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	11/27/2023

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

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W 0000 Bldg. 00	This visit was for the Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey and to the investigation of complaint #IN00411727 completed on 10/10/23. Complaint #IN00411727: Not corrected. Dates of survey: November 21 and 27, 2023. Facility Number: 012557 Provider Number: 15G791 AIMS Number: 201017960A These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/7/23.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 2 of 2 sample clients (A and B), plus 2 additional clients (C and D), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure client B's bedroom closet and furniture in clients B and D's shared living room were in good repair. Findings include: An observation was conducted in the group home on 11/21/23 from 9:15 am to 10:15 am. Clients A, B, C, and D were present in the home throughout the	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: The hole in the closet wall in Client B's bedroom was patched and painted by maintenance personnel on 12/19/23. A new couch has been ordered to replace the broken one in the living room on clients B and D's side and is anticipated to be	12/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Greta Goins	Area Director	12/21/2023

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	observation period. 1. In client B's closet, there was a hole in the wall measuring 1 foot by 1 foot. The drywall was completely removed, and the insulation inside the wall was visible. The bottom foot of the closet across the width of the closet had been patched but was not painted. Area Director (AD) #1 was interviewed on 11/27/23 at 10:35 am and stated, "I'm not sure if it has been reported. I haven't seen a maintenance request. The House Manager (HM) and PD (Program Director) typically fill out the maintenance request, and it goes straight to the maintenance department. It should have been fixed." 2. In the living room on clients B and D's side of the home, there was a large recliner and a three seat sofa with two reclining sections. The foot rest of the recliner and both sides of the sofa were broken. The foot rests would not go all the way down or up. On the left side of the sofa, the hinges of the foot rest were broken and were touching the floor. Direct Support Professional (DSP) #1 was interviewed on 11/21/23 at 10:00 am and stated, "They're broken. It's been that way for years. It has been reported to administration." HM #1 was interviewed on 11/21/23 at 9:55 am and stated, "All of the foot rests are broken. The recliner and sofa." AD #1 was interviewed on 11/27/23 at 10:35 am and stated, "I do not know if the furniture has been reported or looked at. I asked the maintenance manager to look at it. I haven't had		delivered in January. The house coordinator completes a monthly site risk management form and will document maintenance requests that are still outstanding. Going forward, during weekly supervision meetings with the Area Director, the QIDP will review the status of maintenance requests so that additional follow up with maintenance can occur timely. 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 proper procedure for submitting maintenance requests to ensure health and safety of all individuals in the physical plant of the facility. All Program Directors/QIDPs have been trained maintenance request procedures and appropriate follow up. House coordinators will document outstanding maintenance requests on the monthly site risk management forms that are reviewed monthly by the Program Director. Persons responsible: QIDP, house	

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	any follow up on it. If it can't be fixed, we will have to replace it." This deficiency was cited on 10/10/23. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00411727. 9-3-1(a)		coordinator, maintenance	
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 2 of 2 sample clients (A and B), the facility failed to ensure clients A and B's Behavior Support Plan (BSP) goals were achievable and included criteria for discharge from the Extensive Support Needs (ESN) home. Findings include: 1. Client A's record was reviewed on 11/27/23 at 10:00 am. Client A's BSP dated 11/23/23 indicated the following behavior goals and discharge criteria: "[Client A] will decrease her physical aggression to 3 incidents for 6 consecutive months." The review indicated client A had engaged in physical aggression 19 times in the 6 month period May 2023 through October 2023. "[Client A] will decrease her manipulation to 3 incidents for 6 consecutive months."	W 0312	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: ·Behavior clinician will update Client A and B's discharge criteria outlined in the BSP so that it is achievable for them to meet discharge from an ESN setting. The behavior clinician manager, QIDP and Area Director met on 12/21/23 to discuss discharge criteria for all supported individuals and the ISTs will review at routine meetings to determine if criteria is still appropriate and progress towards discharge. How facility will identify other	12/21/2023

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	The review indicated client A had engaged in manipulation 16 times in the 6 month period May 2023 through October 2023. "[Client A] will decrease her property destruction to 0 incidents for 6 consecutive months." The review indicated client A had engaged in property destruction 13 times in the 6 month period May 2023 through October 2023. "[Client A] will decrease her self-injurious behavior (SIB) to 0 reported incidents for 6 consecutive months." The review indicated client A engaged in SIB 22 times in the 6 month period May 2023 through October 2023. "[Client A] will decrease her attention-seeking tactics to 3 incidents for 6 consecutive months." The review did not include data for this goal in the 6 month period May 2023 through October 2023. 2. Client B's record was reviewed on 11/27/23 at 10:10 am. Client B's BSP dated 10/2/23 indicated the following behavior goals and discharge criteria: "[Client B] will decrease incidents of flight response behavior to 0 incidences for 3 consecutive months (requesting to call 911, requesting to go to the hospital, pulling the fire alarm)." The review did not include data for this goal in the 3 month period August 2023 to October 2023. "[Client B] will decrease incidences of self-injurious behavior to 0 incidences for 3 consecutive months (false attempts to self-harm in addition to actual attempts)." The review indicated client B engaged in SIB 3 times in April 2019.		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 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. Person responsible: behavior clinician manager	

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	The review did not include data for this goal in the 3 month period August 2023 to October 2023. "[Client B] will decrease her physical aggression to 0 incidences for 3 consecutive months." The review indicated client B engaged in physical aggression 4 times in April 2019. The review did not include data for this goal in the 3 month period August 2023 to October 2023. "[Client B] will decrease her property destruction to 0 incidences for 3 consecutive months." The review indicated client B engaged in property destruction 6 times in April 2019. The review did not include data for this goal in the 3 month period August 2023 to October 2023. "[Client B] will decrease her elopement to 0 incidences for 3 consecutive months." The review indicated client B attempted to elope 5 times in April 2019. The review did not include data for this goal in the 3 month period August 2023 to October 2023. "[Client B] will decrease suicidal behavior to 0 incidences for 3 consecutive months." The review indicated client B engaged in suicidal behavior 7 times in April 2019. The review did not include data for this goal in the 3 month period August 2023 to October 2023. "[Client B] will decrease verbal aggression to 0 incidences for 3 consecutive months." The review indicated client B engaged in verbal aggression 3 times in April 2019. The review did not include data for this goal in the 3 month period August 2023 to October 2023. "[Client B] will decrease false allegations and manipulation to 0 incidences for 3 consecutive			

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	months." The review did not include data for this goal in the 3 month period August 2023 to October 2023. Area Director (AD) #1 was interviewed on 11/27/23 at 10:35 am and stated, "Zero behaviors for 3 months is not achievable. I spoke to the Behavior Clinician (BC) manager about it. We need to review the data to determine an achievable goal for them. The more serious ones, like elopement, we do want to extinguish those. Some of them, we will never extinguish. [Client A] will never stop SIB. We can help her to reduce it, but it will never stop." AD #1 stated, "The discharge criteria is in the BSP. It is the behavior goals. The wording is vague and isn't specific enough." This deficiency was cited on 10/10/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-5(a)			
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 and interview for 1 of 2 sample clients (A), plus 1 additional client (D), the facility failed to ensure clients A and D were given a beverage with their meals. Findings include: An observation was conducted on 11/21/23 from 9:15 am to 10:15 am. Clients A and D were present in the home throughout the observation period.	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: Site nurse created dining risk plans for clients A and D. All facility staff were trained on the dining risk plans and	12/21/2023

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	At 9:18 am, clients A and D were served oatmeal, toast, and oranges without a beverage. At 9:26 am, clients A and D finished their meals and took their plates to the kitchen. Clients A and D were provided beverages by staff. Direct Support Professional (DSP) #1 was interviewed on 11/21/23 at 9:26 am and stated, "If they have a drink, they won't eat." Area Director (AD) #1 was interviewed on 11/27/23 at 10:35 am and stated, "There should be a drink available while eating. They only had big cups at the home, and staff were concerned they would drink the entire drink and wouldn't eat anything. I asked them to purchase smaller 8 ounce cups. Those were supposed to have been purchased for them to use." This deficiency was cited on 10/10/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-8(a)		providing small amounts of beverages throughout meal and snack times. The QIDP, Nurse, Area Director or other qualified supervisory staff will be responsible to conduct active treatment observations at varying 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	

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			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. Persons responsible: QIDP, Area Director, house coordinator	
W 9999 Bldg. 00	State Findings 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: 19) Use of any physical or manual restraint regardless of: a. planning; b. human rights committee approval; c. informed consent. This state rule was not met as evidenced by: Based on record review and interview for 1 of 1 physical restraint for client A, the facility failed to report one physical restraint for client A to the appropriate state authority within 24 hours of knowledge in accordance with state law. Findings include: The facility's General Event Reports (GERs), Bureau of Disability Services (BDS) reports, and related investigations were reviewed on 11/21/23 at 11:08 am.	W 9999	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 did complete a BDS initial incident report for Client A pertaining to the physical restraint on 11/12/23. A copy of the incident report is uploaded with this submission. QIDP and the administrative coordinator are creating updated survey books to ensure that all BDS incident reports are available and ready for auditing. QIDP completed an incident investigation into the physical restraint on 11/12/23 and it is uploaded with this submission. 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	12/21/2023

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	A GER dated 11/12/23 indicated the following: "[Client A] was up and bouncing on her ball this evening when I arrived. At dinner time, she ate dinner and washed out her plate and her table area. Afterwards, [client A] was on her ball after dinner and urinated on her ball. [Client A] was in time out. She was instructed to cleaned (sic) off her ball with a disinfectant wiped (sic). She was in her room. [Client A] took off her clothes and then defecated on her clothes. She was prompted to clean up her mess. She put on a robe and got gloves to clean up the mess. She was supervised as she cleaned the feces out of her clothes and then was instructed to mop out her room. She tried to tip over the mop bucket and had to (sic) put in a 2 person body hold for 15 minutes to until calm. She finished mopping (sic) floor then she took her shower and got dressed. (Sic) took her medications for the night. Her soiled clothes and bed sheets were washed as well. [Client A] went to bed afterwards with no issues." The review did not indicate the physical restraint was reported to BDS. Area Director (AD) #1 was interviewed on 11/27/23 at 10:35 am and stated, "There are no BDS reports. The 2 person hold should have been reported. Staff need to call the on-call supervisor or PD (program director) if it was during business hours. That person completes the BDS report. The AD (Area Director) is also supposed to be made aware of those. I was not made aware." This state rule was cited on 10/10/23. The facility failed to implement a systemic plan of correction to prevent recurrence.		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 restraint, elopements, non-emergency calls to 911, police intervention, and hospitalization. QIDP will submit	

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	9-3-1(b)		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	