STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G452	A. BUILDING 00 B. WING	07/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00382739. Complaint #IN00382739: Substantiated, Federal and state deficiencies related to the allegation(s) were cited at W149 and W331. Survey dates: 6/27/22, 6/28/22, 6/29/22, 6/30/22, 7/1/22 and 7/5/22. Facility Number: 000966 Provider Number: 15G452 AIM Number: 100244770 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/25/22.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), plus 5 additional clients (D, E, F, G and H), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Findings include: Observations were conducted in the group home on 6/27/22 from 4:03 pm to 6:40 pm, 6/28/22 from	W 0104	W 104 Governing Body (Standard) – Failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID E4VV11 will be fully	08/15/2022

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

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	6:50 am to 9:30 am and 6/28/22 from 4:45 pm to 5:52 pm. Clients A, B, C, D, E, F, G and H were present throughout the observations. On 6/27/22 at 6:13 pm in the kitchen, a blue towel was placed on the floor in front of the refrigerator. Staff #2 indicated the refrigerator is leaking water at the bottom. Staff #2 was interviewed on 6/27/22 at 6:13 pm. Staff #2 stated, "It's been reported multiple times." On 6/27/22 at 6:22 pm in the medication room, the window fell open on the hinge. Staff #2 indicated she would put in an order to fix the window. Staff #2 indicated she was told maintenance had already fixed the window. In the bathroom in the back of the house the light fixture above the sink had 1 of 2 light bulbs working and the light in the shower was not working. Review of maintenance requests was completed on 6/28/22 at 12:38 pm and indicated the refrigerator leaking had been reported on 3/11/22, 5/5/22 and 5/12/22. Requests to fix the window and the light fixtures were not in the reports. An interview with the House Manager (HM) was completed on 6/28/22 at 8:04 am. HM indicated if something is broken at the house anyone can complete a maintenance request and fax it to the Dungarvin main office so that it can be fixed. An interview with the Area Director (AD) was conducted on 7/1/22 at 10:52 am. The AD stated, "The refrigerator should not have a towel under it, I would not want it to cause a tripping hazard." AD indicated the home should be in good repair. AD stated, "Lights should have functioning light		implemented, including the following specifics: • The issue causing leaking under the fridge was repaired by Maintenance. • Maintenance staff also repaired the window that was not staying latched. Due to the age of the home, a latch was special ordered and installed. • Adequate lighting has been ensured in the back bathroom by Maintenance staff. • All staff re-training on the Maintenance Request system. • Senior Director meets with the Maintenance director weekly to review all outstanding requests and prioritize all work needed. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the QIDP is to maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the maintenance and cleanliness of the home and of the services being provided in the home. In addition, Maintenance is	

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	bulbs. If staff can safely change the light bulb, they should do it otherwise put in maintenance request." 9-3-1(a)		to tour the home monthly for any concerns and the Area Director is to conduct look behind visits to verify that concerns are being reported appropriately and that staff demonstrate competency in monitoring the cleanliness and safety of the home.	
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 additional client (F), the facility failed to ensure client F had privacy during the medication pass. Findings include: Observations were conducted in the group home on 6/27/22 from 4:03 pm to 6:40 pm, 6/28/22 from 6:50 am to 9:30 am and 6/28/22 from 4:45 pm 5:52 pm. Clients A, B, C, D, E, F, G and H were present throughout the observations. On 6/27/22 at 4:54 pm client F was called to the medication room. The medication room has an opening with no door or curtain. Staff #1 lifted client F's shirt to put her medication in her Gastrostomy Tube (G-tube). Client F's breasts were out of her shirt. Client B walked to the doorway and was talking with staff #1. Staff #1 told client B they could talk when she was done. Client F was sitting in the chair with her breasts exposed. At 5:01 pm Staff #1 finished administering client	W 0130	W 130 Protection of Clients Rights (Standard) – Failed to ensure client F had privacy during the medication pass. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID E4VV11 will be fully implemented, including the following specifics: • All facility staff retrained on Client Rights and the right to privacy during medication passes. • Once retraining is complete, the QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that facility staff demonstrate competency on promoting the rights and dignity of the clients, including the right to	08/15/2022

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	F's medication in her tube. Staff #1 assisted client F in pulling down her bra that was above her breast and put her breasts back into her bra before she left the medication room. An interview with House manager (HM) was conducted on 6/28/22 at 8:04 am. HM stated, "Staff should provide privacy when passing medications." An interview with Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD indicated staff should maintain privacy during medication. PD stated, "Staff can tuck her shirt under her breasts to maintain privacy." An interview with Registered Nurse (RN) was conducted on 6/30/22 at 1:59 pm. RN stated, "Privacy should be maintained for everyone during medication pass." An interview with Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD stated, "Staff should ensure privacy while passing medication or during a feeding." 9-3-2(a)		privacy during medication passes. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the QIDP is to maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week. These visits are to be in sufficient number and length to allow the QIDP to model and coach staff on protection of client rights. The nurse for the home is also to be present at the home frequently enough to monitor, model, and coach staff on providing for privacy and dignity during medication passes.	

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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 1 of 3 sampled clients (Client A), the facility failed to implement its written policy and procedures to prevent neglect of client A by not obtaining follow up medical care according to doctor's orders. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 6/27/22 at 1:46 pm. A BDDS report dated 3/2/22 indicated the following: "This writer received a call from Highland Direct Support Professional (DSP) at approximately 7:11 pm on 3/1/22 to inform that she was on her way to the Emergency Room (ER) as [client A] had fallen and 'busted his head opened.' He was standing up in the room after staff heard the 'thud' of his fall. Upon noticing the blood, DSP called On call Nurse, who recommended she take him to ER. Staff reported she she (sic) saw [client A] standing in the room with blood running down his head. She promptly called the on call nurse who recommended she take [client A] to the ER. [Client A] received 4 staples and was sent home. He is to see his Primary Care Physician (PCP), [Doctor] in 8 days for staple removal. After speaking with [client A] today, he stated. 'I was trying to weigh myself in the medication (med) room and I lost my balance.' He stated he hit the desk. He denied pain, weakness, headache, dizziness. He is alert	W 0149	W 149 Staff Treatment of Clients (Standard) – Failed to implement its written policy and procedures to prevent neglect of client A by not obtaining follow up medical care according to doctor's orders. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID E4VV11 will be fully implemented, including the following specifics: • Facility staff to review this finding and receive retraining on Policy on Abuse & Neglect. • Facility staff to receive retraining on Dungarvin policy on Reporting Changes in Health Status for Individuals served. • A revised Med Support DSP position has been implemented at the home to ensure that a specific staff is responsible for ensuring that all required appointments are scheduled and completed in a timely fashion. The leadership team of the facility nurse, QIDP, Lead DSP, & Med Support DSP are expected to meet on a weekly basis to review the master medical schedules and ensure that all needed appointments are scheduled and that indicated	08/15/2022

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	and oriented and is able to state what happened." Plan to Resolve: Staff will monitor [client A] when he wants to weigh himself. Staff will continue to monitor [client A] for health safety and well-being. There is no fall risk plan. Interdisciplinary Team (IDT) to discuss whether plan is needed." An Investigation Report and Summary dated 3/9/22 was reviewed on 6/28/22 at 4:05 pm. The Investigation indicated: Finding of Fact: "- [Client A] fell on 3/1/22 resulting in a head injury. -He was diagnosed with Laceration of his scalp, initial encounter. -He received multiple staples while at the ER on 3/1 but the actual amount is unknown. -The staples were ordered to be removed within 8 days which would have been by 3/9/22. - [Client A] was taken to [Urgent Care Center] on 4/3 to have the staples removed. When accessed (sic) he only had 1 staple in a well-healed small laceration on the left parietal (region between temple) and occipital (nape of the neck) scalp. -It is unknown how the other staples were removed from his head and when. -There was no one assigned by the Program Director to ensure the staples were taken out in 8 days. -The Program Director indicated on 3/2/22 that [client A] received 4 staples on the right-side f (sic) his head and need (sic) to follow up with his PCP in 8 days to have them removed. -There was a discrepancy of the location of the staple as the Program Director indicated the right side of his head and [Urgent Care Center] indicated the left side. -All personnel who encountered [Client A] between 3/2/22 and 4/2/22 failed to assist him in		follow up is being completed 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 Going forward, the leadership team of the facility nurse, QIDP, Lead DSP, & Med Support DSP is expected to meet on a weekly basis to review the master medical schedules and ensure that all needed appointments are scheduled and that indicated follow up is being completed in a timely fashion. Reports from this meeting are to be submitted to the Nursing Services Manager and the Area Director. All facility staff receive training on Abuse/Neglect/Exploitation during New Staff Orientation and annually thereafter.	

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	having the staples formed (sic). -All parties, Direct Support Professional (DSP), Program Director and Nursing support lacks accountability for lack of medical follow up. -On 5/7/22 [Client A] went to the ER due to him not feeling well and was totally unrelated to a fall for injury. - [Client A] was seen in the ER for pain to his bottom and was diagnosed with rectal pain and acute prostatitis (inflammation of the prostate gland). -When in the ER on 5/7/22 he did not have any staples in his head and it is unknow (sic) as to why this was indicated in the BDDS report." An Investigation Plan of Correction Report dated 6/9/22 was reviewed on 6/28/22 at 4:05 pm. Investigation indicated: "Subject of Investigation: Allegation of medical neglect-failure to have staples removed as ordered leading the individual to have possibly removed some of the staples himself. Determination of Rights Violation: -There is evidence that the individuals' rights were violated. Statement of Conclusion: -The allegation of medical neglect regarding lack of follow-up care after receiving staples to his head was substantiated. -The investigation found that multiple staff members shared responsibility for this failure, including DSP's, the lead DSP, the Program Director and the Facility Nurse." An interview with the Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD stated, "It is neglect to not follow the doctors' orders. Follow up appointment should be completed as			

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	recommended." An interview with Registered Nurse (RN) was conducted on 6/30/22 at 1:59 pm. RN stated, "I ultimately was responsible." An interview with the Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD indicated, follow ups from medical appointments or ER visits should be completed as ordered or recommended. Staff should document every attempt made to complete the appointment. The AD stated, "in regard to [client A] there was neglect. The lead DSP, Program Director and Nurse did not assure [client A] went back to the doctor in a timely fashion." Policy and Procedure Concerning Abuse, Neglect and Exploitation revised 5/21/21 was reviewed on 6/27/22 at 12:00 pm. The policy indicated: "Purpose Dungarvin believes that each individual has the right to be free from mental, emotional, and physical abuse in his/her daily life. This policy establishes Dungarvin's procedures to prevent abuse, neglect, or exploitation and identifies specific actions to be taken if abuse, neglect, or exploitation occurs or is suspected. ...1. Definitions...C. Neglect is defined as failure to provide appropriate care, supervision or training: failure to provide food and medical services as needed: failure to provide a safe, clean and sanitary environment: and /or failure to provide medical supplies/safety equipment as indicated in the Individual Support Plan (ISP)." This federal tag relates to complaint #IN00382739. 9-3-2(a)			

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W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 3 sampled clients (client B), the facility failed to ensure client B obtained a vision exam on an annual basis. Findings include: A review of client B's Individualized Support Plan (ISP) and medical records was conducted on 6/27/22 at 3:18 pm. The last optical exam was dated 10-9-2020. An appointment was scheduled for 2/15/22 at 10:30 am but was not attended. An interview with the Registered Nurse (RN) was conducted on 6/30/22 at 1:59 pm. RN stated, "Vision exams should be completed every 2 years or annual if stated by the physician." An interview with Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD stated, "Vision exams should be completed yearly or what Medicaid allows." An interview with Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD stated, "Vision exams should be completed annually unless the doctor reports to come in 2 years." 9-3-6(a)	W 0323	W 323 Physician Services (Standard) – Failed to ensure client B obtained a vision exam on an annual basis. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID E4VV11 will be fully implemented, including the following specifics: • Eye appointment for Client B was completed on 8/1/2022. • A revised Med Support DSP position has been implemented at the home to ensure that a specific staff is responsible for ensuring that all required appointments are scheduled and completed in a timely fashion. The leadership team of the facility nurse, QIDP, Lead DSP, & Med Support DSP is expected to meet on a weekly basis to review the master medical schedules and ensure that all needed appointments are scheduled and that indicated follow up is being completed in a timely fashion. How facility will identify other residents potentially affected & what measures taken	08/15/2022

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			All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the leadership team of the facility nurse, QIDP, Lead DSP, & Med Support DSP is expected to meet on a weekly basis to review the master medical schedules and ensure that all needed appointments are scheduled and that indicated follow up is being completed in a timely fashion. Reports from this meeting are to be submitted to the Nursing Services Manager and the Area Director.	
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 2 of 3 sampled clients (A and B), the facility's nursing services failed to meet client A's health needs by not following doctor's orders to have client A's staples removed within 8 days, to update client A's fall risk assessment, and to implement a fall risk plan. The facility's nursing services failed to update client B's fall risk plan to address his change of condition. Findings include: Observations were conducted in the group home on 6/27/22 from 4:03 pm to 6:40 pm, 6/28/22 from	W 0331	W 331 Nursing Services (Standard) – Failed to meet client A's health needs by not following doctor's orders to have client A's staples removed within 8 days, to update client A's fall risk assessment, and to implement a fall risk plan. Failed to update client B's fall risk plan to address his change of condition. Corrective action for resident(s) found to have been affected	08/15/2022

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	6:50 am to 9:30 am and 6/28/22 from 4:45 pm to 5:52 pm. Clients A, B, C, D, E, F, G and H were present throughout the observations. On 6/27/22 at 4:18 pm Client B was walking in the house using a cane. On 6/27/22 at 4:29 pm Client B was talking with Staff #1 and told her that his right foot was hurting. Staff #1 told him he had an appointment with podiatrist scheduled for 6/29/22. On 6/27/22 at 4:48 pm Client B came out of his bedroom using a walker. On 6/27/22 at 5:22 pm Client A walked out to the kitchen. His gait was unsteady, and he shuffled his feet while walking. On 6/28/22 at 7:08 am Client B walked into the medication room using his cane. On 6/28/22 at 7:23 am Client B walked by the medication room using his walker. On 6/28/22 at 8:03 am Client B walked from the kitchen dragging his cane behind him. On 6/28/22 at 5:04 pm Client B was walking using his walker. 1. The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 6/27/22 at 1:46 pm. A BDDS report dated 3/2/22 indicated the following: "This writer received a call from Highland DSP (Direct Support Professional) at approximately		All parts of the POC for the survey with event ID E4VV11 will be fully implemented, including the following specifics: • Facility nurse and QIDP have received retraining on the importance of conducting critical analysis and investigation of all fall incidents in order to address any identified trends or change of condition in a timely manner. • Facility staff trained on the importance of reporting all change of condition per policy. • A revised Med Support DSP position has been implemented at the home to ensure that a specific staff is responsible for ensuring that all required appointments are scheduled and completed in a timely fashion. The leadership team of the facility nurse, QIDP, Lead DSP, & Med Support DSP is expected to meet on a weekly basis to review the master medical schedules and ensure that all needed appointments are scheduled and that indicated follow up is being completed 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	

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	7:11 pm on 3/1/22 to inform that she was on her way to the Emergency Room (ER) as [client A] had fallen and 'busted his head opened.' He was standing up in the room after staff heard the 'thud' of his fall. Upon noticing the blood, DSP called On call Nurse, who recommended she take him to ER. Staff reported she she (sic) saw [client A] standing in the room with blood running down his head. She promptly called the on call nurse who recommended she take [client A] to the ER. [Client A] received 4 staples and was sent home. He is to see his Primary Care Physician (PCP), [Doctor] in 8 days for staple removal. After speaking with [client A] today, he stated. 'I was trying to weigh myself in the medication (med) room and I lost my balance.' He stated he hit the desk. He denied pain, weakness, headache, dizziness. He is alert and oriented and is able to state what happened." An Investigation Plan of Correction Report dated 6/9/22 was reviewed on 6/28/22 at 4:05 pm. The Investigation indicated: "Subject of Investigation: Allegation of medical neglect-failure to have staples removed as ordered leading the individual to have possibly removed some of the staples himself. Determination of Rights Violation: -There is evidence that the individuals' rights were violated. Statement of Conclusion: -The allegation of medical neglect regarding lack of follow-up care after receiving staples to his head was substantiated. -The investigation found that multiple staff members shared responsibility for this failure, including DSP's, the lead DSP, the Program Director and the Facility Nurse."		facility put in place to ensure no recurrence Going forward, the leadership team of the facility nurse, QIDP, Lead DSP, & Med Support DSP is expected to meet on a weekly basis to review the master medical schedules and ensure that all needed appointments are scheduled and that indicated follow up is being completed in a timely fashion. Reports from this meeting are to be submitted to the Nursing Services Manager and the Area Director. QIDP is to meet with Area Director weekly to review all ongoing investigations for thoroughness.	

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	15G452	A. BUILDING 00 B. WING	07/05/2022

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	A BDDS report dated 5/27/22 indicated the following: "This Incident Report (IR) writer received a call from staff last evening to report that [client A] had a fall in the bathroom and was taken to the hospital by paramedics. (He takes himself independently to the bathroom.) He did return to the house that same night with multiple bruises and scratches on his body. Staff must check on [Client A] for pain or any other health concerns. ER visit, he was diagnosed with back strain, contusion of the back, unspecified laterality, and abrasion of knee bilateral. He was given immunization Tdap (ADACEL) 7:33 PM and HYDROcodone (sic)- acetaminophen (Norco) at 7:01 pm. [Client A] needs a doctor's follow up appointment as soon as possible for a visit in 3 days. Staff has noted that they called the Dr. office today and were unable to get in touch with the office. Due to the holiday on Monday, the office will be closed. Staff will call for appointment on Tuesday morning. Staff has reported that [Client A] has been overly obsessed with the bathroom and his bowels, digging and smearing. He has been shaky. He was not able to state why or how he fell and staff did not know he fell until they heard the fall,, (sic) as he went to the bathroom independently." A review of Client A's Individualized Support Plan and Risk plans was completed on 6/27/22 at 1:50 pm. A fall assessment was not completed after his falls. A fall risk plan was not implemented after his falls. An interview with the Registered Nurse was conducted on 6/30/22 at 1:59 pm. RN stated, "Fall Risk Assessments should be completed after a fall." RN indicated she did not know if client A had a fall risk plan in place. RN stated, "Client			

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	should have fall risk plan." An interview with the Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD stated, "I don't know if [Client A] has a fall risk plan or if a fall risk assessment has been completed. [Client A] shuffles when he walks." An interview with the Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD stated, "After a fall a risk assessment should be completed. The nurse should document if a fall risk plan is needed or not." 2. The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 6/27/22 at 1:46 pm. A BDDS report dated 6/21/22 indicated the following: "This IR writer met [Client B] at the [Hospital Emergency Room (ER] on the morning of 6/20/22 after staff called 911 due to frank (sic) blood and blood clots in his catheter. He had been seen at the ER twice prior (06/17/22 and 06/18/22) for blood in his catheter and was sent home both times after hospital staff flushed his catheter and gave orders (and training) for Highland staff to flush catheter at home. Unfortunately, the bleeding became worse on Monday morning and as stated above 911 was called. After further evaluation, a CT scan and a possibly elevated white blood count, [Client B] was admitted. Upon follow up on this date (06/21/22), [Hospital] nurse reported that lesions were noted on his bladder from a recent surgery to remove a stone in his bladder. No infection was noted. Nurse reports that there has been no bleeding today. Catheter was removed this afternoon and if there is no			

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	bleeding and [Client B] is able to urinate without issue, he will return to Highland tomorrow (06/22/22). There will be no new medication orders. Plan to resolve: Upon [Client B's] return tomorrow staff will follow Discharge Orders (DC), if any. Appointment with urologist was canceled due to hospitalization. Follow up CT is scheduled for 07/12/22. Follow up appointment with Urologist will be scheduled upon DC from hospital if warranted." "Follow -Up Description: 6/27/22 1. Please continue to provide updates on individual's mental/medical condition and hospital status, including any additional testing done or treatments provided. 2. What is anticipated length of stay? 3. What are the discharge orders, have staff/ family been trained on new orders? [Client B] was discharged from the hospital today (06/22/22). He returned home via wheelchair van (sic) approximately 4:30 pm. He was returned with no catheter, no antibiotics (antibiotics that he was taking prior to hospitalization have been DC' d). DC diagnosis was Hematoma of Penis and Urinary Tract Infection (UTI). Only new order was for a walker, which will be delivered via [Medical supply company]. Follow up appointments are as follows: [Primary Care Physician], ...[Urologist] ....He has an appointment scheduled for a CT scan of the bladder and a standing order for [Doctor], Wound care. Nurse is aware of orders. Staff is aware of appointments ... ." A review of Client B's record was completed on 6/27/22 at 3:18 pm. Client B's fall risk plan dated 4-01-22 did not include the use of a walker. An interview with the Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD stated, "Risk			

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	plans should be updated as needed or at least annually. If a walker is added, their fall risk plan should be updated to include the use of a walker." An interview with the Registered Nurse (RN) was conducted on 6/30/22 at 1:59 pm. RN stated, "Risk plans should be updated annually or when needed. When a walker is recommended the fall risk plan should be updated." An interview with the Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD indicated risk plans should be updated when adding the use of a walker. This federal tag relates to complaint #IN00382739. 9-3-6(a)			
W 0365 Bldg. 00	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, interview, and record review for 1 of 23 medications administered, the facility failed to ensure the Medication Administration Record (MAR) was documented correctly for client A. Findings include: On 6/27/22 at 6:33 pm, Client A went into the medication room and was administered his Aripiprazole 10 milligrams (mg) used for mood stabilizer, Lorazepam 0.5 mg used for Anxiety and Mirtazapine 7.5 mg used for depression. Client A had XIIDRA - Eye drops, Optic used to treat dry eye disease, that are scheduled to be given twice a day. Staff #1 indicated client A has prescribed eye drops but he has been out for a couple of	W 0365	W 365 Drug Regimen Review (Standard) – Failed to ensure the Medication Administration Record (MAR) was documented correctly for client A. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID E4VV11 will be fully implemented, including the following specifics: • Staff responsible for 6/27 medication error addressed through retraining and corrective action. • All facility staff retraining on	08/15/2022

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	days. The eye drops were not administered. On 6/28/22 at 7:13 am, Client A was in the medication room and House manager (HM) used a warm towel and wiped off his eye and face. HM administered his XIIDRA eye drops in each eye. When asked when the eye drops arrived at the home, HM indicated client A has had his eye drops. When asked if he had run out of his eye drops, HM stated "no". HM was informed staff #1 stated on 6/27/22 that client A was out of the eye drops and had been for a couple of days. HM looked in the Medication Administration Record on the computer in the house and indicated the MAR was marked he received the eye drops last night. Review of June 2022 Medication Administration Record (MAR) on 6/30/22 at 11:15 am indicated XIIDRA eye drops were given. An interview with HM was conducted on 6/28/22 at 8:04 am. HM indicated staff should be following the MAR and only mark the MAR when they have given the medication. An interview with Area Director was conducted on 7/1/22 at 10:52 am. AD indicated staff should follow the MAR when administering medication. If a medication is missed or refused if should be documented in the MAR and nurse should be called. In the MAR staff should go into the detail section and document the reason the medication was not given. An interview with Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD stated, "Staff should document if the medication is not given." PD indicated if the medication is not in the home staff should document the medication was not		Organized System for Medication Administration, including training on how to report and document all medications that are not found in the house, as well as training on never signing an MAR until a medication has been successfully administered. • Once retraining is complete, the QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that facility staff demonstrate competency on medication passing and med pass documentation. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the QIDP and	

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	delivered and mark it as a missed medication. An interview with Registered Nurse (RN) was conducted on 6/30/22 at 1:59 pm. RN stated, "Staff should not mark in the MAR that the medication was administered if it was not administered." 9-3-6(a)		Facility Nurse are to maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the programming and services being provided in the home. This includes monitoring that medications are being documented accurately through observation and coaching.	
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview, and record review for 1 of 23 medications administered, the facility failed to ensure each client's medication was administered without error for client A. Findings include: On 6/27/22 at 6:33 pm, Client A went into the medication room and was administered his Aripiprazole 10 milligrams (mg) (behavior), Lorazepam 0.5 mg (anxiety) and Mirtazapine 7.5 mg (depression). Client A had XIIDRA - Eye drops, Optic that are scheduled to be given twice a day. Staff #1 indicated client A has prescribed eye drops but he has been out for a couple of days. Eye drops were not administered. On 6/28/22 at 7:13 am, Client A was in the medication room and House manager (HM) used a warm towel and wiped off his eye and face. HM administered his XIIDRA eye drops used to treat	W 0369	W 369 Drug Administration (Standard) – Failed to ensure each client's medication was administered without error for client A. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID E4VV11 will be fully implemented, including the following specifics: • Staff responsible for 6/27 medication error addressed through retraining and corrective action. • All facility staff retraining on Organized System for Medication Administration, including training on how to report and document all medications that are not found in	08/15/2022

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	dry eye disease in each eye. When asked when eye drops arrived at the home, HM indicated client A has had his eye drops. When asked if he had run out of his eye drops, HM stated "no". HM was informed staff #1 indicated on 6/27/22 client A was out of the eye drops and had been for a couple of days. HM looked in the Medication Administration Record on the computer in the house and indicated MAR was marked he received the eye drops last night. Review of the June 2022 Medication Administration Record (MAR) on 6/30/22 at 11:15 am indicated XIIDRA eye drops were given. An interview with HM was conducted on 6/28/22 at 8:04 am. HM indicated staff should be following the MAR and only mark the MAR when they have given the medication. An interview with Registered Nurse (RN) was conducted on 6/30/22 at 1:59 pm. RN stated, "MARS should be followed according to what is written." An interview with Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD stated, "Medications should be passed according to current orders." 9-3-6(a)		the house, as well as training on never signing an MAR until a medication has been successfully administered. • Once retraining is complete, the QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct observations at varying times of the day to ensure that facility staff demonstrate competency on medication passing and med pass documentation. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the QIDP and Facility Nurse are to maintain a regular presence in the home through scheduled and unscheduled visits multiple times	

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			per week, to monitor for the overall quality of the programming and services being provided in the home. This includes monitoring that medications are being administered accurately through observation and coaching.	
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' medications were stored in a secure manner. Findings include: Observations were conducted in the group home on 6/27/22 from 4:03 pm to 6:40 pm, 6/28/22 from 6:50 am to 9:30 am and 6/28/22 from 4:45 pm to 5:52 pm. Clients A, B, C, D, E, F, G and H were present throughout the observations. At 4:52 pm, Staff #1 went into the kitchen and brought the lock box from the refrigerator to the medication room. Staff #1 got out Client F's medication and placed it in the syringe. Staff #1 placed the syringe of medication in a transparent plastic cup and placed it on the desk. Staff #1 left the medication room and took the lock box back into the kitchen. The medication cabinet was left unlocked, and the cup of medication was sitting on the desk. Staff #1 walked back into the medication room and called out for client F. Staff #1 then walked out of the medication room,	W 0382	W 382 Drug Storage and Recordkeeping (Standard) – Failed to ensure clients' 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 E4VV11 will be fully implemented, including the following specifics: • Facility staff responsible for the medication being left unattended and the med cabinet being unlocked during the observation is receiving employee counseling and retraining. • All facility staff receiving training to competency on this standard and on Dungarvin's expectation that the medications at ICF/I-DD facilities are to be locked at all times that the trained staff is not immediately accessing the	08/15/2022

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	leaving the medication sitting on the desk and the medication cabinet unlocked. Staff #1 asked client F if she was coming. Client F stated "yes". Staff #1 and client F walked into the medication room. An interview with the Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD indicated medication should be in the locked cabinet. PD stated, "There is no excuse for walking away from medicine with it unlocked." An interview with the Registered Nurse (RN) was conducted on 6/30/22 at 1:59 pm. RN stated, "Medications should be kept locked." An interview with the Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD stated, "Medications should be in a locked area anytime staff are not directly working with them." 9-3-6(a)		cabinet and supervising the immediate area. • Once retraining is complete, the QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct medication pass observations at varying times of the day to ensure that facility staff demonstrate competency on drug storage procedures. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence 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	

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			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.	
W 0475 Bldg. 00	483.480(b)(2)(iv) MEAL SERVICES Food must be served with appropriate utensils. 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 had access to appropriate utensils during meals. Findings include: Observations were conducted in the group home on 6/27/22 from 4:03 pm to 6:40 pm, 6/28/22 from 6:50 am to 9:30 am and 6/28/22 from 4:45 pm to 5:52 pm. Clients A, B, C, D, E, F, G and H were present throughout the observations. -At 5:16 pm clients B, C, and H were sitting at the kitchen table ready for dinner. Client A came into the kitchen and sat at the lower counter by the kitchen table. Clients D and E then came into the kitchen and sat down at the table. Dinner was macaroni and cheese, hamburgers, mixed vegetables, and a fruit cup. Staff #2 was getting out silverware and stated, "We don't have enough forks. We only have 3 forks". Staff #2 gave clients C, D and E a fork and gave a plastic spoon to clients A, B and H. Staff #2 cut up client H's food for her. Client G's food was pureed. Client G was	W 0475	W 475 Meal Services (Standard) – Failed to ensure clients had access to appropriate utensils during meals. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID E4VV11 will be fully implemented, including the following specifics: • Sufficient replacement silverware was purchased to ensure that appropriate utensils are available for use during all meals. • All facility staff will review this finding and related standard and will receive retraining on family style dining, including the importance of teaching dining skills at mealtimes, such as appropriate use of utensils. How facility will identify other residents potentially affected &	08/15/2022

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	using a curved spoon to eat. -At 5:57 pm Staff #2 told client H she could use her fingers to eat the meat if she wanted to. Client H indicated she did not want to eat the meat. An interview with the Program Director (PD) was conducted on 6/30/22 at 1:04 pm. PD stated, "Should have at least 16 forks in the home." An interview with the Area Director (AD) was conducted on 7/1/22 at 10:52 am. AD stated, "We should have enough for everyone that uses forks. We should have enough forks for staff and clients to eat family style dining." 9-3-8(a)		what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Going forward, the QIDP is to maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the programming and services being provided in the home. This includes monitoring that family style dining is occurring at meals, including the provision of appropriate utensils to all individuals sharing the meals.	