STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING 00 B. WING	10/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	474 WHITEWOOD DR VALPARAISO, IN 46385

(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 #IN00411727. Complaint #IN00411727: Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, and W153. Dates of Survey: September 27, 28, October 2, 3, 4, 5, and 10, 2023. Facility Number: 012557 Provider Number: 15G791 Aims Number: 201017960 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/25/23.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 2 of 2 sample clients (A and B), plus 1 additional client (C), the governing body failed to meet the Condition of Participation: Governing Body. The governing body failed to ensure client B was not subjected to physical abuse by her staff, to ensure an allegation of neglect resulting in serious physical harm for client A, an allegation of physical abuse by staff of client B, and a	W 0102	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 10/30/23 on abuse, neglect, and exploitation, and when suspected abuse, neglect, exploitation should be reported.	11/04/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greta Goins	Area Director	11/04/2023

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	self-reported allegation of self-harm for client B were immediately reported to an administrator by staff, and one incident of self-injurious behavior requiring police assistance and medical attention for client C were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C, to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B, and to thoroughly investigate 3 physical restraints for client A within 5 business days. Findings include: 1. The governing body failed to ensure client B was not subjected to physical abuse by her staff, to ensure an allegation of neglect resulting in serious physical harm for client A, an allegation of physical abuse by staff of client B, and a self-reported allegation of self-harm for client B were immediately reported to an administrator by staff, and one incident of self-injurious behavior requiring police assistance and medical attention for client C were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C, to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B, and to thoroughly investigate 3 physical restraints for client A within 5 business days. Please see W104.		Training included what events are reportable, who to report to, timeline of reporting, documentation expectations, and a competency assessment. QIDP was trained on 10/30/23 on conducting thorough investigations of significant incidents, including PRN medication administration as a chemical restraint, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP was also trained on the importance of critically analyzing all possible causes when investigating significant incidents, in order to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. QIDP, Area Director, and Behavior Clinician to meet bi-weekly as needed after staff training to discuss plan implementation observations and documentation and staff progress on implementation of corrective actions in place to prevent recurrence of significant issues. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action	

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	2. The governing body failed to ensure client B was not subjected to physical abuse by her staff, to ensure an allegation of neglect resulting in serious physical harm for client A, an allegation of physical abuse by staff of client B, and a self-reported allegation of self-harm for client B were immediately reported to an administrator by staff, and one incident of self-injurious behavior requiring police assistance and medical attention for client C were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C, to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B, and to thoroughly investigate 3 physical restraints for client A within 5 business days. Please see W122. This federal tag relates to complaint #IN00411727. 9-3-1(a)		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 recurrence: All facility staff have been trained on abuse, neglect, exploitation and incident reporting expectations to ensure health and safety of all individuals. All Program Directors/QIDPs have been trained on mandatory investigation components, investigation timelines, and to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including PRN medication administration as a chemical restraint, elopements, non-emergency calls to 911, police intervention, and hospitalization. Persons responsible: QIDP, Area Director	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over			

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	the facility. Based on record review and interview for 2 of 2 sample clients (A and B), plus 1 additional client (C), the governing body failed to ensure client B was not subjected to physical abuse by her staff, to ensure an allegation of neglect resulting in serious physical harm for client A, an allegation of physical abuse by staff of client B, and a self-reported allegation of self-harm for client B were immediately reported to an administrator by staff, and one incident of self-injurious behavior requiring police assistance and medical attention for client C were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C, to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B, and to thoroughly investigate 3 physical restraints for client A within 5 business days. Findings include: 1. The governing body failed to ensure client B was not subjected to physical abuse by her staff. Please see W127. 2. The governing body neglected to implement their written policy and procedures to prevent and to ensure staff immediately reported one allegation of neglect resulting in serious physical harm for client A, to prevent, immediately report, and suspend staff related to one allegation of physical abuse by staff of client B, to prevent and thoroughly investigate one allegation of self harm	W 0104	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 10/30/23 on abuse, neglect, and exploitation, and when suspected abuse, neglect, exploitation should be reported. Training included what events are reportable, who to report to, timeline of reporting, documentation expectations, and a competency assessment. QIDP was trained on 10/30/23 on conducting thorough investigations of significant incidents, including physical and chemical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP was also trained on the importance of critically analyzing all possible causes when investigating significant incidents, in order to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. The QIDP, Area Director or other qualified supervisory staff are responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on what is abuse,	11/04/2023

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	requiring police intervention for client C, to immediately report a self-reported allegation of self-harm client for C, and to report to BDDS within 24 hours 6 chemical and physical restraints for clients A, B, and C, one hospitalization for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C, and to thoroughly investigate within 5 business days 14 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Please see W149. 3. The governing body failed to ensure staff immediately reported to administration one allegation of neglect resulting in serious physical harm for client A, one allegation of physical abuse by staff of client B, one self-reported allegation of self-harm for client B, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Please see W153. 4. The governing body failed to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Please see W154. 5. The governing body failed to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B. Please see W155. 6. The governing body failed to report the results of an investigation to the administrator for 3		neglect, exploitation, when to report suspected abuse, neglect, exploitation, and documentation expectations. Initially these observations will be conducted at least 2 times per week for the first three weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks. Any observed concerns will be addressed through immediate retraining and coaching. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective. 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 facility staff have been trained on abuse, neglect, exploitation and incident reporting expectations to ensure health and safety of all individuals. All	

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	physical restraints for client A within 5 business days. Please see W156. This federal tag relates to complaint #IN00411727. 9-3-1(a)		Program Directors/QIDPs have been trained on mandatory investigation components, investigation timelines, and to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including chemical and physical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. Persons responsible: QIDP, Area Director	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on record review and interview for 2 of 2 sample clients (A and B), plus 1 additional client (C), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure client B was not subjected to physical abuse by her staff, to ensure an allegation of neglect resulting in serious physical harm for client A, an allegation of physical abuse by staff of client B, and a self-reported allegation of self-harm for client B were immediately reported to an administrator by staff, and one incident of self-injurious behavior requiring police assistance and medical attention for client C were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious	W 0122	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 10/30/23 on abuse, neglect, and exploitation, and when suspected abuse, neglect, exploitation should be reported. Training included what events are reportable, who to report to, timeline of reporting, documentation expectations, and a competency assessment. QIDP was trained on 10/30/23 on conducting thorough investigations of significant incidents, including physical and	11/04/2023

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	behavior requiring police assistance and medical attention for client C, to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B, and to thoroughly investigate 3 physical restraints for client A within 5 business days. Findings include: 1. The facility failed to ensure client B was not subjected to physical abuse by her staff. Please see W127. 2. The facility neglected to implement its written policy to prevent and to ensure staff immediately reported one allegation of neglect resulting in serious physical harm for client A, to prevent, immediately report, and suspend staff related to one allegation of physical abuse by staff of client B, to prevent and thoroughly investigate one allegation of self harm requiring police intervention for client C, to immediately report a self-reported allegation of self-harm client for C, and to report to BDDS within 24 hours 6 chemical and physical restraints for clients A, B, and C, one hospitalization for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C, and to thoroughly investigate within 5 business days 14 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Please see W149. 3. The facility failed to ensure staff immediately reported to administration one allegation of neglect resulting in serious physical harm for client A, one allegation of physical abuse by staff of client B, one self-reported allegation of		chemical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP was also trained on the importance of critically analyzing all possible causes when investigating significant incidents, in order to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. The QIDP, Area Director or other qualified supervisory staff are responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on what is abuse, neglect, exploitation, when to report suspected abuse, neglect, exploitation, and documentation expectations. Initially these observations will be conducted at least 2 times per week for the first three weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks. Any observed concerns will be addressed through immediate retraining and coaching. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the	

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	self-harm for client B, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Please see W153. 4. The facility failed to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Please see W154. 5. The facility failed to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B. Please see W155. 6. The facility failed to report the results of investigations to administrators for 3 physical restraints for client A within 5 business days. Please see W156. This federal tag relates to complaint #IN00411727. 9-3-2(a)		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 recurrence: All facility staff have been trained on abuse, neglect, exploitation and incident reporting expectations to ensure health and safety of all individuals. All Program Directors/QIDPs have been trained on mandatory investigation components, investigation timelines, and to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including chemical and physical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. Persons responsible: QIDP, Area Director	
W 0127 Bldg. 00	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure			

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	that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. Based on record review and interview for 1 of 2 sample clients (B), the facility failed to ensure client B was not subjected to physical abuse by her staff. Findings include: The facility's General Event Reports (GERs), Bureau of Developmental Disabilities Services (BDDS) reports, and related investigations were reviewed on 9/27/23 at 12:00 pm. A BDDS report dated 4/14/23 indicated the following: "Incident Date: 4/13/23. Time: 6:00 pm. A staff called and reported another staff (Direct Support Professional (DSP) #3) was sitting on [client B] to prevent her from eloping. Staff also reported [DSP #3] and [DSP #4] poured water on [client B] while she laid on the hot ground." A follow-up dated 5/25/23 indicated the following: "[Client B] was offered emotional support in discussing her feelings about what caused her to want to leave the program location. She utilized positive affirmations and devotionals with staff support and is understanding of what appropriate restraints/supports are. Allegation of abuse was substantiated and staff were terminated. [Client B] had a bruise on her left elbow approximately 1.5 inches in diameter. Yes, BSP has HRC (Human Rights Committee) approved restraint in the plan. The restraint used during this event was not an approved or trained technique." An Investigation Summary dated 4/18/23	W 0127	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 10/30/23 on abuse, neglect, and exploitation, and when suspected abuse, neglect, exploitation should be reported. Training included what events are reportable, who to report to, timeline of reporting, documentation expectations, and a competency assessment. QIDP was trained on 10/30/23 on conducting thorough investigations of significant incidents, including physical and chemical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP was also trained on the importance of critically analyzing all possible causes when investigating significant incidents, in order to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. QIDP will be re-trained on 11/6/23 on on-call responsibilities and referring staff to the on-call supervisor to address concerns, reporting, etc after normal	11/06/2023

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	indicated the following: An interview summary with client B indicated the following: "[Client B] stated that [DSPs #3 and #4] poured water on her when she was laying on the ground. She said they grabbed her hair to try and get her off the ground and then poured water on her. She stated that she was in the front yard in the grass. [Client B] stated that they put hands on her, but she did not remember specifically how they did so.... [Client B] stated that [DSPs #3 and #4] came out and tried to talk to her. She refused to go inside and laid down on the ground. They then poured water on her. 'I think that's not fair.' [Client B] said that [DSP #4] sat on her while she was laying on the ground. When asked if they attempted to do a restraint on her, she said she didn't know. [Client B] stated she had been restrained before and, 'It wasn't like those.'" An interview summary with DSP #5 indicated the following: "[DSP #5] stated that it was her fault that [client B] 'got out' on 4/13/23. She was on [client B's] side (of the home), and everyone else was on the other side.... [DSP #3] called her name, and she saw [client B] outside. [DSP #4] told her to stay with the other individuals and then came back inside and filled up (sic) 'huge red bowls with water.' [DSP #4] threw the first bowl of water on [client B] and came inside to fill up again, and [DSP #3] threw the second bowl of water. [DSP #5] observed [DSP #3] sitting on top of [client B]. [Client B] wasn't fighting back. She was laying in the grass, and they just sat on top of her.... [DSP #5] called [House Manager (HM) #1] and [Qualified Intellectual Disabilities Professional		business hours to ensure that allegations of abuse, neglect, and exploitation are addressed timely. QIDP has additionally been trained on the on-call system and how it should be utilized. QIDPs that do not follow the on-call system are trained on the expectation that any report and required action thereof is their responsibility to address per policy. The QIDP, Area Director or other qualified supervisory staff are responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on what is abuse, neglect, exploitation, when to report suspected abuse, neglect, exploitation, and documentation expectations. Initially these observations will be conducted at least 2 times per week for the first three weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks. Any observed concerns will be addressed through immediate retraining and coaching. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action	

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	(QIDP) #1] while in the bathroom at the site and then spoke to [QIDP #1] after she had already left the program site." An interview summary with QIDP #1 indicated the following: "[QIDP #1] stated that [DSP #5] contacted her while she was out with her granddaughters. She played phone tag with her and spoke to her on the phone around 6:00 pm. [QIDP #1] notified the Area Director (AD) at 9:00 pm. When asked why the delay, she stated again that she had been out with her granddaughters and when she looked at the video sent by [DSP #5], she knew she needed to suspend (staff) and contacted [AD #1]." An interview summary with DSP #2 indicated the following: "[DSP #2] received a call from [HM #1] to come in early on 4/13/23 and arrived around 10:30 pm. Upon arrival, [DSP #2] stated that both [DSPs #3 and #4] were at the program site and shared that [client B] had 'gotten out' and [DSP #5] video taped them. [DSPs #3 and #4] told [DSP #2] that they were being suspended." Findings of Fact: [DSP #3] sat on [client B] while she was laying on the ground. [Client B] has a bruise on her left elbow. [DSPs #3 and #4] were suspended over the phone and remained on shift until 11:00 pm. [DSPs #3 and #4] poured water on [client B]. No [staff communication] was completed for the 3:00 pm to 11:00 pm shift on 4/13/23. No General Event Report (GER) was completed for [client B] eloping." An Investigation Plan of Correction Report dated		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 recurrence: All facility staff have been trained on abuse, neglect, exploitation and incident reporting expectations to ensure health and safety of all individuals. All Program Directors/QIDPs have been trained on mandatory investigation components, investigation timelines, and to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including chemical and physical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. All Program Directors/QIDPs have been trained on the on-call system and how it should be utilized. Program Directors/QIDPs that do not follow the on-call system are trained on the expectation that any report and required action thereof is their responsibility to address per policy.	

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	4/26/23 indicated the following: "Subject of Investigation: Allegation of abuse. Determination of Rights Violation: Staff failed to adequately and appropriately implement BSP reactive and proactive techniques and used unauthorized methods to gain compliance from individual. Statement of Conclusion: Based on witness statements and video evidence, the allegation of abuse is substantiated. Staff used water as an aversive technique to gain compliance, and sat on the individual when she was on the ground and not being aggressive. Action Steps: Termination [DSPs #3 and #4]. Warning: [QIDP #1] for failure to take immediate action to suspend staff and relieve staff of duties." The review indicated physical abuse of client B by DSPs #3 and #4 was substantiated. Client B's record was reviewed on 9/28/23 at 12:05 pm. Client B's BSP dated 8/23/23 did not indicate staff should pour water on client B or sit on her as a means to manage her maladaptive behaviors. AD #1 was interviewed on 9/28/23 at 1:15 pm and stated, "[DSP #5] was a newer staff. She contacted me on April 14th or 15th and said that she didn't feel comfortable working in the home. She didn't feel comfortable working for a company that did that to individuals. She met with me and said a staff member was sitting on [client B]. The two staff members poured water on [client B] and sat on her. She said she attempted to contact [QIDP #1] about it and wasn't comfortable with how everything played out." AD #1 stated, "The incident occurred on 4/13/23 between 4:30 and		Persons responsible: QIDP, Area Director	

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	5:00 pm. [DSP #5] was in the bathroom trying to call [QIDP #1] between 5:00 and 6:00 pm. She texted [QIDP #1] saying she was uncomfortable and was leaving. She clocked out around 5:30 pm. She spoke to [QIDP #1] on the phone." AD #1 stated, "[QIDP #1] reported to me on the 13th that staff had sat on [client B] and poured water on her. I'd given the directive to suspend, and we would start an investigation. [QIDP #1] reported to me at 9:00 pm on 4/13/23. She said she suspended the staff at that time. She said they left at that time." AD #1 stated, "I completed the investigation. I substantiated staff pouring water on [client B] and sitting on her." AD #1 stated, "We substantiated that the staff remained on shift after we were aware of it. We continued to put the individuals at risk before the staff were suspended and left the home." AD #1 stated, "If [QIDP #1] was not available to handle the situation, it should have been deferred to the on-call PD (program director), so it could have been handled right away." AD #1 stated, "Both [DSP #3 and #4] were terminated. [QIDP #1] was retrained." 9-3-2(a)			
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 19 of 24 allegations of abuse, neglect, and mistreatment reviewed affecting clients A, B, and C, the facility neglected to implement its written policy to prevent and to ensure staff immediately reported one allegation of neglect resulting in serious physical harm for client A, to prevent, immediately report, and suspend staff related to one allegation of physical abuse by staff of client B, to prevent	W 0149	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 10/30/23 on abuse, neglect,	11/04/2023

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	and thoroughly investigate one allegation of self harm requiring police intervention for client C, to immediately report a self-reported allegation of self-harm client for C, and to report to BDDS within 24 hours 6 chemical and physical restraints for clients A, B, and C, one hospitalization for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C, and to thoroughly investigate within 5 business days 14 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Findings include: The facility's General Event Reports (GERs), Bureau of Developmental Disabilities Services (BDDS) reports, and related investigations were reviewed on 9/27/23 at 12:00 pm. 1. A BDDS report written by Qualified Intellectual Disabilities Professional (QIDP) #1 dated 6/26/23 indicated the following: "Incident Date: 6/25/23 Time: 11:00 am. Date of Knowledge: 6/25/23. [Client A] was taken to urgent care after pouring [drain cleaner] in her lap. The [drain cleaner] caused chemical burns on [client A's] thighs and vagina. [Client A] was transported to [hospital] burn unit for treatment. [Client A] was admitted into (sic) hospital. (Sic) burns were cleaned and dressed. Attending physician stated [client A] will remain in (sic) hospital for 3 - 5 days until (sic) injury is healed." The BDDS report did not clearly indicate client A's injury occurred on 6/24/23 between 10:00 pm		and exploitation, and when suspected abuse, neglect, exploitation should be reported. Training included what events are reportable, who to report to, timeline of reporting, documentation expectations, and a competency assessment. All facility staff were trained on 10/30/23 on proper chemical storage. All facility staff were trained on 10/30/23 PRN medication administration, including who can authorize and appropriate documentation. The physical plant of the facility was modified to add two additional locked doors to prevent individuals' access to chemicals. The behavior clinician will be retrained on Dungarvin policy and procedure for documenting and reporting critical/reportable incidents, including what to do when suspected abuse, neglect, exploitation should be reported. Training will include what events are reportable, who to report to, timeline of reporting, and documentation expectations. The nurse will create a PRN protocol for all psychotropic medications prescribed "as needed" for behavior purposes. The protocol will include specific instructions for who and when to call for authorization and documentation expectations. Individuals' BSPs will be updated	

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	and 11:00 pm. A GER written by House Manager (HM #2) dated 6/26/23 at 12:26 pm indicated the following: "Late Entry: On this shift I was informed to take [client A] to urgent care. We arrived (sic) she was taken back into the emergency room. The doctor stated she had burns to her vagina and buttocks area. The doctor stated she needed to be transferred to [hospital] burn unit. While waiting for the confirmation for [client A] to get a bed on the burn unit, she did not complain of any pain or discomfort. When asked was she ok or hurting, she stated she was good. She wanted me to play music on phone, and I did. [Client A] was transferred by ambulance. When we arrived there, she was admitted." The GER indicated it was entered for the 7:00 am to 3:00 pm shift on 6/25/23. The GER did not indicate who directed HM #2 to take client A to urgent care. HM #1's witness statement dated 6/27/23 from 6:45 pm to 7:15 pm indicated the following: - HM #1 indicated she works in the home 80 hours per week. - HM #1's statement indicated the following: "[Client A] had her shower with [DSP #1's] assistance around 9:45 pm or 10:00 pm and went to bed. Talked with [DSP #1] a few minutes. [HM #1] wanted to restock the cabinet in the garage. [DSP #1] was taking out the garbage and sweeping and mopping. [DSP #1] came and said it was 11 and she needed to go. The night staff should be arriving soon. I heard something bang. I came in the house. The night staff was knocking. [Client A] was running through the kitchen. She was not wearing the same pants.		with the PRN protocol specifics. QIDP was trained on 10/30/23 on conducting thorough investigations of significant incidents, including physical and chemical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP was also trained on the importance of critically analyzing all possible causes when investigating significant incidents, in order to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. All QIDPs and on-call supervisors were trained on incident reporting to BDS requirements and timelines. The QIDP, Area Director or other qualified supervisory staff are responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on what is abuse, neglect, exploitation, when to report suspected abuse, neglect, exploitation, and documentation expectations. Initially these observations will be conducted at least 2 times per week for the first three weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks. Any observed concerns will be addressed through immediate retraining and	

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	[Client A] said, 'Wet.' [HM #1] had [client A] pull her pants down, and her pubic hair was slick. [HM #1] had her show her what she did. [Client A] led [HM #1] to staff bathroom and showed her a black bottle of [drain cleaner]. She just looked red around her thighs, and I put some cream on her." - HM #1 indicated client A had cream for a previous rash. - HM #1's statement indicated the following: "I told the staff, 'I don't know what [client A] did, but she poured something on herself. I told them to watch, and, if she had pain, to give her the cream." "[DSP #2] called and said [client A] said it was hurting down there and [HM #1] told [DSP #2] where the cream was in the office in her topicals bin." "I called [QIDP #1] on my way home around 11:30 pm and told her that [client A] had gotten into chemicals. [QIDP #1] advised to go to urgent care in the morning because I told her she was red and irritated. The nurse was not called because it was after 11 pm at night." "[Chemicals] are kept in the locked cabinet in the garage. The [drain cleaner] was in the staff bathroom. There was a clog in the sink. I used it and I didn't get it put back before [client A] got into it." - HM #1 indicated client A's supervision level is line of sight. - HM #1 indicated she reported the incident to QIDP #1. - HM #1's statement indicated the following: "The PD (QIDP #1) did not tell me to call the nurse. It was late." - HM #1 indicated medications not listed on the client's MAR (Medication Administration Record) should not be administered.		coaching. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective. 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 facility staff have been trained on abuse, neglect, exploitation and incident reporting expectations to ensure health and safety of all individuals. All facility staff have additionally been trained on appropriately securing chemicals and PRN medication administration approval and documentation. All Program Directors/QIDPs have been trained on mandatory investigation components, investigation timelines, and to complete thorough, timely investigations of all significant incidents which could be indicative of abuse,	

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	QIDP #1's witness statement dated 6/27/23 indicated the following: "[HM #1] called [QIDP #1] around 11:30 pm on Saturday June 24th and stated that [client A] had poured [drain cleaner] in her lap. [HM #1] reported that she was told to apply cream to the affected areas and monitor. [QIDP #1] asked if she needed to go to urgent care. [HM #1] stated the area was only red, and [client A] was not displaying any sign of pain or discomfort, and she was told to monitor and applying (sic) the cream. [HM #1] stated she applied the cream and informed the overnight when they arrived, and she would check with [HM #2] in the morning." Direct Support Professional (DSP) #1's witness statement dated 6/28/23 indicated the following: - DSP #1 was scheduled to work 7:00 am to 11:00 pm on Saturday 6/24/23 and 7:00 am to 3:00 pm on Sunday 6/25/23. - Chemicals are locked in the staff bathroom and garage. - Clients are not supposed to go into the staff bathroom. - Client A requires one to one supervision when showering. - DSP #1 was not in the home when client A was burned. - The facility nurse should be notified immediately of injuries. - Staff documentation should be completed at the end of the staff's shift. The witness statement indicated the following: "[HM #2] and [DSP #1] looked at the injury (on 6/25/23), and it looked so bad and very red and inflamed with bumps all over her thighs. It looked so bad, they both agreed she needed to go to urgent care." The witness statement indicated the following: "Interviewer called [DSP #1] at 4:30 pm on 6/28/23.		neglect, or exploitation, including chemical and physical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. All behavior clinicians are trained on abuse, neglect, exploitation, and incident reporting expectations to ensure health and safety of all individuals. The Behavior clinician manager will review behavioral concerns with the behavior clinician during supervisory meetings and ensure the proper reporting has taken place. Nursing will review nursing care plans quarterly and revise as needed when PRN medication(s) are changed. Persons responsible: QIDP, Area Director, Behavior Clinician, Nurse	

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	Requested an accurate departure time from work on 6/24/23 due to times conflicting from other witness statements. [DSP #1] stated that she left at 10:00 pm. Interviewer asked why she left prior to her scheduled time and who gave her permission. [DSP #1] stated that [HM #1] gave her permission and stated that she had not called a PD (program director - QIDP). DSP #2's witness statement dated 6/28/23 at 11:00 am indicated the following: "My shift begins at 11 pm. I arrived at 10:30 ish (sic). [DSP #3] was there. We were knocking, ringing the doorbell, and calling numerous times. No one answered. There was one white vehicle outside, it was [HM #1's]. [HM #1] finally opened the door between 11:00 pm and 11:15 pm. Closer to 11:00 pm. [HM #1] immediately attended to [client A] by the washer. They were putting dirty clothing into the laundry basket. Next thing I saw was her instructing [client A] to go into the shower. While getting clothing, she showed staff a rash on [client A's] buttocks and said it was from bouncing on her ball. I only saw some redness. She then closed the bedroom door and dressed [client A] and then she left. She told us that she was going to call [QIDP #1] when she left. I think it was because of the rash. The time was approx. (approximately) 11:30 - 11:40 pm. I then contacted [HM #1] around 12:00 am (6/25/23) because [client A] had woken up and used the restroom and was complaining, 'Hurt. Hurt.' I said [client A] was complaining about her rash. [HM #1] instructed [DSP #2] to apply a cream. The cream was in a box in a tube. She had used it before. It was a white cream. We used it for a rash before in her vaginal area. The cream was locked in a bin below the big medicine cabinet. [DSP #2] applied the cream, and [client A] returned to bed. The vaginal area looked red and			

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	inflamed. She used the restroom every 2 - 3 hours and said she was hurt, and cream was reapplied. After 3:00 am applications, she stayed in bed until morning.... [DSP #1 and HM #2] came in (at 8:00 am on 6/25/23).... I told [HM #2] about the cream and rash. She said she had already been informed by [HM #1] and she was taking [client A] to urgent care. I didn't know there were chemical burns until I returned that afternoon." - DSP #2's statement indicated client A had gained access to chemicals in the staff bathroom a couple of weeks prior. DSP #2 indicated she expressed concern, and HM #1 told her to not worry. HM #2's witness statement dated 6/27/23 indicated the following: - HM #2 indicated HM #1 called and instructed her to take client A to urgent care due to client A pouring drain cleaner on herself. - HM #2 indicated she called QIDP #1 at 8 am to notify her client A was being taken to urgent care. - HM #2 indicated she called QIDP #1 at 11 am to notify her client A was being taken to another hospital. Registered Nurse (RN) #1's witness statement dated 6/29/23 indicated he was on call on the weekend of 6/24/23 and 6/25/23 and indicated the following: "No, I did not receive any calls from that site." Licensed Practical Nurse (LPN) #1's witness statement dated 6/28/23 indicated the following: "[QIDP #1] called me Sunday 6/25/23 at 8:59 pm and asked if I was aware that [client A] was admitted to the [hospital] with 2nd and 3rd degree burns to her vaginal area. I replied, 'No, I was not aware of any of this information. This is the first time I am hearing any of this.' [QIDP #1] stated, '[HM #1] said that she had let you know and that			

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	you said to apply the burn cream and monitor her.' I replied, 'No, that is not true. I did not receive a call Saturday night from [HM #1]. This is the first I'm hearing any of this.'" An investigation Plan of Correction Report dated 6/30/23 indicated the following: "Subject of Investigation: Allegation of neglect. [Client A], supported individual, received chemical burns to her legs and peri area. Determination of Rights Violation: [Client A's] rights were violated by not having adequate supervision/staffing levels in place at the time of the incident. Staff failed to follow policy to ensure chemicals are locked and out of access to the individuals and to obtain the appropriate authorization to leave their shift. Statement of Conclusion: Allegation of neglect was substantiated. [HM #1] was the only staff present, and she failed to adequately report and document [client A's] chemical burns, so that appropriate treatment could be sought. Nurse on-call was not notified for the change of condition. During the investigation, it was discovered that [DSP #1] left her shift one hour early without proper authorization, leaving the site under ratio." Client A's record was reviewed on 9/28/23 at 11:00 am. Client A's Behavior Support Plan (BSP) dated 8/23/23 indicated chemicals should be locked. Client A's BSP indicated the following: "[Client A] requires 24-hour supervision and care to manage life skills and self-care. She has poor impulse control which could lead to physical aggression and significant self-harm. She continues to need training in activities of daily living and life skills which are essential for community living. [Client A's] lack of safety			

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	awareness puts her at significant risk of harm." "If [client A] inflicts bodily injury that requires medical intervention, the on-call nurse for Dungarvin should be notified." Area Director (AD) #1 was interviewed on 9/28/23 at 1:15 pm and stated, "It occurred Saturday night (6/24/23) on the 3:00 pm to 11:00 pm shift. It occurred between 10:00 pm and 11:00 pm. We don't have an exact time. [HM #1] and [DSP #1] were the two staff on shift. They were both scheduled to 11:00 pm." AD #1 stated, "Sunday morning (6/25/23) before noon, [QIDP #1] contacted me saying that [client A] was taken to the emergency room for a burn and was being transported to to a burn unit in [city]. She said that [HM #1] had reported to her Saturday night that [client A] had gotten access to [drain cleaner] and had poured it on herself. I asked why she didn't go the night before. [QIDP #1] said [HM #1] told her that she had called and reported to the nurse. The nurse said to rinse the area and monitor. [LPN #1] is the nurse, and she said nothing was reported to her. No one had contacted her about the burn or exposure to the chemical." AD #1 stated, "[Client A] went to urgent care in [town] then was sent to the ER (emergency room) then to [hospital burn unit]. The staff called [QIDP #1] in the morning. [HM #1] had contacted the staff and told them [client A] should probably go to urgent care and be checked out. [HM #2] called [QIDP #1] and said the same thing. There was still no call to the nurse. They only called me after she had been seen at urgent care and the ER and was on her way to [city]." AD #1 stated, "The overnight staff did reach out to [HM #1] through the night (early morning on 6/25/23). [Client A] was saying that she hurt. They called [HM #1] between midnight and 4:00 am. She instructed them to apply a cream			

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	and told them where to find it. It was a cream that was prescribed several years ago. They applied the cream, and she fell asleep. The morning staff came in at 8:00 am, did morning medications, and took [client A] to urgent care." AD #1 stated, "The staff should not have called the house manager when she was off shift. They should have called the nurse." The review indicated client A's recommended supervision level of line of sight was not implemented. The review indicated client A's BSP restriction of locked chemicals was not implemented. The review indicated DSP #1 left her shift early without administrative approval. The review indicated HM #1 was in the garage at the time of client A's chemical burn and was not inside the home providing supervision. The review indicated HM #1 did not immediately contact the nurse when she discovered client A had poured a caustic chemical on herself. The review indicated HM #1 did not provide appropriate first aid care for client A's suspected burn. The review indicated the medication HM #1 administered to client A's burn was not prescribed to client A and did not have nursing approval. The review indicated QIDP #1 did not instruct HM #1 to contact the nurse when she reported client A's suspected burn. The review indicated HM #2 and DSP #2 did not immediately contact the nurse when they were concerned about client A's health and well-being. The review indicated HM #1 did not instruct HM #2 and DSP #2 to contact the nurse when they expressed concern about client A's health and well-being. The review indicated HM #2 and DSP #2 administered an unprescribed and unapproved			

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	medication to client A's suspected burn. The review indicated QIDP #1, HM #2, and DSP #2 did not contact the nurse or AD #1 when client A went to urgent care and the hospital ER. 2. A BDDS report dated 4/14/23 indicated the following: "Incident Date: 4/13/23. Time: 6:00 pm. A staff called and reported another staff (DSP #3) was sitting on [client B] to prevent her from eloping. Staff also reported [DSP #3] and [DSP #4] poured water on [client B] while she laid on the hot ground." A follow-up dated 5/25/23 indicated the following: "[Client B] was offered emotional support in discussing her feelings about what caused her to want to leave the program location. She utilized positive affirmations and devotionals with staff support and is understanding of what appropriate restraints/supports are. Allegation of abuse was substantiated and staff were terminated. [Client B] had a bruise on her left elbow approximately 1.5 inches in diameter. Yes, BSP has HRC (Human Rights Committee) approved restraint in the plan. The restraint used during this event was not an approved or trained technique." An Investigation Summary dated 4/18/23 indicated the following: An interview summary with client B indicated the following: "[Client B] stated that [DSPs #3 and #4] poured water on her when she was laying on the ground. She said they grabbed her hair to try and get her off the ground and then poured water on her. She stated that she was in the front yard in the grass. [Client B] stated that they put hands on her, but she did not remember specifically how they did			

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	so.... [Client B] stated that [DSPs #3 and #4] came out and tried to talk to her. She refused to go inside and laid down on the ground. They then poured water on her. 'I think that's not fair.' [Client B] said that [DSP #4] sat on her while she was laying on the ground. When asked if they attempted to do a restraint on her, she said she didn't know. [Client B] stated she had been restrained before and, 'It wasn't like those.'" An interview summary with DSP #5 indicated the following: "[DSP #5] stated that it was her fault that [client B] 'got out' on 4/13/23. She was on [client B's] side (of the home), and everyone else was on the other side.... [DSP #3] called her name, and she saw [client B] outside. [DSP #4] told her to stay with the other individuals and then came back inside and filled up (sic) 'huge red bowls with water.' [DSP #4] threw the first bowl of water on [client B] and came inside to fill up again, and [DSP #3] threw the second bowl of water. [DSP #5] observed [DSP #3] sitting on top of [client B]. [Client B] wasn't fighting back. She was laying in the grass, and they just sat on top of her.... [DSP #5] called [HM #1] and [QIDP #1] while in the bathroom at the site and then spoke to [QIDP #1] after she had already left the program site." An interview summary with QIDP #1 indicated the following: "[QIDP #1] stated that [DSP #5] contacted her while she was out with her granddaughters. She played phone tag with her and spoke to her on the phone around 6:00 pm. [QIDP #1] notified the Area Director at 9:00 pm. When asked why the delay, she stated again that she had been out with her granddaughters and when she looked at the video sent by [DSP #5],			

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	she knew she needed to suspend (staff) and contacted [AD #1]." An interview summary with DSP #2 indicated the following: "[DSP #2] received a call from [HM #1] to come in early on 4/13/23 and arrived around 10:30 pm. Upon arrival, [DSP #2] stated that both [DSPs #3 and #4] were at the program site and shared that [client B] had 'gotten out' and [DSP #5] video taped them. [DSPs #3 and #4] told [DSP #2] that they were being suspended." Findings of Fact: [DSP #3] sat on [client B] while she was laying on the ground. [Client B] has a bruise on her left elbow. [DSPs #3 and #4] were suspended over the phone and remained on shift until 11:00 pm. [DSPs #3 and #4] poured water on [client B]. No [staff communication] was completed for the 3:00 pm to 11:00 pm shift on 4/13/23. No GER was completed for [client B] eloping." An Investigation Plan of Correction Report dated 4/26/23 indicated the following: "Subject of Investigation: Allegation of abuse. Determination of Rights Violation: Staff failed to adequately and appropriately implement BSP reactive and proactive techniques and used unauthorized methods to gain compliance from individual. Statement of Conclusion: Based on witness statements and video evidence, the allegation of abuse is substantiated. Staff used water as an aversive technique to gain compliance, and sat on the individual when she was on the ground and not being aggressive. Action Steps:			

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	Termination [DSPs #3 and #4]. Warning: [QIDP #1] for failure to take immediate action to suspend staff and relieve staff of duties." Client B's record was reviewed on 9/28/23 at 12:05 pm. Client B's BSP dated 8/23/23 did not indicate staff should pour water on client B or sit on her as a means to manage her maladaptive behaviors. AD #1 was interviewed on 9/28/23 at 1:15 pm and stated, "[DSP #5] was a newer staff. She contacted me on April 14th or 15th and said that she didn't feel comfortable working in the home. She didn't feel comfortable working for a company that did that to individuals. She met with me and said a staff member was sitting on [client B]. The two staff members poured water on [client B] and sat on her. She said she attempted to contact [QIDP #1] about it and wasn't comfortable with how everything played out." AD #1 stated, "The incident occurred on 4/13/23 between 4:30 and 5:00 pm. [DSP #5] was in the bathroom trying to call [QIDP #1] between 5:00 and 6:00 pm. She texted [QIDP #1] saying she was uncomfortable and was leaving. She clocked out around 5:30 pm. She spoke to [QIDP #1] on the phone." AD #1 stated, "[QIDP #1] reported to me on the 13th that staff had sat on [client B] and poured water on her. I'd given the directive to suspend, and we would start an investigation. [QIDP #1] reported to me at 9:00 pm on 4/13/23. She said she suspended the staff at that time. She said they left at that time." AD #1 stated, "I completed the investigation. I substantiated staff pouring water on [client B] and sitting on her." AD #1 stated, "We substantiated that the staff remained on shift after we were aware of it. We continued to put the individuals at risk before the staff were suspended			

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	and left the home." AD #1 stated, "If [QIDP #1] was not available to handle the situation, it should have been deferred to the on-call PD (program director), so it could have been handled right away." AD #1 stated, "Both [DSP #3 and #4] were terminated. [QIDP #1] was retrained." The review indicated physical abuse of client B by DSPs #3 and #4 was substantiated. The review indicated QIDP #1 did not immediately respond to DSP #5 when she attempted to report an allegation of abuse. The review indicated QIDP #1 did not instruct DSP #5 to contact an administrator on call, as she was not on duty at the time of the report. The review indicated QIDP #1 failed to immediately report the allegation of abuse to her supervisor and did not immediately take action to prevent further abuse by DSPs #3 and #4. 3. Behavior Clinician (BC) #1 was interviewed on 9/29/23 at 11:55 am and stated, "On 9/23/23, [client B] told me she wrapped a sheet around her neck and tried to hang herself. Staff took everything out of her room. Staff said she was threatening to harm herself. To be safe, they removed everything from her room." BC #1 indicated she did not report the allegation of self-harm to an administrator. AD #1 was interviewed on 10/2/23 at 10:07 am and stated, "I was not aware of her actually wrapping sheets around her neck. Staff didn't report it. If she reported to the BC, it should have been reported to administration and to BDDS and investigated." 4a. A BDDS report dated 7/9/23 indicated the following: "[On 7/8/23], [client A] began SIB (self-injurious behavior), aggression, and attempting to leave out			

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	of exits in the home through the night. Staffs (sic) made attempts to redirect. She attempted to SIBs (sic) and was physically aggressive with staff. [Client A] had a blank stare. She would briefly calm down (less than 5 mins (minutes)) and become extremely aggressive, screaming, biting herself, grabbing objects to throw or hit herself/staff with. Staff used HWC (Handle with Care) HRC (Human Rights Committee) approved two person hold for 15 minutes in attempts to keep her safe. Staff called 911. The [name] County Police and EMT (emergency medical technician) arrived and took [client A] to [hospital] for observation. Plan to Resolve: [Client A] is currently still at [hospital] for a 72 hour observation per court order which begins on 7/10/23." The review indicated an investigation was completed on 8/1/23. The review did not indicate whether staff contacted a supervisor or nurse for assistance. The review did not indicate whether staff administered client A's PRN medication. The review did not indicate whether staff implemented proactive procedures listed in her BSP to prevent her aggressive behavior. 4b. A BDDS report dated 7/22/23 indicated client A was administered Alprazolam (treats anxiety) 1 mg (milligram) PRN (as needed) on 7/9/23 due to physical aggression. The review indicated the medication was approved by [QIDP #1], and the facility nurse was not contacted. The review indicated the PRN chemical restraint was not reported within 24 hours of knowledge. The review did not include an investigation. 4c. A BDDS report dated 7/11/23 indicated the			

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	following: " [On 7/10/23], started banging her head with her hands and screaming. Staff number 1 used Handle with Care to restrain her from further hurting herself. Staff called for staff number 2 to assist with a two-person body hug. Staff 3 arrived and switched out staff. [Client A] calm and given a PRN per nurse [client A] (sic). She was given Alprazolam 1 mg tablet. [Client A] calmed down shortly after the PRN took a 30 minute nap. [Client A] was in behavior on and off throughout the shift, but no holds were required. [Client A] was closely monitored throughout the shift." An investigation dated 8/1/23 indicated the incident was not thoroughly investigated within 5 business days. The review did not indicate whether staff implemented proactive procedures listed in her BSP to prevent her aggressive behavior. 4d. A BDDS report dated 7/17/23 indicated client A was admitted to an inpatient psychiatric facility on 7/11/23. The review indicated client A's hospitalization was not reported to BDDS within 24 hours of knowledge. 4e. A BDDS report dated 7/23/23 indicated client A was put in a one arm standing restraint for 6 minutes. An investigation dated 8/15/23 indicated the incident was not thoroughly investigated within 5 business days. 4f. An Incident Follow Up Report dated 8/1/23 indicated client A was placed in one hold for 10 minutes and another hold for 15 minutes on 7/24/23. The report did not indicate when the incident was initially reported to BDDS. The review did not indicate an investigation was			

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	completed. 4g. A BDDS report dated 8/12/23 indicated the following: "[On 8/11/23] [client A] was bouncing on her ball when she jumped up and attacked her housemate, trying to bite her hand. When staff intervene (sic), [client A] bite (sic) staff on (sic) pinky finger. [Client A] was placed in a one-man HRC approved restraint per behavior plan for 5 minutes. [Client A] said sorry and then began to scream and cry 'Head hurt,' and 'Head doctor.' [Client A] then laid down on the floor, refused to get up, and continued to cry and scream, 'Head hurt,' and, 'Head doctor.' When staff attempted to redirect [client A], [client A] got up and attempted to bite staff then [client A] would stop and yell, 'Head hurt,' 'Head doctor.' 911 was called, and [client A] was taken to the hospital. Once at (sic) hospital, she (sic) observed for 6 hours and (sic) released. Once home, [client A] remained awoke (sic) all night but had no further aggressive behavior. No discharge follow-up was recommended." The review did not indicate an investigation was completed. Client A's record was reviewed on 9/28/23 at 11:00 am. Client A's Behavior Support Plan (BSP) dated 8/23/23 did not include specific regarding the use of client A's PRN medications. Client A's BSP did not include specific instructions regarding when to call for police assistance with client A's aggressive behaviors. Client A's BSP indicated the following proactive measures to prevent her maladaptive behaviors: "Allow [client A] to engage in self-directed sensory activities.... Staff should monitor [client A's] mood by observation and should engage her in fun			

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	conversation or activities when she appears depressed and/or anxious.... Staff will encourage [client A] to move to a quieter, calmer area away from her peers, especially a specific peer with whom she is upset, if she appears agitated... Communication: Staff should provide [client A] with positive praise and attention. In addition, staff should ensure that [client A] is receiving regular 1:1 social interaction.... Structured Environment: Keeping [client A's] environment as structured, calm, and consistent as possible will help to mitigate [client A's] SIB target behaviors." 5a. A BDDS report dated 7/18/23 indicated client B's PRN medication was administered on 7/14/23. The review indicated the chemical restraint was not reported within 24 hours of knowledge. The review did not include an investigation. 5b. A BDDS report dated 7/22/23 indicated client B's PRN medication was administered on 7/16/23. The review indicated the chemical restraint was not reported within 24 hours of knowledge. The review indicated the medication was approved by an on-call Program Director (PD), and a nurse was not notified. The review did not include an investigation. 5c. A BDDS report dated 7/22/23 indicated client B's PRN medication was administered on 7/19/23. The review indicated the chemical restraint was not reported within 24 hours of knowledge. The review did not indicate the medication was approved by a nurse. The review did not include an investigation. 5d. A BDDS report dated 7/21/23 indicated client			

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	B's PRN medication was administered twice on 7/21/23. The review did not indicate the medication was approved by a nurse. The review did not include an investigation. 5e. A BDDS report dated 7/23/23 indicated client B's PRN medication was administered on 7/22/23. The review did not indicate the medication was approved by a nurse. The review did not include an investigation. 6a. A BDDS report dated 3/12/23 indicated client A was put in a 2 person hold for 10 minutes and injured her right wrist resulting in minor bruising. The review indicated the restraint was not reported within 24 hours of knowledge. The review did not include an investigation. 6b. A BDDS report dated 3/21/23 indicated the following: "[On 3/19/23], staff stated [client C] was pacing (a sign of agitation). Staff stated they asked [client C] several times what was wrong. [Client C] stated nothing was wrong, she just wanted to lay down and went to her bedroom. Staff went to check on [client C] shortly after going into her bedroom and found [client C] scratching her arm with a piece of plastic. [Client C] had 3 minor scratches on her left arm that was bleeding. Staff called nurse who instructed staff to call police and ambulance. Once at hospital, wounds were clean, antibiotic cream was applied and left to air dry and heal...." The review indicated the self-injury and police involvement was not reported to BDDS within 24 hours of knowledge. The review did not include an investigation. 6c. A BDDS report dated 5/19/23 indicated client C			

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	was put in a two person hold on 5/18/23. The review did not include an investigation. 6d. A BDDS report dated 7/29/23 indicated client C was put in holds twice and received a PRN medication to address her maladaptive behaviors. The review did not include an investigation. AD #1 was interviewed on 9/28/23 at 1:15 pm and stated, "PRN medications are reported to BDDS within 24 hours. The PRN is supposed to be approved by the nurse. I did find the staff weren't following our policy. They were calling the PD or the PD on-call to get authorization." AD #1 indicated restraints should be investigated. AD #1 indicated allegations of abuse and neglect should be reported immediately by staff and to BDDS within 24 hours of knowledge. AD #1 indicated allegations of abuse and neglect should be thoroughly investigated within 5 business days.The facility's Policy and Procedure Concerning Abuse, Neglect, and Exploitation dated 5/21/21 was reviewed on 9/28/23 at 1:00 pm and indicated the following:"Physical abuse is defined as any act which constitutes a violation of the assault, prostitution, or criminal sexual conduct statutes, including intentionally touching another person in a rude, insolent, or angry manner; willful infliction of injury, unnecessary restraint/confinement, resulting from physical or chemical intervention.... Unnecessary restraint/confinement is defined as any physical intervention that limits the			

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	movement or mobility of an individual that is not outlined in an individual's behavior support Plan. 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 as outlined in section III B of this policy.Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury, and is not accidental; any repeated conduct which produces, or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in an individual's presence with intent to cause fear of retaliation or fear of confinement or restraint.... and/or repeated conduct which causes or could reasonably be expected to cause an individual to react in a negative manner.Neglect is defined as failure to provide appropriate care, supervision, or training....Dungarvin responds promptly to actual and suspected abuse. While allegations of suspected or actual abuse may be reported by the individual, family members, visitors, or external stakeholders. Dungarvin employees are required by law to report suspected or actual abuse, neglect, or exploitation....The first step is to immediately contact the program supervisor for the			

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	individual....Within 24 hours of knowledge of the suspected or actual abuse, neglect, or exploitation, the program director/manager... will report the incident to the Bureau of Developmental Disabilities Services (BDDS) using the on-line incident reporting process....The program director/manager, area director/manager, senior director, or his/her delegate will conduct a thorough investigation of any alleged, suspected, or actual abuse, neglect, or exploitation. Within 5 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...."This federal tag relates to complaint #IN00411727.9-3-2(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 4 of 24 allegations of abuse, neglect, and mistreatment reviewed affecting clients A, B, and C, the facility failed to ensure staff immediately reported to administration one allegation of neglect resulting	W 0153	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the	11/04/2023

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	in serious physical harm for client A, one allegation of physical abuse by staff of client B, and a self-reported allegation of self-harm client for C, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Findings include: The facility's General Event Reports (GERs), Bureau of Developmental Disabilities Services (BDDS) reports, and related investigations were reviewed on 9/27/23 at 12:00 pm. 1. A BDDS report written by Qualified Intellectual Disabilities Professional (QIDP) #1 dated 6/26/23 indicated the following: "Incident Date: 6/25/23 Time: 11:00 am. Date of Knowledge: 6/25/23. [Client A] was taken to urgent care after pouring [drain cleaner] in her lap. The [drain cleaner] caused chemical burns on [client A's] thighs and vagina. [Client A] was transported to [hospital] burn unit for treatment. [Client A] was admitted into (sic) hospital. (Sic) burns were cleaned and dressed. Attending physician stated [client A] will remain in (sic) hospital for 3 - 5 days until (sic) injury is healed." The BDDS report did not clearly indicate client A's injury occurred on 6/24/23 between 10:00 pm and 11:00 pm. A GER written by House Manager (HM #2) dated 6/26/23 at 12:26 pm indicated the following: "Late Entry: On this shift I was informed to take [client A] to urgent care. We arrived (sic) she was taken back into the emergency room. The doctor stated she had burns to her vagina and buttocks area. The		following specifics: QIDP retrained on 10/30/23 on BDS policy on Reportable Incidents including the requirement that all reportable incidents must be reported within 24 hours in accordance with state law. All facility staff were retrained on 10/30/23 on Dungarvin policy on Incident Reporting; training to focus on requirement that all reportable incidents must be immediately reported and directly to a Program Director. All facility staff were retrained on 10/30/23 on reporting changes of condition to the nurse on-call and the QIDP/Program Director on-call. All facility staff who fail to comply with this regulation and Dungarvin policy on Incident Reporting will be subject to both retraining and disciplinary action in accordance with Dungarvin policy. QIDP was trained on 10/30/23 on conducting thorough investigations of significant incidents, including physical and chemical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP was also trained on the importance of critically analyzing all possible causes when investigating significant incidents, in order to create a corrective action plan to	

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	doctor stated she needed to be transferred to [hospital] burn unit. While waiting for the confirmation for [client A] to get a bed on the burn unit, she did not complain of any pain or discomfort. When asked was she ok or hurting, she stated she was good. She wanted me to play music on phone, and I did. [Client A] was transferred by ambulance. When we arrived there, she was admitted." The GER indicated it was entered for the 7:00 am to 3:00 pm shift on 6/25/23. The GER did not indicate who directed HM #2 to take client A to urgent care. HM #1's witness statement dated 6/27/23 from 6:45 pm to 7:15 pm indicated the following: - HM #1 indicated she works in the home 80 hours per week. - HM #1's statement indicated the following: "[Client A] had her shower with [DSP #1's] assistance around 9:45 pm or 10:00 pm and went to bed. Talked with [DSP #1] a few minutes. [HM #1] wanted to restock the cabinet in the garage. [DSP #1] was taking out the garbage and sweeping and mopping. [DSP #1] came and said it was 11 and she needed to go. The night staff should be arriving soon. I heard something bang. I came in the house. The night staff knocking. [Client A] was running through the kitchen. She was not wearing the same pants. [Client A] said, 'Wet.' [HM #1] had [client A] pull her pants down, and her pubic hair was slick. [HM #1] had her show her what she did. [Client A] led [HM #1] to staff bathroom and showed her a black bottle of [drain cleaner]. She just looked red around her thighs, and I put some cream on her." - HM #1 indicated client A had cream for a previous rash. - HM #1's statement indicated the following:		effectively prevent recurrence of the type of incident being investigated. All QIDPs and on-call supervisors were trained on incident reporting to BDS requirements and timelines. The QIDP, Area Director or other qualified supervisory staff are responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on what is abuse, neglect, exploitation, when to report suspected abuse, neglect, exploitation, and documentation expectations. Initially these observations will be conducted at least 2 times per week for the first three weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks. Any observed concerns will be addressed through immediate retraining and coaching. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective. The behavior clinician will be retrained on Dungarvin policy and	

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	"I told the staff, 'I don't know what [client A] did, but she poured something on herself. I told them to watch, and, if she had pain, to give her the cream." "[DSP #2] called and said [client A] said it was hurting down there and [HM #1] told [DSP #2] where the cream was in the office in her topicals bin." "I called [QIDP #1] on my way home around 11:30 pm and told her that [client A] had gotten into chemicals. [QIDP #1] advised to go to urgent care in the morning because I told her she was red and irritated. The nurse was not called because it was after 11 pm at night." "[Chemicals] are kept in the locked cabinet in the garage. The [drain cleaner] was in the staff bathroom. There was a clog in the sink. I used it and I didn't get it put back before [client A] got into it." - HM #1 indicated client A's supervision level is line of sight. - HM #1 indicated she reported the incident to QIDP #1. - HM #1's statement indicated the following: "The PD (QIDP #1) did not tell me to call the nurse. It was late." - HM #1 indicated medications not listed on the client's MAR (Medication Administration Record) should not be administered. QIDP #1's witness statement dated 6/27/23 indicated the following: "[HM #1] called [QIDP #1] around 11:30 pm on Saturday June 24th and stated that [client A] had poured [drain cleaner] in her lap. [HM #1] reported that she was told to apply cream to the affected areas and monitor. [QIDP #1] asked if she needed to go to urgent care. [HM #1] stated the area was only red, and [client A] was not displaying any sign of pain or discomfort, and she		procedure for documenting and reporting critical/reportable incidents, including what to do when suspected abuse, neglect, exploitation should be reported. Training will include what events are reportable, who to report to, timeline of reporting, and documentation expectations. 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 facility staff have been trained on reportable incidents and when to notify nursing staff of changes of condition and who to get authorization for PRN administration from. QIDP is responsible to be aware of all reportable incidents and to report them according to state law. Area Director and QIDP to do targeted review of Therap documentation on incidents during weekly supervision meetings to ensure that all incidents have been reported as required. All facility staff have been trained on abuse, neglect, exploitation and incident reporting expectations to ensure health and safety of all individuals.	

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	was told to monitor and applying (sic) the cream. [HM #1] stated she applied the cream and informed the overnight when they arrived, and she would check with [HM #2] in the morning." Direct Support Professional (DSP) #1's witness statement dated 6/28/23 indicated the following: - DSP #1 was scheduled to work 7:00 am to 11:00 pm on Saturday 6/24/23 and 7:00 am to 3:00 pm on Sunday 6/25/23. - Chemicals are locked in the staff bathroom and garage. - Clients are not supposed to go into the staff bathroom. - Client A requires one to one supervision when showering. - DSP #1 was not in the home when client A was burned. - The facility nurse should be notified immediately of injuries. - Staff documentation should be completed at the end of the staff's shift. The witness statement indicated the following: "[HM #2] and [DSP #1] looked at the injury (on 6/25/23), and it looked so bad and very red and inflamed with bumps all over her thighs. It looked so bad, they both agreed she needed to go to urgent care." The witness statement indicated the following: "Interviewer called [DSP #1] at 4:30 pm on 6/28/23. Requested an accurate departure time from work on 6/24/23 due to times conflicting from other witness statements. [DSP #1] stated that she left at 10:00 pm. Interviewer asked why she left prior to her scheduled time and who gave her permission. [DSP #1] stated that [HM #1] gave her permission and stated that she had not called a PD (program director - QIDP). DSP #2's witness statement dated 6/28/23 at 11:00		All Program Directors/QIDPs have been trained on mandatory investigation components, investigation timelines, and to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including chemical and physical restraints, elopements, non-emergency calls to 911, police intervention, and hospitalization. All behavior clinicians are trained on abuse, neglect, exploitation, and incident reporting expectations to ensure health and safety of all individuals. Persons responsible: QIDP, Area Director, behavior clinician	

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	am indicated the following: "My shift begins at 11 pm. I arrived at 10:30 ish (sic). [DSP #3] was there. We were knocking, ringing the doorbell, and calling numerous times. No one answered. There was one white vehicle outside, it was [HM #1's]. [HM #1] finally opened the door between 11:00 pm and 11:15 pm. Closer to 11:00 pm. [HM #1] immediately attended to [client A] by the washer. They were putting dirty clothing into the laundry basket. Next thing I saw was her instructing [client A] to go into the shower. While getting clothing, she showed staff a rash on [client A's] buttocks and said it was from bouncing on her ball. I only saw some redness. She then closed the bedroom door and dressed [client A] and then she left. She told us that she was going to call [QIDP #1] when she left. I think it was because of the rash. The time was approx. (approximately) 11:30 - 11:40 pm. I then contacted [HM #1] around 12:00 am (6/25/23) because [client A] had woken up and used the restroom and was complaining, 'Hurt. Hurt.' I said [client A] was complaining about her rash. [HM #1] instructed [DSP #2] to apply a cream. The cream was in a box in a tube. She had used it before. It was a white cream. We used it for a rash before in her vaginal area. The cream was locked in a bin below the big medicine cabinet. [DSP #2] applied the cream, and [client A] returned to bed. The vaginal area looked red and inflamed. She used the restroom every 2 - 3 hours and said she was hurt, and cream was reapplied. After 3:00 am applications, she stayed in bed until morning.... [DSP #1 and HM #2] came in (at 8:00 am on 6/25/23).... I told [HM #2] about the cream and rash. She said she had already been informed by [HM #1] and she was taking [client A] to urgent care. I didn't know there were chemical burns until I returned that afternoon." - DSP #2's statement indicated client A had gained			

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	access to chemicals in the staff bathroom a couple of weeks prior. DSP #2 indicated she expressed concern, and HM #1 told her to not worry. HM #2's witness statement dated 6/27/23 indicated the following: - HM #2 indicated HM #1 called and instructed her to take client A to urgent care due to client A pouring drain cleaner on herself. - HM #2 indicated she called QIDP #1 at 8 am to notify her client A was being taken to urgent care. - HM #2 indicated she called QIDP #1 at 11 am to notify her client A was being taken to another hospital. Registered Nurse (RN) #1's witness statement dated 6/29/23 indicated he was on call on the weekend of 6/24/23 and 6/25/23 and indicated the following: "No, I did not receive any calls from that site." Licensed Practical Nurse (LPN) #1's witness statement dated 6/28/23 indicated the following: "[QIDP #1] called me Sunday 6/25/23 at 8:59 pm and asked if I was aware that [client A] was admitted to the [hospital] with 2nd and 3rd degree burns to her vaginal area. I replied, 'No, I was not aware of any of this information. This is the first time I am hearing any of this.' [QIDP #1] stated, '[HM #1] said that she had let you know and that you said to apply the burn cream and monitor her.' I replied, 'No, that is not true. I did not receive a call Saturday night from [HM #1]. This is the first I'm hearing any of this.'" An investigation Plan of Correction Report dated 6/30/23 indicated the following: "Subject of Investigation: Allegation of neglect. [Client A], supported individual, received chemical burns to her legs and peri area.			

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	Determination of Rights Violation: [Client A's] rights were violated by not having adequate supervision/staffing levels in place at the time of the incident. Staff failed to follow policy to ensure chemicals are locked and out of access to the individuals and to obtain the appropriate authorization to leave their shift. Statement of Conclusion: Allegation of neglect was substantiated. [HM #1] was the only staff present, and she failed to adequately report and document [client A's] chemical burns, so that appropriate treatment could be sought. Nurse on-call was not notified for the change of condition. During the investigation, it was discovered that [DSP #1] left her shift one hour early without proper authorization, leaving the site under ratio." Area Director (AD) #1 was interviewed on 9/28/23 at 1:15 pm and stated, "It occurred Saturday night (6/24/23) on the 3:00 pm to 11:00 pm shift. It occurred between 10:00 pm and 11:00 pm. We don't have an exact time. [HM #1] and [DSP #1] were the two staff on shift. They were both scheduled to 11:00 pm." AD #1 stated, "Sunday morning (6/25/23) before noon, [QIDP #1] contacted me saying that [client A] was taken to the emergency room for a burn and was being transported to to a burn unit in [city]. She said that [HM #1] had reported to her Saturday night that [client A] had gotten access to [drain cleaner] and had poured it on herself. I asked why she didn't go the night before. [QIDP #1] said [HM #1] told her that she had called and reported to the nurse. The nurse said to rinse the area and monitor. [LPN #1] is the nurse, and she said nothing was reported to her. No one had contacted her about the burn or exposure to the chemical." AD #1 stated, "[Client A] went to urgent care in [town] then was sent to the ER			

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	(emergency room) then to [hospital burn unit]. The staff called [QIDP #1] in the morning. [HM #1] had contacted the staff and told them [client A] should probably go to urgent care and be checked out. [HM #2] called [QIDP #1] and said the same thing. There was still no call to the nurse. They only called me after she had been seen at urgent care and the ER and was on her way to [city]." AD #1 stated, "The overnight staff did reach out to [HM #1] through the night (early morning on 6/25/23). [Client A] was saying that she hurt. They called [HM #1] between midnight and 4:00 am. She instructed them to apply a cream and told them where to find it. It was a cream that was prescribed several years ago. They applied the cream, and she fell asleep. The morning staff came in at 8:00 am, did morning medications, and took [client A] to urgent care." AD #1 stated, "The staff should not have called the house manager when she was off shift. They should have called the nurse." The review indicated HM #1 did not immediately contact the nurse when she discovered client A had poured a caustic chemical on herself. The review indicated HM #1 did not provide appropriate first aid care for client A's suspected burn. The review indicated QIDP #1 did not instruct HM #1 to contact the nurse when she reported client A's suspected burn. The review indicated HM #2 and DSP #2 did not immediately contact the nurse when they were concerned about client A's health and well-being. The review indicated HM #1 did not instruct HM #2 and DSP #2 to contact the nurse when they expressed concern about client A's health and well-being. The review indicated QIDP #1, HM #2, and DSP #2 did not contact the nurse or AD #1 when client			

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	A went to urgent care and the hospital ER. 2. A BDDS report dated 4/14/23 indicated the following: "Incident Date: 4/13/23. Time: 6:00 pm. A staff called and reported another staff (DSP #3) was sitting on [client B] to prevent her from eloping. Staff also reported [DSP #3] and [DSP #4] poured water on [client B] while she laid on the hot ground." A follow-up dated 5/25/23 indicated the following: "[Client B] was offered emotional support in discussing her feelings about what caused her to want to leave the program location. She utilized positive affirmations and devotionals with staff support and is understanding of what appropriate restraints/supports are. Allegation of abuse was substantiated and staff were terminated. [Client B] had a bruise on her left elbow approximately 1.5 inches in diameter. Yes, BSP has HRC (Human Rights Committee) approved restraint in the plan. The restraint used during this event was not an approved or trained technique." An Investigation Summary dated 4/18/23 indicated the following: An interview summary with client B indicated the following: "[Client B] stated that [DSPs #3 and #4] poured water on her when she was laying on the ground. She said they grabbed her hair to try and get her off the ground and then poured water on her. She stated that she was in the front yard in the grass. [Client B] stated that they put hands on her, but she did not remember specifically how they did so.... [Client B] stated that [DSPs #3 and #4] came out and tried to talk to her. She refused to go inside			

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	15G791	A. BUILDING 00 B. WING	10/10/2023

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	and laid down on the ground. They then poured water on her. 'I think that's not fair.' [Client B] said that [DSP #4] sat on her while she was laying on the ground. When asked if they attempted to do a restraint on her, she said she didn't know. [Client B] stated she had been restrained before and, 'It wasn't like those.'" An interview summary with DSP #5 indicated the following: "[DSP #5] stated that it was her fault that [client B] 'got out' on 4/13/23. She was on [client B's] side (of the home), and everyone else was on the other side.... [DSP #3] called her name, and she saw [client B] outside. [DSP #4] told her to stay with the other individuals and then came back inside and filled up (sic) 'huge red bowls with water.' [DSP #4] threw the first bowl of water on [client B] and came inside to fill up again, and [DSP #3] threw the second bowl of water. [DSP #5] observed [DSP #3] sitting on top of [client B]. [Client B] wasn't fighting back. She was laying in the grass, and they just sat on top of her.... [DSP #5] called [HM #1] and [QIDP #1] while in the bathroom at the site and then spoke to [QIDP #1] after she had already left the program site." An interview summary with QIDP #1 indicated the following: "[QIDP #1] stated that [DSP #5] contacted her while she was out with her granddaughters. She played phone tag with her and spoke to her on the phone around 6:00 pm. [QIDP #1] notified the Area Director at 9:00 pm. When asked why the delay, she stated again that she had been out with her granddaughters and when she looked at the video sent by [DSP #5], she knew she needed to suspend (staff) and contacted [AD #1]."			

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	An interview summary with DSP #2 indicated the following: "[DSP #2] received a call from [HM #1] to come in early on 4/13/23 and arrived around 10:30 pm. Upon arrival, [DSP #2] stated that both [DSPs #3 and #4] were at the program site and shared that [client B] had 'gotten out' and [DSP #5] video taped them. [DSPs #3 and #4] told [DSP #2] that they were being suspended." Findings of Fact: [DSP #3] sat on [client B] while she was laying on the ground. [Client B] has a bruise on her left elbow. [DSPs #3 and #4] were suspended over the phone and remained on shift until 11:00 pm. [DSPs #3 and #4] poured water on [client B]. No [staff communication] was completed for the 3:00 pm to 11:00 pm shift on 4/13/23. No GER was completed for [client B] eloping." An Investigation Plan of Correction Report dated 4/26/23 indicated the following: "Subject of Investigation: Allegation of abuse. Determination of Rights Violation: Staff failed to adequately and appropriately implement BSP reactive and proactive techniques and used unauthorized methods to gain compliance from individual. Statement of Conclusion: Based on witness statements and video evidence, the allegation of abuse is substantiated. Staff used water as an aversive technique to gain compliance, and sat on the individual when she was on the ground and not being aggressive. Action Steps: Termination [DSPs #3 and #4]. Warning: [QIDP #1] for failure to take immediate action to suspend staff and relieve staff of			

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	duties." AD #1 was interviewed on 9/28/23 at 1:15 pm and stated, "[DSP #5] was a newer staff. She contacted me on April 14th or 15th and said that she didn't feel comfortable working in the home. She didn't feel comfortable working for a company that did that to individuals. She met with me and said a staff member was sitting on [client B]. The two staff members poured water on [client B] and sat on her. She said she attempted to contact [QIDP #1] about it and wasn't comfortable with how everything played out." AD #1 stated, "The incident occurred on 4/13/23 between 4:30 and 5:00 pm. [DSP #5] was in the bathroom trying to call [QIDP #1] between 5:00 and 6:00 pm. She texted [QIDP #1] saying she was uncomfortable and was leaving. She clocked out around 5:30 pm. She spoke to [QIDP #1] on the phone." AD #1 stated, "[QIDP #1] reported to me on the 13th that staff had sat on [client B] and poured water on. I'd given the directive to suspend, and we would start an investigation. [QIDP #1] reported to me at 9:00 pm on 4/13/23. She said she suspended the staff at that time. She said they left at that time." AD #1 stated, "I completed the investigation. I substantiated staff pouring water on [client B] and sitting on her." AD #1 stated, "We substantiated that the staff remained on shift after we were aware of it. We continued to put the individuals at risk before the staff were suspended and left the home." AD #1 stated, "If [QIDP #1] was not available to handle the situation, it should have been deferred to the on-call PD (program director), so it could have been handled right away." AD #1 stated, "Both [DSP #3 and #4] were terminated. [QIDP #1] was retrained." The review indicated QIDP #1 did not immediately respond to DSP #5 when she attempted to report			

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	an allegation of abuse. The review indicated QIDP #1 did not instruct DSP #5 to contact an administrator on call, as she was not on duty at the time of the report. The review indicated QIDP #1 failed to immediately report the allegation of abuse to her supervisor. 3. Behavior Clinician (BC) #1 was interviewed on 9/29/23 at 11:55 am and stated, "On 9/23/23, [client B] told me she wrapped a sheet around her neck and tried to hang herself. Staff took everything out of her room. Staff said she was threatening to harm herself. To be safe, they removed everything from her room." BC #1 indicated she did not report the allegation of self-harm to an administrator. AD #1 was interviewed on 10/2/23 at 10:07 am and stated, "I was not aware of her actually wrapping sheets around her neck. Staff didn't report it. If she reported to the BC, it should have been reported to administration and to BDDS and investigated." 4. A BDDS report dated 3/21/23 indicated the following: "[On 3/19/23], staff stated [client C] was pacing (a sign of agitation). Staff stated they asked [client C] several times what was wrong. [Client C] stated nothing was wrong, she just wanted to lay down and went to her bedroom. Staff went to check on [client C] shortly after going into her bedroom and found [client C] scratching her arm with a piece of plastic. [Client C] had 3 minor scratches on her left arm that was bleeding. Staff called nurse who instructed staff to call police and ambulance. Once at hospital, wounds were clean, antibiotic cream was applied and left to air dry and heal...."			

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	The review indicated the self-injury and police involvement was not reported to BDDS within 24 hours of knowledge. AD #1 was interviewed on 9/28/23 at 1:15 pm and indicated allegations of abuse and neglect should be reported immediately by staff and to BDDS within 24 hours of knowledge. This federal tag relates to complaint #IN00411727. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 12 of 24 allegations of abuse, neglect, and mistreatment reviewed affecting clients A, B, and C, the facility failed to thoroughly investigate 10 chemical and physical restraints for clients A, B, and C, one allegation of peer to peer aggression for client A, and one incident of self-injurious behavior requiring police assistance and medical attention for client C. Findings include: The facility's General Event Reports (GERs), Bureau of Developmental Disabilities Services (BDDS) reports, and related investigations were reviewed on 9/27/23 at 12:00 pm. 1a. A BDDS report dated 7/22/23 indicated client A was administered Alprazolam (treats anxiety) 1 mg (milligram) PRN (as needed) on 7/9/23 due to physical aggression. The review indicated the medication was	W 0154	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: QIDP was retrained on 10/30/23 on conducting thorough investigations of significant incidents, including chemical and physical restraint, peer to peer aggression, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP also received retraining on the importance of critically analyzing all possible causes when investigating significant incidents, to create a corrective action plan to effectively prevent recurrence of the type of incident being	11/04/2023

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	approved by [Qualified Intellectual Disabilities Professional (QIDP) #1], and the facility nurse was not contacted. The review did not include an investigation. 1b. An Incident Follow Up Report dated 8/1/23 indicated client A was placed in one hold for 10 minutes and another hold for 15 minutes on 7/24/23. The report did not indicate when the incident was initially reported to BDDS. The review did not indicate an investigation was completed. 1c. A BDDS report dated 8/12/23 indicated the following: "[On 8/11/23] [client A] was bouncing on her ball when she jumped up and attacked her housemate, trying to bite her hand. When staff intervene (sic), [client A] bite (sic) staff on (sic) pinky finger. [Client A] was placed in a one-man HRC (Human Rights Committee) approved restraint per behavior plan for 5 minutes. [Client A] said sorry and then began to scream and cry 'Head hurt,' and 'Head doctor.' [Client A] then laid down on the floor, refused to get up, and continued to cry and scream, 'Head hurt,' and, 'Head doctor.' When staff attempted to redirect [client A], [client A] got up and attempted to bite staff then [client A] would stop and yell, 'Head hurt,' 'Head doctor.' 911 was called, and [client A] was taken to the hospital. Once at (sic) hospital, she (sic) observed for 6 hours and (sic) released. Once home, [client A] remained awoke (sic) all night but had no further aggressive behavior. No discharge follow-up was recommended." The review did not indicate an investigation was completed. 2a. A BDDS report dated 7/18/23 indicated client B's PRN medication (Clonazepam 0.5 mg		investigated. All facility staff were trained on 10/30/23 on PRN medication administration, including who can authorize administration and appropriate documentation. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective. QIDP is implementing aggressive documentation review and check ins with the individuals served and the staff on duty to ensure that all concerns are being accurately documented and reported. Area Director is reviewing actions taken to fully implement this plan of correction during weekly supervision with the QIDP. All issues reviewed and action taken are reviewed during this supervision meeting so that the Area Director can verify that appropriate measures are being taken to thoroughly investigate all allegations of abuse, neglect and mistreatment at the facility, including chemical and physical restraints, peer to peer aggression, elopement, 911 calls, police intervention, and other	

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	(milligrams) tablet, Indication/Purpose: Anxiety Disorder, 1 tablet by mouth twice a day as needed) was administered on 7/14/23. The review did not include an investigation. 2b. A BDDS report dated 7/22/23 indicated client B's PRN medication (Clonazepam 0.5 mg) was administered on 7/16/23. The review indicated the medication was approved by an on-call Program Director (PD), and a nurse was not notified. The review did not include an investigation. 2c. A BDDS report dated 7/22/23 indicated client B's PRN medication (Clonazepam 0.5 mg) was administered on 7/19/23. The review did not indicate the medication was approved by a nurse. The review did not include an investigation. 2d. A BDDS report dated 7/21/23 indicated client B's PRN medication (Clonazepam 0.5 mg) was administered twice on 7/21/23. The review did not indicate the medication was approved by a nurse. The review did not include an investigation. 2e. A BDDS report dated 7/23/23 indicated client B's PRN medication (Clonazepam 0.5 mg) was administered on 7/22/23. The review did not indicate the medication was approved by a nurse. The review did not include an investigation. 3a. A BDDS report dated 3/12/23 indicated client A was put in a 2 person hold for 10 minutes and injured her right wrist resulting in minor bruising. The review did not include an investigation. 3b. A BDDS report dated 3/21/23 indicated the		events that pose a risk to the health and safety of the individuals served at the facility. 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 facility staff are trained upon hire, annually and as needed on PRN procedures and who/when to notify and obtain required authorization. All new QIDPs are being trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including chemical and physical restraint, peer to peer aggression, elopements, non-emergency calls to 911, police intervention, and hospitalization. Persons responsible: QIDP	

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	following: "[On 3/19/23], staff stated [client C] was pacing (a sign of agitation). Staff stated they asked [client C] several times what was wrong. [Client C] stated nothing was wrong, she just wanted to lay down and went to her bedroom. Staff went to check on [client C] shortly after going into her bedroom and found [client C] scratching her arm with a piece of plastic. [Client C] had 3 minor scratches on her left arm that was bleeding. Staff called nurse who instructed staff to call police and ambulance. Once at hospital, wounds were clean, antibiotic cream was applied and left to air dry and heal...." The review did not include an investigation. 3c. A BDDS report dated 5/19/23 indicated client C was put in a two person hold on 5/18/23. The review did not include an investigation. 3d. A BDDS report dated 7/29/23 indicated client C was put in holds twice and received a PRN medication to address her maladaptive behaviors. The review did not include an investigation. AD (Area Director) #1 was interviewed on 9/28/23 at 1:15 pm and indicated restraints should be investigated. AD #1 indicated allegations of abuse and neglect should be thoroughly investigated. 9-3-2(a)			
W 0155 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 24 allegations of abuse, neglect, and mistreatment	W 0155	Corrective action for resident(s) found to have been affected All parts of the POC for the survey	11/06/2023

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	reviewed affecting client B, the facility failed to immediately suspend 2 staff persons involved in an allegation of physical abuse against client B. Findings include: The facility's General Event Reports (GERs), Bureau of Developmental Disabilities Services (BDDS) reports, and related investigations were reviewed on 9/27/23 at 12:00 pm. A BDDS report dated 4/14/23 indicated the following: "Incident Date: 4/13/23. Time: 6:00 pm. A staff called and reported another staff (DSP #3) was sitting on [client B] to prevent her from eloping. Staff also reported [DSP #3] and [DSP #4] poured water on [client B] while she laid on the hot ground." A follow-up dated 5/25/23 indicated the following: '[Client B] was offered emotional support in discussing her feelings about what caused her to want to leave the program location. She utilized positive affirmations and devotionals with staff support and is understanding of what appropriate restraints/supports are. Allegation of abuse was substantiated and staff were terminated. [Client B] had a bruise on her left elbow approximately 1.5 inches in diameter. Yes, BSP (Behavior Support Plan) has HRC (Human Rights Committee) approved restraint in the plan. The restraint used during this event was not an approved or trained technique." An Investigation Summary dated 4/18/23 indicated the following: An interview summary with client B indicated the following: "[Client B] stated that [DSPs #3 and #4] poured		with event ID will be fully implemented, including the following specifics: QIDP was retrained on Dungarvin policy and procedure pertaining to suspending staff immediately when there is an allegation of abuse, neglect, or exploitation. QIDP will be re-trained on 11/6/23 on on-call responsibilities and referring staff to the on-call supervisor to address concerns, reporting, etc after normal business hours to ensure that allegations of abuse, neglect, and exploitation are addressed timely. QIDP has additionally been trained on the on-call system and how it should be utilized. QIDPs that do not follow the on-call system are trained on the expectation that any report and required action thereof is their responsibility to address per 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 QIDPs are being trained on Dungarvin policy pertaining to abuse, neglect and exploitation	

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	water on her when she was laying on the ground. She said they grabbed her hair to try and get her off the ground and then poured water on her. She stated that she was in the front yard in the grass. [Client B] stated that they put hands on her, but she did not remember specifically how they did so.... [Client B] stated that [DSPs #3 and #4] came out and tried to talk to her. She refused to go inside and laid down on the ground. They then poured water on her. 'I think that's not fair.' [Client B] said that [DSP #4] sat on her while she was laying on the ground. When asked if they attempted to do a restraint on her, she said she didn't know. [Client B] stated she had been restrained before and, 'It wasn't like those.'" An interview summary with DSP #5 indicated the following: "[DSP #5] stated that it was her fault that [client B] 'got out' on 4/13/23. She was on [client B's] side (of the home), and everyone else was on the other side.... [DSP #3] called her name, and she saw [client B] outside. [DSP #4] told her to stay with the other individuals and then came back inside and filled up (sic) 'huge red bowls with water.' [DSP #4] threw the first bowl of water on [client B] and came inside to fill up again, and [DSP #3] threw the second bowl of water. [DSP #5] observed [DSP #3] sitting on top of [client B]. [Client B] wasn't fighting back. She was laying in the grass, and they just sat on top of her.... [DSP #5] called [House Manager (HM) #1] and [Qualified Intellectual Disabilities Professional (QIDP) #1] while in the bathroom at the site and then spoke to [QIDP #1] after she had already left the program site." An interview summary with QIDP #1 indicated the		and the suspension of staff when ANE occurs or is suspected. All QIDPs are trained on Dungarvin on-call procedures. Area Directors will review on-call notes from QIDPs weekly. Persons responsible: QIDP, Area Director	

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	following: "[QIDP #1] stated that [DSP #5] contacted her while she was out with her granddaughters. She played phone tag with her and spoke to her on the phone around 6:00 pm. [QIDP #1] notified the Area Director at 9:00 pm. When asked why the delay, she stated again that she had been out with her granddaughters and when she looked at the video sent by [DSP #5], she knew she needed to suspend (staff) and contacted [AD #1]." An interview summary with DSP #2 indicated the following: "[DSP #2] received a call from [HM #1] to come in early on 4/13/23 and arrived around 10:30 pm. Upon arrival, [DSP #2] stated that both [DSPs #3 and #4] were at the program site and shared that [client B] had 'gotten out' and [DSP #5] video taped them. [DSPs #3 and #4] told [DSP #2] that they were being suspended." Findings of Fact: [DSP #3] sat on [client B] while she was laying on the ground. [Client B] has a bruise on her left elbow. [DSPs #3 and #4] were suspended over the phone and remained on shift until 11:00 pm. [DSPs #3 and #4] poured water on [client B]. No [staff communication] was completed for the 3:00 pm to 11:00 pm shift on 4/13/23. No GER was completed for [client B] eloping." An Investigation Plan of Correction Report dated 4/26/23 indicated the following: "Subject of Investigation: Allegation of abuse. Determination of Rights Violation: Staff failed to adequately and appropriately implement BSP reactive and proactive techniques and used			

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	15G791	A. BUILDING 00 B. WING	10/10/2023

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	unauthorized methods to gain compliance from individual. Statement of Conclusion: Based on witness statements and video evidence, the allegation of abuse is substantiated. Staff used water as an aversive technique to gain compliance, and sat on the individual when she was on the ground and not being aggressive. Action Steps: Termination [DSPs #3 and #4]. Warning: [QIDP #1] for failure to take immediate action to suspend staff and relieve staff of duties." The review indicated physical abuse of client B by DSPs #3 and #4 was substantiated. The review indicated QIDP #1 did not immediately respond to DSP #5 when she attempted to report an allegation of abuse. The review indicated QIDP #1 did not instruct DSP #5 to contact an administrator on call, as she was not on duty at the time of the report. The review indicated QIDP #1 failed to immediately report the allegation of abuse to her supervisor and did not immediately take action to prevent further abuse by DSPs #3 and #4. AD (Area Director) #1 was interviewed on 9/28/23 at 1:15 pm and stated, "[DSP #5] was a newer staff. She contacted me on April 14th or 15th and said that she didn't feel comfortable working in the home. She didn't feel comfortable working for a company that did that to individuals. She met with me and said a staff member was sitting on [client B]. The two staff members poured water on [client B] and sat on her. She said she attempted to contact [QIDP #1] about it and wasn't comfortable with how everything played out." AD #1 stated, "The incident occurred on 4/13/23 between 4:30 and 5:00 pm. [DSP #5] was in the			

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	bathroom trying to call [QIDP #1] between 5:00 and 6:00 pm. She texted [QIDP #1] saying she was uncomfortable and was leaving. She clocked out around 5:30 pm. She spoke to [QIDP #1] on the phone." AD #1 stated, "[QIDP #1] reported to me on the 13th that staff had sat on [client B] and poured water on. I'd given the directive to suspend, and we would start an investigation. [QIDP #1] reported to me at 9:00 pm on 4/13/23. She said she suspended the staff at that time. She said they left at that time." AD #1 stated, "I completed the investigation. I substantiated staff pouring water on [client B] and sitting on her." AD #1 stated, "We substantiated that the staff remained on shift after we were aware of it. We continued to put the individuals at risk before the staff were suspended and left the home." AD #1 stated, "If [QIDP #1] was not available to handle the situation, it should have been deferred to the on-call PD (program director), so it could have been handled right away." AD #1 stated, "Both [DSP #3 and #4] were terminated. [QIDP #1] was retrained." 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 3 of 24 allegations of abuse, neglect, and mistreatment reviewed affecting client A, the facility failed to thoroughly investigate 3 physical restraints for client A within 5 business days.	W 0156	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics:	11/04/2023

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	Findings include: The facility's General Event Reports (GERs), Bureau of Developmental Disabilities Services (BDDS) reports, and related investigations were reviewed on 9/27/23 at 12:00 pm. 1a. A BDDS report dated 7/9/23 indicated the following: "[On 7/8/23], [client A] began SIB (self-injurious behavior), aggression, and attempting to leave out of exits in the home through the night. Staffs (sic) made attempts to redirect. She attempted to SIBs (sic) and was physically aggressive with staff. [Client A] had a blank stare. She would briefly calm down (less than 5 mins (minutes)) and become extremely aggressive, screaming, biting herself, grabbing objects to throw or hit herself/staff with. Staff used HWC (Handle with Care) HRC (Human Rights Committee) approved two person hold for 15 minutes in attempts to keep her safe. Staff called 911. The [name] County Police and EMT (emergency medical technician) arrived and took [client A] to [hospital] for observation. Plan to Resolve: [Client A] is currently still at [hospital] for a 72 hour observation per court order which begins on 7/10/23." The review indicated an investigation was completed on 8/1/23. 1b. A BDDS report dated 7/11/23 indicated the following: " [On 7/10/23], started banging her head with her hands and screaming. Staff number 1 used Handle with Care to restrain her from further hurting herself. Staff called for staff number 2 to assist with a two-person body hug. Staff 3 arrived and switched out staff. [Client A] calm and given		QIDP was retrained on 10/30/23 on conducting thorough investigations of significant incidents, including physical and chemical restraint, peer to peer aggression, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP also received retraining on the importance of critically analyzing all possible causes when investigating significant incidents, to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated and within the required timeline. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective. QIDP is implementing aggressive documentation review and check ins with the individuals served and the staff on duty to ensure that all concerns are being accurately documented and reported. Area Director is reviewing actions taken to fully implement this plan of correction during weekly supervision with the QIDP.	

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	a PRN per nurse [client A] (sic). She was given Alprazolam 1 mg tablet. [Client A] calmed down shortly after the PRN took a 30 minute nap. [Client A] was in behavior on and off throughout the shift, but no holds were required. [Client A] was closely monitored throughout the shift." An investigation dated 8/1/23 indicated the incident was not thoroughly investigated within 5 business days. 1c. A BDDS report dated 7/23/23 indicated client A was put in a one arm standing restraint for 6 minutes. An investigation dated 8/15/23 indicated the incident was not thoroughly investigated within 5 business days. AD (Area Director) #1 was interviewed on 9/28/23 at 1:15 pm and indicated allegations of abuse and neglect should be thoroughly investigated within 5 business days. 9-3-2(a)		All issues reviewed and action taken are reviewed during this supervision meeting so that the Area Director can verify that appropriate measures are being taken to thoroughly investigate all allegations of abuse, neglect and mistreatment at the facility, including physical and chemical restraint, peer to peer aggression, elopement, 911 calls, police intervention, and other events that pose a risk to the health and safety of the individuals served at the facility. 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 QIDPs are being trained to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including physical and chemical restraint, peer to peer aggression, elopements, non-emergency calls to 911, police intervention, and hospitalization. Going forward, the Area Director will review GERs, BDS incident reports, and Therap documentation weekly with the QIDP to ensure incident	

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			investigation timelines are met. Persons responsible: QIDP, Area Director	
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 1 of 2 sample clients (A), the facility failed to promote client A's dignity in regards to her appearance. Findings include: Observations were conducted in the group home on 9/27/23 from 4:45 pm to 7:45 pm and on 9/28/23 from 8:15 am to 9:30 am. Client A was present throughout the observation periods. Throughout the observation periods, client A wore black pants with rips approximately 4 inches high above each knee. The material of client A's pants was ripped across the front of her thigh from one side seam to the other. The material was missing from her pants. Client A's pants were also ripped across the front of her pants from the seam at the crotch of her pants to each side seam and to just below her hips. Client A's underwear was visible when she walked and sat throughout the observation periods. Client A's shirt was not long enough to cover her hips and upper thighs. Direct Support Professional (DSP) #5 was interviewed on 9/27/23 at 7:00 pm and stated, "[Client A] has been ripping her clothes up. She asks for ripped pants. It's what she wants." DSP #6 was interviewed on 9/28/23 at 6:30 am and	W 0268	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on individual rights and dignity on 10/30/23. An inventory of Client A's clothing will be completed to ensure she continues to have appropriate clothing available to her. The QIDP, Area Director or other qualified supervisory staff are responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on what individual rights and dignity are, and that Client A is dressed appropriately and not indecently exposed. Initially these observations will be conducted at least 2 times per week for the first three weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks.	11/04/2023

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	stated, "[Client A] is struggling with adjustment to [House Manager (HM) #1] being gone. She ripped up everything [HM #1] had brought for her. She ripped up her pants." Area Director (AD) #1 was interviewed on 9/28/23 at 1:15 pm and stated, "[Client A] started ripping her clothing. She started biting it. She bends over and bites the crotch of her pants and tears it with her teeth. She rips it and tries to flush it down the toilet." AD #1 stated, "It's something we haven't seen before. She is doing it as a way to get attention from staff." AD #1 stated, "If she's not exposing herself inappropriately, staff allow her to wear it until it's an appropriate time to change. They shouldn't give her extra attention for tearing her clothing to help curb that behavior." AD #1 stated, "Torn pants should have been removed and thrown away. Staff need to do an inventory of her clothing. They should give her a longer shirt to put on, so she's not exposed." 9-3-5(a)		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 facility staff are trained on individual rights and dignity upon hire, annually and as needed. All QIDPs are trained on individual rights and dignity. QIDP and behavior clinician will conduct observations in the home multiple times per week and will provide retraining and coaching to facility staff as needed immediately. Persons responsible: QIDP, Area Director	
W 0290 Bldg. 00	483.450(b)(5) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Standing or as needed programs to control inappropriate behavior are not permitted. Based on record review and interview for 2 of 2 sample clients (A and B), the facility failed to ensure clients A and B's Behavior Support Plans (BSPs) indicated when and how their PRN (as needed) medications should be used to address their maladaptive behaviors.	W 0290	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics:	11/06/2023

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	Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 9/28/23 at 12:00 pm. 1. Client A's BDDS reports indicated her PRN medication Alprazolam (self-harm and aggression) 1 mg (milligram) was administered on 7/9/23 and did not indicate a nurse approved the medication. Client A's record was reviewed on 9/28/23 at 11:00 am. Client A's Medication Administration Record (MAR) for September 2023 indicated the following medications used as needed to manage her maladaptive behaviors: "Alprazolam 1 mg tablet. Indication/Purpose: Actively self-harming or aggressive. Cannot redirect. Give 1 tablet by mouth every 12 hours as needed for anxiety." Client A's BSP dated 8/23/23 did not include specific instructions for staff regarding administration of client A's PRN psychiatric medication. 2. Client B's BDDS reports indicated her PRN medication Clonazepam (anxiety) 0.5 mg was administered on 7/16/23, 7/19/23, twice on 7/21/23, 7/22/23, and did not indicate a nurse approved the medication. Client B's record was reviewed on 9/28/23 at 12:05 pm. Client B's MAR for September 2023 indicated the following medications used as needed to manage her maladaptive behaviors: "Clonazepam 0.5 mg tablet. Indication/Purpose:		Client A' BSP will be updated with a PRN protocol for maladaptive behaviors, including who can authorize, when to administer, and how to document. Client B' BSP will be updated with a PRN protocol for maladaptive behaviors, including who can authorize, when to administer, and how to document. Nurse will create PRN risk plans for Client A and B for psychotropic medications used for managing maladaptive behaviors. Going forward the behavior clinician will notify the nurse of any changes during psychiatry appointments; the nurse will update the PRN risk plans and the behavior clinician will update the BSP for HRC approval. 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: Nurse will update risk plans for PRN psychotropic medications used to manage maladaptive behaviors when medication changes are made by the psychiatrist. Behavior Clinician will update program site with HRC approved BSPs annually and as	

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	Anxiety disorder. Give 1 tablet by mouth twice a day as needed." Client B's BSP dated 8/27/23 did not include specific instructions for staff regarding administration of client B's PRN psychiatric medication. Area Director (AD) #1 was interviewed on 10/2/23 at 10:07 am and stated, "The BSP should indicate when and how to give PRN medications." Licensed Practical Nurse (LPN) #1 was interviewed on 10/10/23 at 10:00 am and stated, "For PRN medications, the nurse has to be called and the PD (Program Director) both. The PD cannot approve them on their own. They need to be made aware because they are the one who does the state reports. The nurse gives permission." LPN #1 stated, "It's protocol, but it also should be in their BSP." Nurse Manager #1 was interviewed on 10/10/23 at 9:20 am and stated, "There should be a written plan of when to call the nurse for a PRN medication. It's also taught in our medication classes and reinforced when we're in the home." 9-3-5(a)		needed for revisions to plan and/or medication changes. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. Persons responsible: QIDP, nurse, behavior clinician, Area Director -	
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 2 sample clients (A), the facility failed to ensure client A's Behavior Support Plan (BSP) goals were	W 0312	Corrective action for resident(s) found to have been affected All parts of the POC for the survey	11/06/2023

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	achievable and included criteria for discharge from the Extensive Support Needs (ESN) home. Findings include: Client A's record was reviewed on 9/28/23 at 11:00 am. Client A's Medication Administration Record (MAR) for September 2023 indicated the following medications were used to manage client A's target behaviors: "Chlorpromazine 20 mg (milligram) tablet. Indication/Purpose: To help calm down mood swings and help decrease aggression. Divalproex 250 mg tablet. Indication Purpose: Mood disorder. Lorazepam 1 mg tablet. Indication/Purpose: To help with anxiety, aggravation, and mood disorder. Naltrexone 50 mg tablet. Indication/Purpose: Mood disorder. Paliperidone 6 mg tablet. Indication/Purpose: Mood disorder. Quetiapine 400 mg tablet. Quetiapine 200 mg tablet. Indication/Purpose: Bipolar disorder. Alprazolam 1 mg tablet. Indication/Purpose: Anxiety. Actively self-harming or aggressive. Cannot redirect." Client A's BSP dated 8/23/23 did not include discharge criteria. Client A's BSP indicated the following: Target Behaviors: Physical Aggression: This behavior occurs on average once a month. April 2023 - 2 incidents, May 2023 - 3 incidents, June 2023 - 0 incidents, July 2023 - 8 incidents, August 2023 2 incidents, September 2023 - 2 incidents.		with event ID will be fully implemented, including the following specifics: ·Behavior clinician will update Client A's BSP with an appropriate medication reduction plan. ·Behavior clinician will update Client A's discharge criteria outlined in the BSP so that it is achievable for her to meet discharge from an ESN setting. The Behavior Clinician is involved in all psychiatry appointments and will obtain HRC approval for psychotropic medications. The behavior clinician will work with the psychiatrist and interdisciplinary team to create appropriate medication reduction plans The behavior clinician, QIDP and/or Area Director will review discharge criteria quarterly to determine if criteria is still appropriate and progress towards discharge. 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: Behavior Clinician will update program site with HRC approved	

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	Self-Injurious Behavior: This behavior occurs on average 4 times a month. April 2023 - 1 incident, May 2023 - 8 incidents, June 2023 - 1 incident, July 2023 - 1 incident, August 2023 - 1 incident. Manipulation: This behavior occurs on average daily, typically when new staff are in the home. April 2023 - 1 incident, May 2023 - 2 incidents, June 2023 - 0 incidents, July 2023 - 3 incidents, August 2023 - 1 incident, September 2023 - 1 incident. Property Destruction: This behavior occurs on average twice a month. April 2023 - not indicated, May 2023 - not indicated, June 2023 - 0 incidents, July 2023 - 4 incidents, August 2023 - 4 incidents, September 2023 - 4 incidents. Attention Seeking was indicated as a behavior being tracked but was not indicated in client A's BSP. April 2023 - 1 incident, May 2023 - 4 incidents, June 2023 - 1 incident, July 2023 - 4 incidents, August 2023 - 3 incidents, September 2023 - 2 incidents. Client A's BSP indicated the following goals: "[Client A] will decrease her physical aggression to 3 incidents for 6 consecutive months. [Client A] will decrease her manipulation to 0 incidents for 6 consecutive months. [Client A] will decrease her property destruction to 0 incidents for 6 consecutive months. [Client A] will decrease her self-injurious behavior to 3 reported incidents for 6 consecutive months. [Client A] will decrease her attention seeking tactics to 0 incidents for 6 consecutive months." Client A's BSP indicated the following medication reduction plan: "Once [client A's] targeted behaviors occur at a		BSPs annually and as needed for revisions to plan and/or medication changes, including changes to medication reduction plans and discharge criteria. QIDP and Nurse is to audit MAR, BSPs and Therap for HRC approved medications and BSPs and will also report any non-compliance to Area Director for follow up. Going forward the behavior clinician, QIDP, and Area Director will review discharge criteria quarterly to determine appropriateness and progress. Persons responsible: behavior clinician, QIDP, nurse, Area Director	

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	rate of 0 incidents for 3 consecutive months, [client A's] treatment team will collaborate with her prescribing psychiatrist to develop an appropriate medication reduction plan." Area Director (AD) #1 was interviewed on 10/2/23 at 10:07 am and stated, "Zero behaviors is not achievable. Behavior goals should be achievable." 9-3-5(a)			
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 1 of 2 sample clients (B), the facility's nursing services failed to ensure client B's physician recommendations were followed for her ovarian cyst, her medication side effects were addressed, and her dental recommendations were followed. Findings include: Client B's record was reviewed on 9/28/23 at 12:05 pm. 1. A gynecologist note dated 6/30/23 indicated the following: "Ovarian cysts. Check ultrasound in 6 - 8 weeks and schedule follow up appointment with me after the ultrasound to review." The note indicated a follow up appointment was scheduled for 8/28/23. A note dated 7/31/23 indicated an ultrasound was completed.	W 0331	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: QIDP, House Coordinator, and/or med DSP will meet with the nurse every other week, if not weekly, to review medical appointments. It will include any missed or cancelled appointments or appointments rescheduled due to individual refusal. All facility staff were retrained on 10/30/23 on changes in condition in individuals and documentation of side effects of medications. QIDP, House Coordinator, and/or med DSP will update consultation forms with concerns discussed with nursing staff for	11/04/2023

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	The review did not indicate client B had seen her gynecologist to follow up and did not have an appointment scheduled. Area Director (AD) #1 was interviewed on 10/2/23 at 10:07 am and stated, "The follow up should have been scheduled." Licensed Practical Nurse (LPN #1) was interviewed on 10/10/23 at 10:00 am and stated, "The appointment should be rescheduled. They wanted to make sure the cyst wasn't too large and if it would need to be removed." Nurse Manager #1 was interviewed on 10/10/23 at 9:20 am and stated, "The follow up should have happened." 2. Observations were conducted in the group home on 9/27/23 from 4:45 pm to 7:45 pm and on 9/28/23 from 8:15 am to 9:30 am. Client B was present throughout the observation periods. Throughout the observation periods, client B's hands and head shook. She sat slumped over with her head down. Client B's hair was thin and appeared brittle. Her speech was slow and slurred. Client B was interviewed on 9/27/23 at 7:15 pm and stated, "I don't know why I'm shaking. I move slow, and I have trouble thinking and concentrating. My hair is falling out, and I'm losing weight." DSP #5 was interviewed on 8/27/23 at 7:00 pm and stated, "[Client B's] tremors are a side effect of her medication. The nurse is aware. Her hair falling out is also a side effect."		appropriate follow up. Nurse will submit weekly assessments and appointment reviews to nursing manager and Area Director for review. 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 nurses are trained on assessments and appointments. All facility staff, QIDP, House Coordinator and med DSP are trained on medical appointment documentation upon hire and as needed. All facility staff are trained on tracking side effects and reporting/documenting changes in condition. Nursing manager will audit nursing assessments and appointment review and will report concerns to QIDP and Area Director as needed. Persons responsible: QIDP, house coordinator, Nurse, Area Director	

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	Direct Support Professional (DSP) #6 was interviewed on 9/28/23 at 6:30 am and stated, "[Client B] was in the hospital about a month ago. They changed her meds (medications). She started losing weight and shaking. It's been reported to the nurse. She knows." DSP #6 stated, "She had to have a one to one staff because she was shaking so bad. She couldn't walk." DSP #6 stated, "Her hair loss is also recent. I think it's because of her meds." A staff note dated 8/30/23 indicated client B participated in a telehealth appointment with her psychiatrist and indicated the following: "Behaviors reported. Medications changed per doctor. Depakote (mood disorder) increased to three times a day. Guanfacine (ADHD (Attention Deficit Hyperactivity Disorder)) added. Follow up on 11/1/23." The staff note did not indicate client B's tremors, hair loss, and difficulty in ambulation was discussed with the psychiatrist. Client B's record indicated medication side effects were being tracked. Tremors, hair loss, and lethargy were not symptoms included in the tracking. Client B's record did not include staff notes reporting their concerns to the nurse or Qualified Intellectual Disabilities Professional (QIDP). AD #1 was interviewed on 10/2/23 at 10:07 am and stated, "[Client B] had tremors before her hospitalization. They would get worse when she had extreme ranges in emotion. She would shake more. She also makes herself shake more to get attention from staff." AD #1 stated, "She didn't have trouble walking. Assisting her with trouble walking would not have been normal. She had been sitting and laying for about a week in the			

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	hospital. She might have been more weak than usual." AD #1 stated, "To my knowledge, the hair loss is new." AD #1 stated, "Typically the nurse attends the psychiatrist appointments. The Behavior Clinician (BC) is supposed to attend, too." AD #1 stated, "The hair loss and other concerns should have been mentioned to the psychiatrist." LPN #1 was interviewed on 10/10/23 at 10:00 am and stated, "I'm not at the appointments. I don't know what is discussed. I can address it with the staff at the house to bring it up to the doctor." LPN #1 stated, "The psychiatrist has made numerous changes just since August." LPN #1 stated, "This is not the first time her hair has fallen out. She will also pull it out herself." LPN #1 stated, "Medication side effects are tracked by staff." 3. The facility's nursing services failed to ensure client B was seen by a dentist as recommended. Please see W356. 9-3-6(a)			
W 0350 Bldg. 00	483.460(e)(3) DENTAL SERVICES The facility must provide education and training in the maintenance of oral health. Based on record review and interview for 2 of 2 sample clients (A and B), the facility failed to ensure clients A and B had goals to address their dental hygiene needs. Findings include: 1. Client A's record was reviewed on 9/28/23 at 11:00 am.	W 0350	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: ISP goal for Client A to address deficiencies in oral dental hygiene was started on 11/2/23.	11/04/2023

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	Client A's most recent dental visit dated 8/16/23 indicated the following: "Diagnoses: Gingival hyperplasia all quads (overgrowth of gum tissue). Gingivectomy 4 quads (removal of gum tissue to prevent damage to the bone. Recall exam in any office 6 months." Client A's ISP (Individual Support Plan) dated 5/1/23 did not include a dental hygiene goal to teach client A to improve her oral health. 2. Client B's record was reviewed on 9/28/23 at 12:05 pm. Client B's most recent dental visit dated 5/5/22 indicated the following: "Patient reported pain with eating and brushing lower front teeth.... No decay. Gums on lower front teeth are slightly inflamed with light to moderate tartar and bleeding. Patients pain is likely gum related. Patient stated she brushes about 2 times a week and never flosses. Stressed flossing at least 2 times a week and brushing 2 times a day, angling the toothbrush towards gum line and brushing in gentle circles. Patient is also 6 months late for cleaning. Stressed 6 month recall. Follow up Appointment? Yes. After 11/6/22. Call us after 10/10/22." Client B's ISPs dated 5/4/22 and 8/8/23 did not include a dental hygiene goal to teach her to improve her oral health. Area Director (AD) #1 was interviewed on 10/2/23 at 10:07 am and stated, "They should have a goal to address their dental hygiene." 9-3-6(a)		ISP goal for Client B to address deficiencies in oral dental hygiene was started on 11/2/23. Going forward the QIDP will review appointment outcomes and notes and update or create ISP goals as 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: All QIDPs are trained on creating ISP goals. QIDP will monitor appointments and goals monthly to ensure goals and health needs are addressed. Area Director will review ISP goals and appointment outcomes at least quarterly to ensure all health goals are addressed. **Persons responsible: QIDP, Area Director**	

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W 0356 Bldg. 00	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 2 sample clients (B), the facility failed to ensure client B was seen by a dentist as recommended. Findings include: Client B's record was reviewed on 9/28/23 at 12:05 pm. Client B's most recent dental visit dated 5/5/22 indicated the following: "Patient reported pain with eating and brushing lower front teeth.... No decay. Gums on lower front teeth are slightly inflamed with light to moderate tartar and bleeding. Patients pain is likely gum related. Patient stated she brushes about 2 times a week and never flosses. Stressed flossing at least 2 times a week and brushing 2 times a day, angling the toothbrush towards gum line and brushing in gentle circles. Patient is also 6 months late for cleaning. Stressed 6 month recall. Follow up Appointment? Yes. After 11/6/22. Call us after 10/10/22." An undated handwritten note attached to the dentist's consultation form dated 5/5/22 indicated the following: "3/16/23 - canceled. Insurance won't pay. Too soon. 9/25/23 - canceled. Dentist had emergency. Rescheduled to 10/27/23."	W 0356	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: Client B had a dental appointment on 10/27/23. The QIDP, Nurse, house coordinator and med DSP were retrained on Dungarvin procedure pertaining to medical directives and adaptive equipment costs if not covered by insurance. The QIDP, nurse, nursing manager, and/or Area Director will conduct bi-monthly reviews of appointments to determine trends in missed appointments, if applicable, and confirm that follow up to completed appointments is scheduled appropriately. 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	11/04/2023

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	Area Director (AD) #1 was interviewed on 10/2/23 at 10:07 am and stated, "The re-visit should happen as recommended by the dentist. It's something Dungarvin would cover to ensure she was getting the treatment she needed." Licensed Practical Nurse (LPN) #1 was interviewed on 10/10/23 at 10:00 am and stated, "If the dentist recommended a 6 month revisit, it should be done. If the insurance won't pay, Dungarvin would just have to eat it." Nurse Manager #1 was interviewed on 10/10/23 at 9:20 am and indicated the dentist recommendations should be followed. 9-3-6(a)		recurrence: All facility staff are trained on appointments and appointment documentation requirements and expectations. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the QIDP and Area Director for follow up. Nursing manager and Area Director will audit appointments for trends and completion. Persons responsible: QIDP, house coordinator, nurse, Area Director	
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview for 2 of 2 sample clients (A and B), plus 2 additional clients (C and D), the facility failed to provide clients A, B, C, and D with a beverage at meal times. Findings include: Observations were conducted in the group home on 9/27/23 from 4:45 pm to 7:45 pm and on 9/28/23 from 8:15 am to 9:30 am. Clients A, B, C, and D were present in the home for the duration of the observation period. 1. On 9/27/23 at 6:30 pm, clients A, B, C, and D	W 0460	Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were retrained on 10/30/23 on following dining risk plans and providing beverages at mealtimes. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying	11/04/2023

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	were served baked chicken thighs and legs with corn, green beans, and noodles. Clients A, B, C, and D were not offered a beverage until they were finished eating. At 6:45 pm, Direct Support Professional (DSP) #5 stated, "Do you all want a (flavored drink) pack?" Clients B and C left their plates at the table and followed DSP #5 to the medication room. Clients B and C returned with foil drink packages with a straw. DSP #5 gave clients A and D their drinks. 2. On 9/28/23 at 9:18 am, clients A, C, and D were served toast with jelly and a sausage patty. Clients A, C, and D were not offered a beverage until they finished eating. At 9:21 am, Client A asked for milk. House Manager (HM) #2 told client A to wait. At 9:23 am, client D pushed her chair back from the table and stated, "I want some milk." HM #2 stated, "I'll get you some." HM #2 took client D's plate from the table and put it in the sink. HM #2 gave client D a cup of milk. At 9:23 am, client A again asked for milk. HM #2 and DSP #7 did not respond to client A's request. At 9:27 am client A went to the kitchen and asked for milk. DSP #7 stated, "I know [client A]. I'm getting it." DSP #7 gave client A a cup of milk. DSP #7 was interviewed on 9/28/23 at 9:33 am and stated, "If we give them a drink, they won't eat. We wait until they are done eating." Area Director (AD) #1 was interviewed on 10/2/23 at 10:07 am and stated, "They should have drinks at meals. They normally have a choice of what is on the menu. They have their cups of water or their preferred beverage." AD #1 stated, "[Client A] will drink her drink and not want to eat her food. Staff should do prompts for her." 9-3-8(a)		times of the day to ensure that facility staff demonstrate following dining plans and provide adequate beverages during mealtimes to individuals. Initially these observations will be conducted 2 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 1 time per week for the next two weeks and then titrate to 1 time per month for 2 months. 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 individual risk plans and dining plans. All staff are required to complete annual retraining on dining plans or when they are updated. QIDP is to maintain a regular, frequent presence in the home and provide direct coaching and redirection to any staff who fail to follow policy and training. Nurse will also report any violations to the QIDP and Area Director for follow up.	

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W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: (11) An emergency intervention for the individual resulting from b. a medical or psychiatric condition; (18) Use of any PRN (as needed) medication related to an individual's behavior; (19) Use of any physical or manual restraint. This state rule was not met as evidenced by: Based on record review and interview for 2 of 3 sample clients (A and B), the facility failed to report to the appropriate state authority within 24 hours of knowledge for client A the use of PRN (as needed) medications used to control maladaptive behavior on two occasions, for client B on three occasions, and one hospitalization for client A. Findings include: The facility's General Event Reports (GERs), Bureau of Developmental Disabilities Services	W 9999	Persons responsible: QIDP, nurse, Area Director Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID will be fully implemented, including the following specifics: All facility staff were trained on 10/30/23 on abuse, neglect, and exploitation, and when suspected abuse, neglect, exploitation should be reported. Training included what events are reportable, who to report to, timeline of reporting, documentation expectations, and a competency assessment. QIDP was trained on 10/30/23 on conducting thorough investigations of significant incidents, including PRN medication administration as a chemical restraint, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP was also trained on the importance of critically analyzing all possible causes when investigating significant incidents, in order to create a corrective action plan to effectively prevent recurrence of the type of incident being investigated. Going forward, during weekly	11/04/2023

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	(BDDS) reports, and related investigations were reviewed on 9/27/23 at 12:00 pm. 1a. A BDDS report dated 7/22/23 indicated client A was administered Alprazolam (treats anxiety) 1 mg (milligram) PRN (as needed) on 7/9/23 due to physical aggression. The review indicated the PRN chemical restraint was not reported within 24 hours of knowledge. 1b. A BDDS report dated 7/17/23 indicated client A was admitted to an inpatient psychiatric facility on 7/11/23. The review indicated client A's hospitalization was not reported to BDDS within 24 hours of knowledge. 2a. A BDDS report dated 7/18/23 indicated client B's PRN medication was administered on 7/14/23. The review indicated the chemical restraint was not reported within 24 hours of knowledge. 2b. A BDDS report dated 7/22/23 indicated client B's PRN medication was administered on 7/16/23. The review indicated the chemical restraint was not reported within 24 hours of knowledge. 2c. A BDDS report dated 7/22/23 indicated client B's PRN medication was administered on 7/19/23. The review indicated the chemical restraint was not reported within 24 hours of knowledge. 3a. A BDDS report dated 3/12/23 indicated client A was put in a 2 person hold for 10 minutes and injured her right wrist resulting in minor bruising. The review indicated the restraint was not reported within 24 hours of knowledge. AD (Area Director) #1 was interviewed on 9/28/23 at 1:15 pm and stated, "PRN medications are		supervision meetings with the Area Director, the QIDP will review the status of every major incident currently under review, and the QIDP will be responsible to present the status of each investigation to ensure that the investigations and resulting action plans are timely, thorough, and effective. Late submission of incident reports will result in disciplinary action according to Dungarvin policy and procedure for failure to meet state requirements. 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 facility staff have been trained on abuse, neglect, exploitation and incident reporting expectations to ensure health and safety of all individuals. All Program Directors/QIDPs have been trained on mandatory investigation components, investigation timelines, and to complete thorough, timely investigations of all significant incidents which could be indicative of abuse, neglect, or exploitation, including PRN medication administration as a chemical	

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	reported to BDDS within 24 hours." AD #1 indicated allegations of abuse and neglect should be reported immediately by staff and to BDDS within 24 hours of knowledge. 9-3-1(a)		restraint, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP will submit incident report to BDS timely, within the 24 hours. Area Director will review all incident reports at least monthly for timely submission and address late submissions accordingly. Persons responsible: QIDP, Area Director	