] on a walk and talked with him about his behavior and how he scared his housemates. [Client B] apologized to his housemates and finished the evening with no further incidents." An additional BDDS report dated 10/15/21 indicated client H sustained a bruise during the incident. The review did not include an investigation. 3. A BDDS report dated 11/1/21 indicated the following: "[Client B] became upset because his housemate got into the shower before him. [Client B] went up and pushed his housemate then reported to staff what he did. No injuries was sustain (sic) from this incident." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 10/30/21 did not include a review of client B's BSP, interviews with staff and clients, or recommendations to prevent future incidents. 4. A BDDS report dated 11/1/21 indicated the following: "[Client B] was with staff in the kitchen when his housemate came in, and [client B] started slapping him unprovoked. Staff tried to redirect him verbally without success. When [client B] could not be redirect (sic) so staff placed him in a one person hold with his arms held to his side. [Client B] immediately calm (sic) down and staff released in less than 5 minutes. [Client B] was upset because he did not want to share his time with a housemate...."		How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new Program Director/QIDPs are being trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including peer to peer abuse/aggression. A new form which was piloted in 2021 has been finalized to streamline the process to review these incidents critically and develop action plans to prevent recurrence.	

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	03/01/2022

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
	- The BDDS report did not indicate the date the allegation occurred. An investigation dated 10/31/21 did not include a review of client B's BSP, interviews with staff and clients, or recommendations to prevent future incidents. 5. A BDDS report dated 11/11/21 indicated the following: "For reasons unprompted 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 restrained him for approximately 10 minutes until he calmed down...." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 11/10/21 did not include a review of client B's BSP, interviews with staff and clients, or recommendations to prevent future incidents. 6. A BDDS report dated 12/19/21 indicated the following: "[Client B] went into an unknown unprovoked behavior and shoved his housemate, [client A] knocking her to the ground. [Client A] did not sustain any lacerations due to the fall; however, she did have some redness to her right knee." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 12/17/21 did not include a review of client B's BSP, interviews with staff and clients, or recommendations to prevent future incidents. Qualified Intellectual Disabilities Professional			

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	03/01/2022

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
	(QIDP #1) was interviewed by phone on 2/25/22 at 1:20 pm and stated, "We did not have a meeting to address [client B's] behaviors. I don't know what was going on with him. We couldn't find anything that was triggering it. I took him to the psych in December, and they changed his medications. We haven't seen that problem since then." QIDP #1 indicated he oversaw client B's BSP (Behavior Support Plan) and had not discussed revisions or retraining of staff with client B's IDT (interdisciplinary team). Area Director (AD) #1 was interviewed by phone on 2/25/22 at 1:00 pm. AD #1 indicated she was not supervising the group home at the time of client B's 6 incidents of peer to peer aggression. AD #1 indicated she was unaware of steps taken to prevent future aggression by client B towards his peers. The facility Policy and Procedure Concerning Abuse, Neglect, and Exploitation dated April 2011 was reviewed on 2/16/22 at 4:15 pm and indicated the following: "Abuse, neglect, or exploitation of the individuals served is strictly prohibited in any Dungarvin service delivery setting.... Physical abuse is defined as any act with constitutes a violation of the assault, prostitution, or criminal sexual conduct statues (sic) including intentionally touching another person in a rude, insolent, or angry manner; infliction of injury... Any restraint that is done to prevent serious harm or injury to the individual or others may be necessary in emergency situations; however, each instance will be investigated as potential abuse...." The program director/manager, area director/manager, senior director or his/her delegate will conduct a thorough investigation or			

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	03/01/2022

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
	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." 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 record review and interview for 1 of 22 allegations of abuse, neglect, and/or mistreatment reviewed, the facility failed to immediately report an allegation of exploitation for client A to the Bureau of Developmental Disabilities Services (BDDS) with 24 hours in accordance with state law. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/16/22 at 11:50 am. 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	W 0153	**W 153** Staff Treatment of Clients (Standard) – Failed to immediately report an allegation of exploitation for client A to the Bureau of Developmental Disabilities services (BDDS) within 24 hours 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 ID BFLD11 will be fully implemented, including the following specifics: · Program Director/QIDP has reviewed this deficiency and been retrained on the expectation that all allegations of abuse, neglect, or exploitation must be reported to	04/01/2022

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	03/01/2022

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
	(medication) calculation, there are 29 Klonopin (treats anxiety and seizures, a controlled substance) tablets missing." 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 medications, the sheets weren't done correctly. When the incoming staff came in, they thought the medications were missing. The staff told the nurse, the medications were found on the 5th. I turned in the report and investigation on December 13th." Area Director (AD) #1 was interviewed by phone on 2/25/22 at 1:00 pm and stated, "The medications went missing on December 4th." AD #1 indicated QIDP #1 was notified of the missing medication on 12/4/21. AD #1 stated, "[QIDP #1] had not verified if the medication was still missing. It was found, and the nurse knew about it, but [QIDP #1] thought it was still missing." AD #1 stated, "It was reported on 12/13/21." AD #1 stated, "It should have been reported to BDDS within 24 hours of knowledge." This federal tag relates to complaint #IN00369156. 9-3-2(a)		BDDS within 24 hours of knowledge. · Program Director/QIDP has been retrained on reviewing all staff documentation on every business day to ensure that no reportable incidents are missed or reported late. · Going forward, during weekly supervision meetings with the Area Director, the QIDP will report on any issues discovered during daily review of staff documentation to ensure that all concerns have been reported in a timely fashion. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new Program Director/QIDPs are being trained on this standard and the Dungarvin policy regarding Incident reporting as part of their new staff orientation process. The Area Director will review the status of all investigations into significant incidents during weekly supervision meetings with the Program Director/QIDP.	

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	03/01/2022

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 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 10 of 22 allegations of abuse, neglect, and/or exploitation reviewed, the facility failed to complete thorough investigations for 2 falls resulting in injury for client C, 6 allegations of peer to peer aggression by client B, 1 fall resulting in injury for client A, and 1 allegation of exploitation of client A. Findings include. The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/16/22 at 11:50 am. 1. A BDDS report dated 7/16/21 indicated the following: "DSP (Direct Support Professional) was completing night duties when she heard a loud noise. DSP went to the area of the noise and found [client C] had fell (sic) while trying to use the bathroom. Staff immediately assisted [client C] to bed and looked for any injuries. DSP noticed he sustained a scrape to his right knee. DSP applied ice periodically to prevent any swelling. [Client C] did not appear to have received any other injuries. He was awaken (sic) for his morning hygiene and breakfast. The scrape he received was not bleeding nor was it swollen. DSP did not observe [client C] lumping (sic) or appeared to be in any distress. [Client C] went to day program with no concerns or issues." An investigation dated 7/17/21 did not include a review of client C's high risk plans, interviews with staff and clients, or recommendations to prevent	W 0154	**W 154** Staff Treatment of Clients (Standard) - Facility failed to complete thorough investigations for 3 falls resulting in injury, 6 allegations of peer-to-peer aggression, and 1 allegation of exploitation. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · Program Director/QIDP has reviewed this deficiency and been retrained on the expectation that all allegations of abuse, neglect, and exploitation, including incidences of falls resulting in injury, peer to peer aggression, and alleged exploitation, require a thorough investigation to be completed within 5 business days. · Going forward, during weekly supervision meetings with 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 investigation to ensure that the investigations and resulting action plans are timely, thorough, and	04/01/2022

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	03/01/2022

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
	future injuries. 2. A BDDS report dated 7/31/21 indicated the following: "On 7/30/21, this writer was notified from staff that [client C] had multiple 'willful' apnea attacks (holding his breath) throughout the evening. At med pass, staff went to administer [client C's] medication. He got up then fell over and hit his head. He had a bump that formed instantly between his right eye and ear. Staff contacted the nurse and was (sic) instructed to take him to (sic) emergency room (ER) due to head injury. ER completed a head CT (computerized tomography) scan, a complete blood panel, and urine analysis. Results were normal, and he was discharged home from ER." An investigation dated 8/2/21 did not include a review of client C's high risk plans, interviews with staff and clients, or recommendations to prevent future injuries. 3. A BDDS report dated 9/11/21 indicated the following: "While out in the community, staff was preparing to leave. All the individuals were on the van, and staff was speaking to one of the individual (sic) when [client B] started hitting [client D] telling her to, 'Shut the f*** up.' [Client D] (sic) speaking to staff, so it's unclear why [client B] started striking her. When [client A] started crying, [client B] then struck her as well as [client H]. Staff was able to gain control without having to place [client B] in a hold. Another staff sat with [client B] on the van during the ride back to the site. [Client B] was find and no further incidents happened at the site...." - The BDDS report did not indicate the date the allegation occurred.		effective. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new Program Director/QIDPs are being trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including falls with injury, missing meds/controlled medications, alleged exploitation, and peer to peer aggression. A new form which was piloted in 2021 has been finalized to streamline the process to review these incidents critically and develop action plans to prevent recurrence.	

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	03/01/2022

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
	An investigation dated 9/9/21 did not include a review of client B's Behavior Support Plan (BSP), interviews with staff and clients, a review of staff actions, or recommendations to prevent incidents. 4. A BDDS report dated 10/13/21 indicated the following: "[Client B] was in the dining area with his head on the table, when, all of a sudden, he jumps up and starts flipping tables and chairs. Then he went into the living room flipping chairs and lamps. One lamp was broken. Staff was able to talk him down without having to put him in a hold. When why (sic) he went into an explosive behavior (sic), 'He smiled and said everything (sic) fine. I hate Dungarvin and don't want to be here anymore.' Staff took [client B] on a walk and talked with him about his behavior and how he scared his housemates. [Client B] apologized to his housemates and finished the evening with no further incidents." An additional BDDS report dated 10/15/21 indicated client H sustained a bruise during the incident. The review did not include an investigation. 5. A BDDS report dated 11/1/21 indicated the following: "[Client B] became upset because his housemate got into the shower before him. [Client B] went up and pushed his housemate then reported to staff what he did. No injuries was sustain (sic) from this incident." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 10/30/21 did not include a			

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	03/01/2022

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
	review of client B's BSP, interviews with staff and clients, or recommendations to prevent future incidents. 6. A BDDS report dated 11/1/21 indicated the following: "[Client B] was with staff in the kitchen when he housemate came in, and [client B] started slapping him unprovoked. Staff tried to redirect him verbally without success. When [client B] could not be redirect (sic) so staff placed him in a one person hold with his arms held to his side. [Client B] immediately calm (sic) down and staff released in less than 5 minutes. [Client B] was upset because he did not want to share his time with a housemate...." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 10/31/21 did not include a review of client B's BSP, interviews with staff and clients, or recommendations to prevent future incidents. 7. A BDDS report dated 11/11/21 indicated the following: "For reason unprompted 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 restrained him for approximately 10 minutes until he calmed down...." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 11/10/21 did not include a review of client B's BSP, interviews with staff and clients, or recommendations to prevent future incidents.			

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	03/01/2022

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
	8. A BDDS report dated 12/19/21 indicated the following: [Client B] went into an unknown unprovoked behavior shoved his housemate, [client A] knocking her to the ground. [Client A] did not sustain any lacerations due to the fall; however, she did have some redness to her right knee." - The BDDS report did not indicate the date the allegation occurred. An investigation dated 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 dated 12/13/21 did not include a review of the facility's policies and procedures concerning storage of medications or a review of medication counts. The investigation did not indicate recommendations to prevent future incidents. 10. A BDDS report dated 2/11/22 indicated the following: "When [client A] returned to the facility, she stated, 'Knee hurt, knee hurt.' Program Director (PD) had her left (sic) her pants leg and noticed that she had an (sic) mild abrasion under her right knee. When asked what happened, she repeatedly stated, 'Fell Down, fell down.' [Client A] is not able to articulate exactly what happened other than 'fell down.' PD called [day service			

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	03/01/2022

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
	provider] in an attempt to gather additional information. No staff was able to provide any additional information." An investigation dated 2/13/22 did not include interviews with staff providing care at the time of the injury or a review of client A's high risk plans. Area Director (AD) #1 was interviewed by phone on 2/25/22 at 1:00 pm and stated, "Investigations should include interviews with staff and clients. For falls, the investigation should look at a pattern. Were staff following the plans. Should there be revisions to risk plans or training to prevent recurrence. The investigator should look for underlying medical issues that need to be discussed." AD #1 stated, "For peer to peer incidents, the investigator should find out the triggers, are they targeting certain people, are revisions indicated to the support plans, is retraining needed to prevent recurrence, were staff implementing the BSP (Behavior Support Plan)." AD #1 stated, "When medication goes missing, we need to look at what happened, interview staff and clients, what is being done to prevent recurrence, training for staff." This federal tag relates to complaint #IN00369156. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 22 allegations of abuse, neglect, and mistreatment	W 0156	**W 156** Staff Treatment of Clients	04/01/2022

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	03/01/2022

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
	reviewed, the facility failed to conduct an investigation of one allegation of exploitation for client A within 5 business days. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 2/16/22 at 11:50 am. 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 dated 12/13/21 did not include a review of the facility's policies and procedures concerning storage of medications or a review of medication counts. The investigation did not indicate recommendations to prevent future incidents. 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 medications, the sheets weren't done correctly. When the incoming staff came in, they thought the medications were missing. The staff told the nurse, the medications were found on the 5th. I turned in the report and investigation on December 13th." Area Director (AD) #1 was interviewed by phone		(Standard) - Facility failed to conduct an investigation of one allegation of exploitation for client A within 5 business days. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · Program Director/QIDP has reviewed this deficiency and been retrained on the expectation that all allegations of exploitation require a thorough investigation to be completed within 5 business days. · Going forward, during weekly supervision meetings with 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 investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective. 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	

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	03/01/2022

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
	on 2/25/22 at 1:00 pm and stated, "The medications went missing on December 4th." AD #1 indicated QIDP #1 was notified of the missing medication on 12/4/21. AD #1 stated, "[QIDP #1] had not verified if the medication was still missing. It was found, and the nurse knew about it, but [QIDP #1] thought it was still missing." AD #1 stated, "It was reported on 12/13/21." AD #1 stated, "Investigations should be completed within 5 business days." This federal tag relates to complaint #IN00369156. 9-3-2(a)		recurrence All new Program Director/QIDPs are being trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including missing medications/missing controlled medications. A new form which was piloted in 2021 has been finalized to streamline the process to review these incidents critically and develop action plans to prevent recurrence.	
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 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 infomration, 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 medications. Findings include:	W 0192	**W 192** Staff Training Program (Standard) - Facility failed to ensure staff working in the home were adequately trained to implement plans and policies regarding medication storage and record keeping. Also failed to ensure staff working were adequately trained to provide privacy for individuals' medical information, to ensure meds were stored in a secure manner, to ensure the keys to the office and med cabinet were kept in a secure location, and to accurately account for clients' controlled medications. Corrective action for resident(s)	04/01/2022

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	03/01/2022

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
	1. The facility failed to ensure staff working in the home were adequately trained to ensure privacy of clients A, B, D, E and F's medical information. Please see W129. 2. The facility failed to ensure staff working in the home were adequately trained to ensure clients A, B, C, D, E, F, G, and H's medications were stored in a secure manner. Please see W382. 3. The facility failed to ensure staff working in the home were adequately trained 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. Please see W383. 4. The facility failed to ensure staff working in the home were adequately trained to accurately account for clients A, B, E, and G's controlled medications. Please see W385. This federal tag relates to complaint #IN00369156. 9-3-3(a)		found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · All facility staff have been retrained on the expectation that all medications must be secured in a locked cabinet at all times. · Program Director/QIDP and Facility nurse have been retrained on their responsibility to ensure that staff working in the home are adequately trained in plans and policies regarding medication storage and record keeping, locking medications, protecting the privacy of health information, securing the med room, and accounting of all controlled medications. · Program Director/QIDP and Facility Nurse held an all-staff mandatory meeting to retrain on all of these policies and procedures in place at the facility to ensure medications are stored and accounted for safely and health information privacy is maintained at all times. 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	

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	03/01/2022

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
			recurrence All new employees are trained on the policy on drug storage and transference as part of new staff orientation. All staff are required to complete annual retraining on Medication Administration which covers med storage. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who violate policy and procedure. Nurse will also report any violations to the PD/QIDP for follow up.	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. 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's nursing services failed to provide adequate oversight to ensure proper storage and record keeping for clients A, B, C, D, E, F, G, and H's medications. The facility's nursing services failed to ensure privacy of 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 key to the office and medication cabinet were kept in a secure locations for clients A, B, C, D, E, F, G, and H, and to accurately account for clients A, B, E, and G's controlled medications. Findings include:	W 0331	**W 331** Nursing Services (Standard) - Facility nursing services failed to provide adequate oversight to ensure proper storage and record keeping for medications, to ensure privacy for clients' medical information, to ensure medications were stored in a secure manner, to ensure the key to the office and med cabinet were stored in a secure manner, and to accurately account for controlled medications. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the	04/01/2022

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	03/01/2022

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
	1. The facility's nursing services failed to ensure privacy of clients A, B, D, E and F's medical information. Please see W129. 2. The facility's nursing services failed to ensure clients A, B, C, D, E, F, G, and H's medications were stored in a secure manner. Please see W382. 3. The facility's nursing services failed 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. Please see W383. 4. The facility's nursing services failed to accurately account for clients A, B, E, and G's controlled medications. Please see W385. This federal tag relates to complaint #IN00369156. 9-3-6(a)		following specifics: · Facility nurse reviewed this finding and the related deficiencies. Facility nurse then provided retraining to all facility staff regarding the proper storage and record keeping for medications, the privacy of clients' medical information, the safe storage of the office and med cabinet keys, and proper accounting of controlled medications. · Facility nurse provides a weekly, written report to the Program Director/QIDP, Area Director, and Nursing Services Director. Facility nurse has added a section to her report where she reports her observations of the proper storage and record keeping for medications, the privacy of medical information, proper key storage, and the counts of the controlled medications. · Program Director/QIDP, Facility Nurse, and Area Director week meetly to review these observations and other nursing review items for the week. <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</u>	

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	03/01/2022

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
			facility put in place to ensure no recurrence Facility nurses will maintain regular presence in the homes. Nurses provide all initial training on Med Core and agency policies regarding Medication storage and record keeping for medications, locking medications, double locking controlled medications and counting of controlled medications. Nurses also provide the annual training where this is reviewed. Facility nurse will observe for ongoing staff competence in these areas during weekly site visits and report all concerns to the Program Director/QIDP and Area Director for the home.	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview 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 clients A, B, C, D, E, F, G, and H's medications were stored in a secure manner. 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. On 2/15/22 at 3:52 pm, the door to the office	W 0382	**W 382** Drug Storage and Recordkeeping (Standard) - Facility failed to ensure medications were stored in a secure manner. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · All facility staff will be retrained on the expectation that	04/01/2022

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	03/01/2022

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
	containing medications was locked. The door was a half door, and the top portion was open throughout the observation period. Throughout the observation period, the key was in the lock on the outside of the door. Throughout the observation period, there were 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). Clonazepam 1 milligrams (mg) (treats symptoms of panic disorder). Clozapine 25 mg (treats symptoms of schizophrenia). Clozapine 100 mg (treats symptoms of schizophrenia). Vitamin D 5000 unit (treat and prevents bone disorders). Loratadine 10 mg (treats symptoms of hay fever/ conjunctivitis). Nortriptyline 10 mg (treats symptoms of nerve pain). Lamotrigine 150 mg (treats symptoms of epilepsy). Client D Vascepa 1 gram (gm)(treats symptoms of heart attack/ stroke). Client G Loratadine 10 mg (treats symptoms of allergies). Lamotrigine 200 mg (treats symptoms of seizures). Lamotrigine 100 mg (treats symptoms of epilepsy). Clonazepam .5 mg (treats symptoms of panic disorder) Client C		all medications must be secured in a locked cabinet at all times. · QIDP and nurse will be responsible to verify that medication is stored in a locked cabinet during regular, frequent visits in the home. · Staff who were responsible to have locked the med cabinet on the date of the observation have received employee counseling in addition to the retraining for all staff. Similarly, any staff found to have left the medications unsecured during an observation will receive corrective action and/or retraining in accordance with Dungarvin policy. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new employees are trained on the policy on drug storage and transference as part of new staff orientation. All staff are required to complete annual retraining on Medication Administration which covers med storage. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who leave the med closet	

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	03/01/2022

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
	Fenofibrate 145 mg (treats symptoms of high cholesterol). Metformin 1000 mg (treats symptoms of diabetes). Jardiance 25 mg (treats symptoms of Diabetes), Docusate SOD 100 mg (treats symptoms of constipation). Atorvastatin 20 mg (treats symptoms of high cholesterol). Amlodipine 5 mg (treats symptoms of high blood pressure). Calcium 600 (used to prevent or treat low blood calcium levels). Pantoprazole 20 mg (treats symptoms of gastroesophageal reflux disease). Vitamin D 5000 unit (treat and prevents bone disorders). Vascepa 1 mg (treats symptoms of heart attack/ stroke). Propranolol 60 mg (treats symptoms of high blood pressure). Divalproex 500 mg (treats symptoms of seizures). Trazodone 100 mg (treats symptoms of depression, anxiety, or a combination of depression and anxiety). Olanzapine 5 mg (treats symptoms of schizophrenia). Quetiapine 200 mg (treats symptoms of depression/bi-polar). Sertraline 50 mg (treats symptoms of depression,obsessive compulsive disorder). The medication storage cabinet containing PRN (as needed) medications was unlocked throughout the observation period. 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 of the cart. The medication cart and the narcotics		unsecured. Nurse will also report any violations to the PD/QIDP for follow up.	

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	03/01/2022

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
	box were unlocked. At 4:04 pm Direct Support Professional (DSP) #2 was in the office. Client D used the key in the office door to unlock and open the door and walked into the office. DSP #2 walked her out. DSP #2 left the office and went into the living room. DSP #2 did not lock the medication cart, take the keys with him, or secure the office door when he left. DSP #2 brought client A from the living room and administered her 4 pm medication. DSP #2 left the medication room and did not lock the medication cart or narcotics box. The key was left in the handle of the medication room door. At 4:55 pm, Client D used the key on the outside of medication room door and walked inside. Staff were not in the medication room. DSP #2 was interviewed on 2/15/22 at 4:17 pm and indicated she does not pass medications. DSP #2 indicated she had been trained to pass medication. DSP #2 indicated all medications should be kept in a locked cabinet. DSP #1 was interviewed on 2/15/22 at 4:40 pm and indicated medications were kept in the medication cart. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/15/22 at 5:02 pm and stated, "All medications should be locked at all times. Narcotics should be double locked." Registered Nurse (RN) #1 was interviewed on 2/16/22 at 1:37 pm. RN #1 stated "The medication room should be locked with the key on the staff at all times." RN #1 stated, "The medication cart should be locked, controlled medications should be double locked, and new medications should be in the bottom of the cart and locked in a drawer			

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	03/01/2022

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
	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)			
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to 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 Recordkeeping (Standard) - Facility failed to ensure the keys to the office and medication cabinet were kept in a secure location. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · All facility staff have been retrained on how they are to ensure the keys to the office and medication cabinet are to be either carried by staff or placed in a secure location only accessible to staff members at all times. · QIDP and nurse have been verifying the location of the med	04/01/2022

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	03/01/2022

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
	of the cart. The cart and the narcotics box were unlocked. At 4:04 pm Direct Support Professional (DSP) #2 was in the office. Client D used the key in the office door to unlock and open the door and walked into the office. DSP #2 walked her out. DSP #2 left the office and went into the living room. DSP #2 did not lock the medication cart, take the keys with him, or secure the office door when he left. DSP #2 brought client A from the living room and administered her 4 pm medication. DSP #2 left the room with client A. The medication cart was unlocked, and the key to the medication room was left in the door handle. At 4:55 pm, Client D, used the key on the outside of medication room door and walked inside. Staff were not in the medication room. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 2/15/22 at 5:02 pm and stated, "The key for the medication room should be hanging on the handle inside the medication room. The clients here cannot use the key to open the door." QIDP #1 indicated the clients in the home would not reach over the half door to unlock the door or to get the key. QIDP #1 stated, "When staff leave the medication room, they should close and lock the door." Registered Nurse (RN) #1 was interviewed on 2/16/22 at 1:37 pm. RN #1 stated "The medication room should be locked with the key on the staff at all times." Area Director (AD) #1 was interviewed by phone on 2/16/22 at 11:08 am and stated, "The staff should carry the key to the medication room with them."		room and med closet keys during all scheduled and unscheduled visits/observations several times per week to verify staff competence after the retraining. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new employees are trained on the policy on drug storage and transference as part of new staff orientation. Part of the onsite staff orientation process involves training staff on how the keys to the med room, closet, and controlled medication box are to be maintained safely at all times. All staff are required to complete annual retraining on Medication Administration which covers med storage. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who leave the med closet unsecured. Nurse will also report any violations to the PD/QIDP for follow up.	

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	03/01/2022

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
	This federal tag relates to complaint #IN00369156. 9-3-6(a)			
W 0385 Bldg. 00	483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs. Based on record review and interview for 2 of 3 sample clients (A and B), plus 2 additional clients (E and G), the facility failed to accurately account for clients A, B, E, and G's controlled medications. Findings include: The facility's medication count sheets were reviewed on 2/15/22 at 5:40 pm. 1. Client A's undated Narcotic Record indicated the following: "Clonazepam (treats seizures and anxiety), 1 mg (milligram). 2/15, 7 am, Amount on hand 11, Amount given -1, Amount left 10. 2/15, 4 pm, Amount on hand 10, Amount given -1, Amount left 9. 2/15, 8 pm, Amount on hand 9, Amount given -1, Amount left 8." Client A's Clonazepam medication card contained 9 pills at 5:40 pm. The record indicated staff completed the 8 pm count before the 8 pm medication pass took place. 2. Client B's undated Narcotic Record indicated the following: "Clonazepam, 0.5 mg. 2/15, 7 am, Amount on hand 10, Amount Given -1, Amount Left 9. 2/15, 3 pm, Amount on hand 9, Amount given -1,	W 0385	**W 385** Drug Storage and Recordkeeping (Standard) - Facility failed to accurately account for clients' controlled medications. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · All facility staff have been retrained on Dungarvin procedure for storage of and documentation of controlled medications. · The employee responsible for documenting the 8pm narcotic counts before the 8pm med pass has received retraining and disciplinary action in accordance with Dungarvin policy & procedure. · QIDP and nurse have been auditing the narcotic count sheets during all scheduled and unscheduled site visits several times per week to ensure that the counts are accurate, and that staff demonstrate competency regarding completing the counts and documenting their audits. · Any staff found to have	04/01/2022

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	03/01/2022

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
	Amount left 8. 2/15, 8 pm, Amount on hand 8, Amount given -1, Amount left 7." Client B's Clonazepam medication card contained 8 pills at 5:40 pm. The record indicated staff completed the 8 pm count before the 8 pm medication pass took place. 3. Client E's Narcotic Record dated 1/24/22 indicated the following: "Onfi (Clobazam, treats seizures), 10 mg. 2/15, 8 pm, Amount on hand 8, Amount given -1, Amount left 7." Client E's Clobazam medication card contained 8 pills at 5:40 pm. The record indicated staff completed the 8 pm count before the 8 pm medication pass took place. Client E's Narcotic Record dated 2/15/22 indicated the following: "Vimpat (anticonvulsant), 200 mg. 2/15, 7 am, Amount on hand 7, Amount given -1, Amount left 6. 2/15, 8 pm, Amount on hand 6, Amount given -1, Amount left 5." Client E's Vimpat medication card contained 6 pills at 5:40 pm. The record indicated staff completed the 8 pm count before the 8 pm medication pass took place. 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. 2/15, 8 pm, Amount on hand 3, Amount given 1.5, Amount left 1.5."		improperly documented controlled medication counts during an observation will receive corrective action and/or retraining in accordance with Dungarvin policy. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new employees are trained on the procedures to follow for counting controlled medications on every shift and every time a controlled medication is administered. All staff are required to complete annual retraining on Medication Administration which covers controlled medication storage and counting. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow this training. Nurse will also report any violations to the PD/QIDP for supervisory follow up.	

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	03/01/2022

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
	Client G's Clonazepam medication card contained 3 pills at 5:40 pm. The record indicated staff completed the 8 pm count before the 8 pm medication pass took place. Licensed Practical Nurse (LPN) #1 was interviewed on 2/16/22 at 12:37 pm and stated, "Medication counts should be done once per shift. If a medication is being administered, the staff should never sign before the medication is swallowed or administered. The person passing the 4 pm medication should not sign for the 8 pm medication count." Area Director (AD) #1 was interviewed by phone on 2/25/22 at 1:00 pm and stated, "No documentation should be done ahead of schedule. It cannot be accurate that way. Medications that need to be counted should be counted every shift and every time they are passed. Every shift makes sure we have the right amount. When they pass the medication, they sign off that it is correct." This federal tag relates to complaint #IN00369156. 9-3-6(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. 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 staff working in the home implemented proactive/preventative infection control measures during a world wide pandemic of	W 0455	**W 455** Infection Control (Standard) - Facility failed to ensure staff working in the home implemented proactive/preventative infection control measures during a	04/01/2022

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	03/01/2022

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
	COVID-19. 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. Client D opened the door and greeted surveyors #1 and #2. Direct Support Professional (DSP) #1 walked up to client D and took her temperature. DSP #1 did not address the surveyors, ask to take their temperatures, ask about symptoms of COVID-19, or ask the surveyors to sanitize their hands. The facility's COVID-19 Pandemic Guidelines dated 2/1/22 were reviewed on 2/16/22 at 4:00 pm and indicated the following: "6. Visitors must take their temperature prior to the visit.... 7. All visitors must complete a health screening document upon arriving for the visit and provide their best contact phone number or email address in case we need to follow-up with a contact notification...." Licensed Practical Nurse (LPN) #1 was interviewed on 2/16/22 at 12:37 pm and stated, "Staff need to take visitors' temperature and have them sign the COVID sign in form before they can go any further." 9-3-7(a)		worldwide pandemic of COVID-19. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID BFLD11 will be fully implemented, including the following specifics: · All facility staff have been retrained on the facility's COVID-19 Pandemic Guidelines, including the requirement for all visitors to be screened by taking their temperature and completing the health screening document for 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 follow the COVID-19 Pandemic Guidelines during an observation will receive corrective action and/or retraining in accordance with Dungarvin policy. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence All new employees are trained on	

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	03/01/2022

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
			the Infection control policies including Dungarvin's COVID-19 Pandemic guidelines as part of new staff orientation. All staff are required to complete annual retraining on Medication Administration which covers infection control policies and procedures. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail 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.	