STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G573	A. BUILDING 00 B. WING	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	51778 TROWBRIDGE LN SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 predetermined full recertification and state licensure survey. This visit included the COVID-19 focused infection control survey. Survey Dates: August 3, 4, 5, 6, 11, and 12, 2021. Facility Number: 001087 Provider Number: 15G573 AIMS Number: 100234320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/23/21.	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 observation, record review, and interview for 3 of 3 sampled clients (#1, #2, and #3), plus 3 additional clients (#4, #5, and #7), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to conduct thorough investigations regarding 2 incidents of property destruction for client #2 and 1 unwitnessed fall with injury for client #7, to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs, and to provide oversight for clients #1, #2, #3, #4's, #5's and #7's health care needs.	W 0102	W102 (Condition) Governing Body and Management – failed to conduct thorough investigations regarding incidents of property destruction and fall with injury, to develop aggressive active treatment programs, to provide oversight for health care needs. Citations at W104, W195, W318. Corrective action for resident(s) found to have been affected Dungarvin Indiana has developed an aggressive action plan to come into full compliance with all	09/11/2021

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

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	Findings include: 1. The governing body failed to conduct thorough investigations regarding 2 incidents of property destruction for client #2 and 1 unwitnessed fall with injury for client #7, to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs, and to provide oversight for clients #1, #2, #3, #4's, #5's and #7's health care needs. Please see W104. 2. The governing body failed to meet the Condition of Participation: Active Treatment Services by failing to develop and implement an aggressive active treatment program to meet the needs of clients #1, #2, and #3, to ensure clients #1, #2, and #3 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission, to complete assessments to address clients #1, #2, and #3's specific behavioral needs, to develop Individual Service Plans (ISPs) for clients #1, #2, and #3 within 30 days of admission, and to develop individualized active treatment schedules for clients #1, #2, and #3. Please see W195. 3. The governing body failed to meet the Condition of Participation: Health Care Services by failing to ensure client #3 saw a primary care physician within 30 days of admission, to ensure clients #1, #2, and #3 had hearing exams completed within 30 days of admission and to ensure client #3 had a vision exam completed within 30 days of admission, to ensure client #3 had a tuberculosis test completed within 30 days of admission, to ensure client #3 had a dental exam completed within 30 days of admission, to provide adequate nursing oversight for clients #1, #2, #3, and #4's health care needs, to ensure		Conditions of Participation established by the Secretary of Health and Human Services. Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Program Director/QIDP is receiving re-training on the thorough completion of investigations. ·Area Director will review all specific actions implemented in this plan of correction during weekly supervision with the Program Director/QIDP. The Area Director will verify that appropriate measures are being taken to thoroughly investigate all allegations and significant incidents at the facility, including incidents of property destruction and falls for a period of six months. If, at six months, there are no further incidents of failures to follow investigation policy, this enhanced monitoring will return to standard Dungarvin Policy and Procedure. ·ISPs have been developed for clients #1, 2 and 3, and the presence of a current ISP has been verified for all other individuals residing at the facility. All facility staff are being trained to competency on the assessments that have been completed and the formal and	

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	client #4's medications were not prepared ahead of time, to ensure clients #1, #2, #3, #5, and #7's medications were administered without error, to ensure staff administering client #4's medications had completed Core A/Core B medication training, to ensure clients #1, #2, #3, #5, and #7's medications were secured when not in use, and to follow universal precautions in regards to hand washing for clients #1, #2, #3, #4, #5, and #7. Please see W318. 9-3-1(a)		informal goals identified in the primary domains for each individual. ·Individualized active treatment schedules have been revised for each individual served to reflect their current daily activities and all staff are receiving training to competency regarding the daily individual activity schedules as well as the house's group activity schedule. Training will focus on how to engage the individuals in learning opportunities throughout the day. ·The Comprehensive Functional Assessments for Clients 1, 2, & 3 are finalized and placed in the client files. ·We have verified that current Comprehensive Functional Assessments are in place for all other individuals residing at the facility. ·The QIDP is being retrained on this standard and on the expectation that a CFA must be completed for a newly admitted individual within the first 30 days of admission. ·The Life Skills Profile Assessments (LSP), which include an assessment of specific behavioral needs, have been completed and entered into the client files for clients #1, 2 and 3. Further, the presence of current LSPs for all other individuals residing at the facility have been verified.	

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			·The QIDP is being retrained on the expectation that the Life Skills Profile must be completed for a newly admitted individual within the first 30 days of admission, prior to the IST meeting to develop the IPP/ISP. ·The QIDP is being retrained on the expectation that the ISP must be developed and implemented for a newly admitted individual within the first 30 days of admission. ·The QIDP is also being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the QIDP in ensuring that all requirements are met before and immediately after a new admission. ·The Program Director / QIDP will be retrained on the standard that an active treatment schedule must be individualized to reflect the actual day to day programs to be implemented by staff for each person served. ·The expectation has been set that the Lead DSP and Program Director / QIDP will work together to develop an active treatment schedule for each individual residing in the facility. ·Facility staff will be trained to competency on the active treatment schedules and the importance of provision of active treatment services at every opportunity in this setting. ·Dungarvin affirms that the QIDP will be responsible for	

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			ensuring active treatment ·All facility staff to be retrained on the programs put in place in each individual's ISP. ·All facility staff will be retrained on how to utilize all teachable moments of the day to incorporate formal and informal learning opportunities for the individuals served. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct observations at varying times of the day to ensure that facility staff demonstrate competency on implementation of the programs for each individual. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching by the QIDP. ·Client #3 saw his primary care physician on 6/30/21 for his admission physical. A copy of this physical was obtained and placed in his medical record for review. His follow up appointment with a new local PCP is scheduled on 9/10/21.	

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			·The new PCP has ordered hearing evaluations for clients #1, 2, and 3, and the referral coordinator within the PCP's provider system is finalizing the process. In reviewing the cause of the delay in getting this scheduled, it was reported that the previous provider who was completing all of the hearing evaluations for Dungarvin informed us that they could no longer accept Medicaid, which caused a delay finding a new provider who requires the referral document from the primary care physician's office. As soon as the referrals are processed, these appointments will be run at the first possible date. Dungarvin will regularly follow up with the PCP office to update status. ·Client #3 had a vision exam prior to admission. The optometrist's office is faxing a copy of the report from the visit and it is being placed into his medical file. ·Client #3 saw his primary care physician on 6/30/21 for his admission physical. His TB test was administered at this appointment. A copy of the reading of the TB is being obtained and placed in his medical record for review. His follow up appointment with a new local PCP is scheduled on 9/10/21. ·Client #3 saw his dentist on	

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			6/10/2021 and is due to be seen again in December 2021. Written documentation of the appointment was obtained from the dental office and placed in his medical file. ·All facility staff to be retrained to competency on this finding and on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration, which reiterates the Medication Administration training that the staff member who prepares the medication must be the staff member who administers the medication and also states that staff in ICF-I/DDs must be trained in Med Core A and B before handling/passing medications. ·All supervisory staff to be retrained on the expectation that appropriate staffing must be arranged at all ICF/I-DD facilities, including staff trained in Med Core A and B on schedule to administer all medications. ·All facility staff receiving training to competency on this finding and on Dungarvin policy on handwashing, Policy C-17, Exposure Control Plan. ·All facility staff receiving training to competency on this standard and on Dungarvin's expectation that the medications at	

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			ICF/I-DD facilities are to be locked at all times that the trained staff is not immediately accessing the cabinet and supervising the immediate area. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment and/or medication pass observations at varying times of the day to ensure that facility staff demonstrate competency on all areas of retraining covered in this Plan of Correction. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. ·Verification of all of the above training will be on file. 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 Dungarvin has assigned an Area Director to monitor implementation	

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			of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 3 of 3 sample clients (#1, #2, and #3), plus 3 additional clients (#4, #5 and #7), the governing body failed to conduct thorough investigations regarding 2 incidents of property destruction for client #2 and 1 unwitnessed fall with injury for client #7, to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs, and to provide oversight for clients #1, #2, #3, #4's, #5's and #7's health care needs. Findings include: 1. The governing body failed to conduct thorough investigations regarding 2 incidents of property destruction for client #2 and 1 unwitnessed fall with injury for client #7. Please see W154. 2. The governing body failed to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs. Please see W196. 3. The governing body failed to provide oversight over nursing services for clients #1, #2, #3, #4's, #5's and #7's health care needs. Please see W331.	W 0104	W104 (Standard) Governing Body – failed to conduct thorough investigations regarding 2 incidents of property destruction, one fall with injury, failed to develop and implement aggressive active treatment programs, failed to provide oversight over nursing services for clients. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Program Director/QIDP is receiving re-training on the thorough completion of investigations. ·Area Director will review all specific actions implemented in this plan of correction during weekly supervision with the Program Director/QIDP. The Area Director will verify that appropriate measures are being taken to thoroughly investigate all	09/11/2021

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	9-3-1(a)		allegations and significant incidents at the facility, including incidents of property destruction and falls for a period of six months. If, at six months, there are no further incidents of failures to follow investigation policy, this enhanced monitoring will return to standard Dungarvin Policy and Procedure. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
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 1 of 3 sample clients (#2), plus 1 additional client (#7),	W 0154	W154 (Standard) Staff Treatment of Clients – failed	09/11/2021

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	the facility failed to conduct thorough investigations regarding 2 incidents of property destruction for client #2 and 1 unwitnessed fall with injury for client #7. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/4/21 at 10:52 am. 1. A BDDS report dated 7/6/21 indicated the following: "On 7/5/21, staff reported that [client #2] stated that he wants his Dad and was not having a good day. He decided to take a walk down the street and then began to run all the way to the end of the street. Staff walked and ran behind [client #2] and walked back to the house with him. When he got in the house, [client #2] screamed that he hated everyone, he threw the tv in the living room on the floor twice, breaking it in half. He threw the entertainment system down, cracking it in several places. [Client #2] went to the back yard, threw the lawn chair at staff and bruising (sic) her arm. He went to a pile of wood in the yard and started to swing a two by four at staff before he hit the house. [Client #2] went back inside the house and took food out of the fridge, opened the food containers, and stuck his hands inside of the food. [Client #2] tossed the medical cabinets down and swiped everything off the tables while yelling and screaming that he hated everyone, and he wanted to leave. [Client #2] snatched the washer off the wall and broke the hose at the back of the washer letting water spill onto the floor and into the basement. [Client #2] went into his room, tore down the blinds, threw his clothes and his roommate's (sic) from their		to conduct thorough investigations regarding two incidents of property destruction for client #2 and one unwitnessed fall with injury for client #7. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Program Director/QIDP is receiving re-training on the thorough completion of investigations. ·Area Director will review all specific actions implemented in this plan of correction during weekly supervision with the Program Director/QIDP. The Area Director will verify that appropriate measures are being taken to thoroughly investigate all allegations and significant incidents at the facility, including incidents of property destruction and falls for a period of six months. If, at six months, there are no further incidents of failures to follow investigation policy, this enhanced monitoring will return to standard Dungarvin Policy and Procedure. . How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients.	

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	closet onto the floor. He threatened to fight everyone in the house by using his roommate's colored pencils. Staff took the colored pencils and placed them in the medical cabinet for safety. [Client #2] picked up his cup of lemonade and threw it all over the living room and ran outside, kicking cars in the driveway. Then he threw an object and broke a window in the living room. [Client #2] came back inside and threw the computer and wall pictures down. He tipped over two large cabinets and staff were able to restrain him." - An investigation dated 7/13/21 did not include an interview with client #2 or other clients in the home and did not include corrective action to be taken. 2. A BDDS report dated 7/13/21 indicated the following: "On 7/11/21, [client #2] received money after his family visited with him. He informed staff that he would like to go to the store the next day to purchase an item. On 7/12/21, [client #2] asked staff to take him to the store, and staff agreed and prompted him to take a shower and brush his teeth before heading out to the store. [Client #2] did not want to take a shower or brush his teeth, and rather than discuss this with the staff, he immediately went into a destructive behavior. He threw an agency computer to the floor, went into his room and when he came out, he went in the kitchen, threw plates to the floor and went back to his room and was throwing items around trying to break things. He got a fork and butter knife from the kitchen and went to his room. Staff followed [client #2] to his room and when staff opened the door, [client #2] had the fork and knife to his chest saying that he wants to kill himself. Staff managed to convince [client #2] to turn over the fork and knife, and then [client		Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	#2] went outside by the driveway and started throwing stones around, cracking the windshield on a staff's car. He then attacked staff and threw a stone directly at her foot. Dungarvin staff utilized a one person hold as trained in Dungarvin Crisis Intervention while another staff called the police. [Client #2] was in the restraint for approximately 3-4 minutes while staff were waiting for the police to arrive." - An investigation dated 7/13/21 did not include interviews with client #2 or other clients in the home and did not indicate corrective action to be taken. Qualified Intellectual Disabilities Professional (QIDP #1) was interviewed on 8/4/21 at 4:00 pm and stated, "We are working on a behavior plan for [client #2]. We did talk about how to redirect him. We didn't talk about when he's destructive. The first episode went on for some time. Staff did follow him when he walked along the street. When he came back, he went into this destruction of property. Staff were still talking to him, trying to calm him down. He doesn't pay attention. He has to do what he needs to do until he's done before he can calm down. Eventually he did calm down and apologized for the damage. The second incident wasn't as long as the first one. Missing his dad is the trigger. Once staff talk to him, take him outside, it has seemed to work." Behavior Clinician Manager (BCM) #1 was interviewed on 8/11/21 at 12:46 pm and stated, "[Client #2's] Behavior Support Plan will be done by the end of [August]. Staff have not had any training from me on [client #2's] behaviors." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "The investigation			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	51778 TROWBRIDGE LN SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	should include an interview with [client #2]. We need the formal behavior plan. That would be the corrective action." 3. A BDDS report dated 7/30/21 indicated the following: "At 5 pm on 7/29/21, [client #7] told staff he was having pain on his shoulder on the same side where he has a history of a fracture and has a metal rod in his arm from the shoulder to his elbow. He stated to staff that he had fallen the evening prior when standing up from a chair on the back porch and that no staff had witnessed the fall. The nurse and Program Director had been at the home earlier to check on him, and he had not earlier told anyone about this fall. Plan to Resolve (Immediate and Long Term). The nurse came to check the area and due to the history with this arm and the fact that it did appear that there could be some mild swelling in the area, she wanted it checked out to be sure. [Client #7] was taken to the emergency room at [name of hospital]. He was released back home around 9 pm. They found no acute fractures and he was diagnosed with a contusion to his right upper arm. Was instructed to use ice or PRN (as needed) Tylenol or Ibuprofen if he experienced pain." - The review did not include an investigation for client #7's fall. Area Director (AD) #1 was interviewed by phone on 8/12/21 at 9:30 am and stated, "We did discuss the fall, but we didn't fill out the form." AD #1 stated, "I would expect an investigation." 9-3-2(a)			
W 0159	483.430(a) QIDP			

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Bldg. 00	Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the QIDP (Qualified Intellectual Disability Professional) failed to effectively integrate, coordinate, and monitor clients #1, #2, and #3's active treatment programs. The QIDP failed to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs, to ensure clients #1, #2, and #3 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission, to complete an assessment to address clients #1, #2, #3's specific behavioral needs, to develop Individual Service Plans (ISPs) for clients #1, #2, and #3 within 30 days of admission, and to ensure clients #1, #2, and #3 active treatment schedules were individualized to meet their needs. Findings include: 1. The QIDP failed to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs. Please see W196. 2. The QIDP failed to ensure clients #1, #2, and #3 had CFAs completed within 30 days of admission. Please see W210. 3. The QIDP failed to complete an assessment to address clients #1, #2, #3's specific behavioral needs. Please see W214. 4. The QIDP failed to develop ISPs for clients	W 0159	W159 (Standard) QIDP – failed to effectively integrate, coordinate, and monitor active treatment programs. Failed to complete Comprehensive Functional Assessments (CFAs) completed within 30 days of admission, to complete an assessment to address specific behavioral needs, to develop Individual Service Plans (ISPs), and to ensure active treatment schedules were individualized. Findings at W196, W210, W214, W226, W249, W250. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·ISPs have been developed for clients #1, 2 and 3, and the presence of a current ISP has been verified for all other individuals residing at the facility. All facility staff are being trained to competency on the assessments that have been completed and the formal and informal goals identified in the primary domains for each individual. ·Individualized active treatment schedules have been revised for each individual served to reflect	09/11/2021

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	#1, #2, and #3 within 30 days of admission. Please see W226. 5. The QIDP failed to ensure clients #1, #2, and #3's active treatment programs were implemented during formal and informal training opportunities. Please see W249. 6. The QIDP failed to ensure clients #1, #2, and #3 active treatment schedules were individualized to meet their needs. Please see W250. 9-3-3(a)		their current daily activities and all staff are receiving training to competency regarding the daily individual activity schedules as well as the house's group activity schedule. Training will focus on how to engage the individuals in learning opportunities throughout the day. ·The Comprehensive Functional Assessments for Clients 1, 2, & 3 are finalized and placed in the client files. ·We have verified that current Comprehensive Functional Assessments are in place for all other individuals residing at the facility. ·The QIDP is being retrained on this standard and on the expectation that a CFA must be completed for a newly admitted individual within the first 30 days of admission. ·The Life Skills Profile Assessments (LSP), which include an assessment of specific behavioral needs, have been completed and entered into the client files for clients #1, 2 and 3. Further, the presence of current LSPs for all other individuals residing at the facility have been verified. ·The QIDP is being retrained on the expectation that the Life Skills Profile must be completed for a newly admitted individual within the first 30 days of admission, prior to the IST meeting to develop	

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			the IPP/ISP. ·The ISPs for clients #1, 2 and 3 have been completed and entered into the client files. Further, the ISPs for all other individuals residing at the facility have also been completed and entered. ·The QIDP is being retrained on the expectation that the ISP must be developed and implemented for a newly admitted individual within the first 30 days of admission. ·The QIDP is also being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the QIDP in ensuring that all requirements are met before and immediately after a new admission. ·The Program Director / QIDP will be retrained on the standard that an active treatment schedule must be individualized to reflect the actual day to day programs to be implemented by staff for each person served. ·The expectation has been set that the Lead DSP and Program Director / QIDP will work together to develop an active treatment schedule for each individual residing in the facility. ·Facility staff will be trained to competency on the active treatment schedules and the importance of provision of active treatment services at every opportunity in this setting. ·Dungarvin affirms that the	

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			QIDP will be responsible for ensuring active treatment ·All facility staff to be retrained on the programs put in place in each individual's ISP. ·All facility staff will be retrained on how to utilize all teachable moments of the day to incorporate formal and informal learning opportunities for the individuals served. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to observations at varying times of the day to ensure that facility staff demonstrate competency on implementation of the programs for each individual. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching by the QIDP. 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	

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			recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), plus 1 additional clients (#7), the facility failed to ensure staff were adequately trained to meet clients #1, #2, #3, and #7's needs. Findings include: 1. The facility failed to provide staff with adequate training to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs. Please see W196. 2. The facility failed to provide staff with adequate training to ensure client #7's food was served in a manner consistent with his dining plan. Please see W474. 9-3-3(a)	W 0189	W189 (Standard) Staff Training Program – failed to ensure staff were adequately trained to meet needs of clients #1, 2, 3, and 7. Findings at W196, W474. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·ISPs have been developed for clients #1, 2 and 3, and the presence of a current ISP has been verified for all other individuals residing at the facility. All facility staff are being trained to competency on the assessments that have been completed and the formal and informal goals identified in the primary domains for each	09/11/2021

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			individual. ·Individualized active treatment schedules have been revised for each individual served to reflect their current daily activities and all staff are receiving training to competency regarding the daily individual activity schedules as well as the house's group activity schedule. Training will focus on how to engage the individuals in learning opportunities throughout the day. ·All facility staff receiving training to competency on dining risk plans for the individuals at the facility. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on implementation of the risk plans for each individual. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. ·The QIDP is receiving re-training on the expectation that	

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			the QIDP will ensure that all facility staff are adequately trained to meet the active treatment and health and safety needs of the individuals supported at all times. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), plus 3 additional clients (#4, #5, and #7), the facility failed to provide adequate training for staff to address clients #1, #2, #3, #4, #5, and #7's health care needs. Findings include: 1. The facility failed to provide staff with	W 0192	W192 (Standard) Staff Training Program – failed to ensure staff were adequately trained to meet health care needs of clients #1, 2, 3, 4, 5 and 7. Findings at W367, W368, W370, W382, W455 Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021	09/11/2021

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	adequate training to ensure client #4's medications were not prepared ahead of time. Please see W367. 2. The facility failed to provide staff with adequate training to ensure clients #1, #2, #3, #5, and #7's medications were administered without error. Please see W368. 3. The facility failed to provide staff with adequate training to ensure staff passing client #4's medications had completed Core A/Core B medication training. Please see W370. 4. The facility failed to provide staff with adequate training to ensure clients #1, #2, #5, and #7's medications were secured when not in use. Please see W382. 5. The facility failed to provide staff with adequate training to ensure universal precautions were implemented in regards to hand washing for clients #1, #2, #3, #4, #5, and #7. Please see W455. 9-3-3(a)		Survey with Event ID GII011 will be fully implemented, including the following specifics: An aggressive staff training program has been initiated to bring all staff into compliance with training to competency on the active treatment and health care needs for each individual served at the facility. Details of this training include: ·All facility staff to be retrained to competency on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration, which reiterates the Medication Administration training that the staff member who prepares the medication must be the staff member who administers the medication and also states that staff in ICF-I/DDs must be trained in Med Core A and B before handling/passing medications. ·An audit of all staff working at the facility has been completed and any staff who has not passed Med Core A and B will either successfully complete the training or be removed from the schedule. ·All facility staff receiving training to competency on Dungarvin's expectation that the	

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			medications at ICF/I-DD facilities are to be locked at all times that the trained staff is not immediately accessing the cabinet and supervising the immediate area. ·All facility staff receiving training to competency on this finding and on Dungarvin policy on handwashing, Policy C-17, Exposure Control Plan. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0195 Bldg. 00	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. Based on observation, record review, and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility failed to meet the Condition of Participation: Active Treatment Services. The facility failed to develop and implement an aggressive active treatment program to meet the	W 0195	W195 (Condition) Active Treatment Services – failed to ensure that specific active treatment services requirements are met. Failed to develop and implement and aggressive active treatment program, ensure CFAs	09/11/2021

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	needs of clients #1, #2, and #3, to ensure clients #1, #2, and #3 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission, to complete assessments to address clients #1, #2, and #3's specific behavioral needs, to develop Individual Service Plans (ISPs) for clients #1, #2, and #3 within 30 days of admission, and to develop individualized active treatment schedules for clients #1, #2, and #3. Findings include: 1. The facility failed to ensure the QIDP (Qualified Intellectual Disability Professional) effectively integrated, coordinated, and monitored clients #1, #2, and #3's active treatment programs. Please see W159. 2. The facility failed to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs. Please see W196. 3. The facility failed to ensure clients #1, #2, and #3 had CFAs completed within 30 days of admission. Please see W210. 4. The facility failed to complete an assessment to address clients #1, #2, and #3's specific behavioral needs. Please see W214. 5. The facility failed to develop ISPs for clients #1, #2, and #3 within 30 days of admission. Please see W226. 6. The facility failed to ensure clients #1, #2, and #3's active treatment programs were implemented during formal and informal training opportunities. Please see W249.		complete within 30 days of admission, complete assessments to address specific behavioral needs, to develop ISPs within 30 days of admission, and to develop individualized active treatment schedules. Findings at W159, W196, W210, W214, W226, W249, W250. Corrective action for resident(s) found to have been affected Dungarvin Indiana has developed an aggressive action plan to come into full compliance with all Conditions of Participation established by the Secretary of Health and Human Services. Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·ISPs have been developed for clients #1, 2 and 3, and the presence of a current ISP has been verified for all other individuals residing at the facility. All facility staff are being trained to competency on the assessments that have been completed and the formal and informal goals identified in the primary domains for each individual. ·Individualized active treatment schedules have been revised for each individual served to reflect their current daily activities and all staff are receiving training to competency regarding the daily	

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	7. The facility failed to ensure clients #1, #2, and #3 active treatment schedules were individualized to meet their needs. Please see W250. 9-3-4(a)		individual activity schedules as well as the house's group activity schedule. Training will focus on how to engage the individuals in learning opportunities throughout the day. ·The Comprehensive Functional Assessments for Clients 1, 2, & 3 are finalized and placed in the client files. ·We have verified that current Comprehensive Functional Assessments are in place for all other individuals residing at the facility. ·The QIDP is being retrained on this standard and on the expectation that a CFA must be completed for a newly admitted individual within the first 30 days of admission. ·The Life Skills Profile Assessments (LSP), which include an assessment of specific behavioral needs, have been completed and entered into the client files for clients #1, 2 and 3. Further, the presence of current LSPs for all other individuals residing at the facility have been verified. ·The QIDP is being retrained on the expectation that the Life Skills Profile must be completed for a newly admitted individual within the first 30 days of admission, prior to the IST meeting to develop the IPP/ISP. ·The ISPs for clients #1, 2 and 3 have been completed and	

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			entered into the client files. Further, the ISPs for all other individuals residing at the facility have also been completed and entered. ·The QIDP is being retrained on the expectation that the ISP must be developed and implemented for a newly admitted individual within the first 30 days of admission. ·The QIDP is also being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the QIDP in ensuring that all requirements are met before and immediately after a new admission. ·The Program Director / QIDP will be retrained on the standard that an active treatment schedule must be individualized to reflect the actual day to day programs to be implemented by staff for each person served. ·The expectation has been set that the Lead DSP and Program Director / QIDP will work together to develop an active treatment schedule for each individual residing in the facility. ·Facility staff will be trained to competency on the active treatment schedules and the importance of provision of active treatment services at every opportunity in this setting. ·Dungarvin affirms that the QIDP will be responsible for ensuring active treatment ·All facility staff to be retrained	

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			on the programs put in place in each individual's ISP. ·All facility staff will be retrained on how to utilize all teachable moments of the day to incorporate formal and informal learning opportunities for the individuals served. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct observations at varying times of the day to ensure that facility staff demonstrate competency on implementation of the programs for each individual. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching by the QIDP. 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	

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	15G573	A. BUILDING 00 B. WING	08/12/2021

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			recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0196 Bldg. 00	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. Based on observation, record review, and interview for 3 of 3 sample clients, the facility failed to develop and implement an aggressive active treatment program to meet clients #1, #2, and #3's specific needs. Findings include: Observations were conducted at the group home on 8/3/21 from 1:24 pm through 3:30 pm and from 5:30 pm through 8:30 pm, and on 8/4/21 from 7:30 am through 9:00 am. Clients #1, #2, and #3 were present in the home for the duration of the observation period.	W 0196	W196 (Standard) Active Treatment – failed to develop and implement an aggressive active treatment program to meet clients #1, 2 and 3's specific needs. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·ISPs have been developed for clients #1, 2 and 3, and the	09/11/2021

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	On 8/3/21 at 1:24 pm client #1 was playing video games in his bedroom, client #2 was playing video games, and client #3 was sitting in the living room drinking an energy drink and using his cell phone. Direct Support Professionals (DSPs) #1, #2, and #3 were in the medication area talking. At 1:45 pm, clients #1 and #2 were playing video games. Client #3 was seated on a sofa in the living room. DSPs #1, #2, and #3 were standing in the kitchen talking to one another. At 2:00 pm, client #1 was playing video games. Client #2 came into the kitchen and wandered through the house. Client #3 was sitting on a sofa in the living room. At 2:16 pm, client #1 was playing video games. Client #2 left the home for a medical appointment. Client #3 went to the back yard with his housemate. At 2:22 pm, client #1 went on a walk with his housemate. Client #3 was in the back yard with his housemate. At 2:45 pm, clients #1 and #3 were outside. Client #2 was at a medical appointment. At 3:00 pm, client #1 was in his bedroom playing video games. Client #3 was seated on a sofa in the living room looking at his cell phone. Client #2 was at a medical appointment. House staff did not prompt clients #1 or #3 to participate in activities. On 8/3/21 at 5:30 pm, client #2 was seated at the		presence of a current ISP has been verified for all other individuals residing at the facility. All facility staff are being trained to competency on the assessments that have been completed and the formal and informal goals identified in the primary domains for each individual. ·Individualized active treatment schedules have been revised for each individual served to reflect their current daily activities and all staff are receiving training to competency regarding the daily individual activity schedules as well as the house's group activity schedule. Training will focus on how to engage the individuals in learning opportunities throughout the day. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on implementation of the programs for each individual. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns	

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	dining table eating sausages and mixed vegetables. Client #1 was in the kitchen making toast. Client #3 was sitting on a sofa in the living room looking at his phone. DSP #4 offered to cook a pizza for client #7. DSP #6 was sitting in a desk chair in the medication area. DSP #5 was sitting in a rocking chair in the dining area with his eyes closed. At 5:37 pm, client #1 ate carrots. DSPs #5 and #6 were looking at their phones. DSP #4 was washing dishes. At 5:51 pm, clients #1 and #2 were in their bedrooms. Client #3 was seated on a sofa in the living room, looking at his cell phone. At 6:12 pm, client #3 was seated on a sofa in the living room, looking at his cell phone. Client #1 was using a computer in the living room. Client #2 was in his bedroom. At 6:19 pm, DSP #5 stated, "Their goals are written on the fridge. It says they need to clean their rooms and the bathrooms." - House staff did not prompt clients #1, #2, or #3 to engage in activities. At 6:22 pm, DSP #4 stated, "[Qualified Intellectual Disabilities Professional (QIDP #1)] wants them to eat at 5:00 pm. Other administrators say 7:00 pm. I don't know when they're supposed to eat. There is no schedule for clients to help with cooking." At 6:32 pm, DSP #6 was in the medication area, looking at his cell phone. At 6:36 pm, DSP #5 began passing medications.		will be addressed through immediate retraining and coaching by the QIDP. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	At 6:45 pm, DSP #4 prompted client #3 to clean the bathroom floor. At 6:49 pm, client #2 was in the kitchen asking DSP #4 for cookies. Client #1 was using his cell phone. Client #3 was in his bedroom. At 7:07 pm, client #3 was eating handheld microwaveable sandwiches in the living room. Client #2 was eating cookies and milk at the dining table. Clients #1 and #3 were drinking energy drinks. At 7:15 pm, DSP #6 was in the medication area looking at his cell phone. Client #1 warmed up 8 sausage links on a plate and poured syrup on the plate. Client #1 sat down in a recliner in the living room and began to eat the sausages with his fingers. Client #1 got up and got a plastic knife and fork from the kitchen. Client #1 sat back down in the recliner. Client #1 got up again and dumped the sausage links in the garbage. Client #1 got a frozen pizza out of the freezer and put it in the oven. Client #2 was using a computer in the living room. At 7:35 pm, client #1 refused to take his medications. At 7:42 pm, client #2 took his medications. At 8:00 pm, clients #1, #2, and #3 were in their bedrooms. On 8/4/21 at 7:30 am, clients #1, #2, and #3 were in their bedrooms. At 7:50 am, client #3 sat on a sofa in the living room.			

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	At 8:11 am, client #1 ate sausage patties at the dining table with his fingers. Client #3 returned to his bedroom. At 8:20 am, client #1 asked the surveyor to look at his video games. Client #1 asked the surveyor to sit in the living room to look at pictures he had colored. Client #1 stated, "I did graduate high school. I would like to get a job at [name of department stores]. I like coloring and playing video games. I also like cooking. I have 2 cookbooks in my room. They let me cook here sometimes. There isn't a schedule." Client #1 stated, "I don't know the names of my medications. I know one is for seizures, one is for anxiety, and one is for depression. I don't know what the others are." Client #1 stated, "I don't like being here. I get into arguments with some of the other clients. There are a lot of rules. I have to do chores. I do my own laundry, but only when I want to. We are going bowling on Friday, but staff don't have activities for us. I choose from things I brought with me." At 8:30 am, client #3 was in his bed. Client #2 was in his bedroom. Client #1 was playing video games. - Throughout the observation periods, staff did not engage clients in meaningful activities. Clients were not encouraged to help prepare meals or clean up the kitchen after meals. Staff did not make attempts to engage clients in conversations. 1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's record indicated an admission date of 7/1/21 and did not include an ISP. Client #1's undated active treatment schedule was not specific to his individual needs and			

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	interests and did not reflect his daily routine and schedule. 2. Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's record indicated an admission date of 7/2/21 and did not include an ISP. Client #2's undated active treatment schedule was not specific to his individual needs and interests and did not reflect his daily routine and schedule. 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21 and did not include an ISP. Client #3's undated active treatment schedule was not specific to his individual needs and interests and did not reflect his daily routine and schedule. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Active treatment is getting the individuals to participate in their daily activities. Whatever is going on at the house. If they are preparing meals, having them to participate in those activities. Staff should invite clients to participate. Make sure they are engaged in whatever is going on in the house. Staff should model participation. Clients should be engaged in cooking and cleaning. Staff should not be in the med (medication) room on their phones. Staff should not be chatting by themselves. Even if the clients are watching a movie, staff should sit with them and talk to them about what is going on. They should participate in the activities with them. If the clients are in their rooms playing a game, staff should peek in to let the individual know they are in the house. Communicating with			

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	the individuals is very important. Staff should always be engaging them." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Staff have done a chore chart to give some visual guidance. That works with these guys. They're all capable of helping with chores. If someone wants time to themselves, staff need to invite the client to participate every 15 minutes." 9-3-4(a)			
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to ensure clients #1, #2, and #3 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission. Findings include: 1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's record indicated an admission date of 7/1/21 and did not include a completed CFA. 2. Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's record indicated an admission date of 7/2/21 and did not include a completed CFA. 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm.	W 0210	W210 (Standard) Individual Program Plan – failed to ensure clients #1, 2, and 3 had CFAs completed within 30 days of admission. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·The Comprehensive Functional Assessments for Clients 1, 2, & 3 are being finalized and placed in the client files. ·We have verified that current Comprehensive Functional Assessments are in place for all other individuals residing at the	09/11/2021

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	Client #3's record indicated an admission date of 7/2/21 and did not include a completed CFA. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "The CFA should be completed within 30 days of admission." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "The CFA should be done in 30 days." 9-3-4(a)		facility. ·The QIDP is being retrained on this standard and on the expectation that a CFA must be completed for a newly admitted individual within the first 30 days of admission. ·The QIDP is also being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the QIDP in ensuring that all requirements are met before and immediately after a new admission. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0214 Bldg. 00	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs.			

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	Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to complete an assessment to address clients #1, #2, #3's specific behavioral needs. Findings include: 1. Client #2's record was reviewed on 8/4/21 at 12:40 pm. Client #2's record indicated an admission date of 7/1/21 and did not include a behavioral assessment or Behavior Support Plan (BSP). The facility's Bureau of Developmental Disabilities (BDDS) reports were reviewed on 8/4/21 at 10:52 am. a. A BDDS report dated 7/6/21 indicated the following: "On 7/5/21, staff reported that [client #2] stated that he wants his dad and was not having a good day. He decided to take a walk down the street and then began to run all the way to the end of the street. Staff walked and ran behind [client #2] and walked back to the house with him. When he got to the house, [client #2] screamed that he hated everyone. He threw the TV (television) in the living room on the floor twice, breaking it in half. He threw the entertainment system down, cracking it in several places. [Client #2] went to the back yard, threw the lawn chair at staff and bruising her arm. He went to a pile of wood in the yard and started to swing a two by four at staff before he hit the house. [Client #2] went back inside the house and took food out of the fridge, opened the food containers and stuck his hand inside of the food. [Client #2] tossed the medical cabinets down and swiped everything off the tables while yelling and screaming that he hated everyone, and he wanted to leave. [Client #2] snatched the washer off the wall and broke	W 0214	W214 (Standard) Individual Program Plan – failed to complete an assessment to address clients #1, 2 & 3's specific behavioral needs. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·The Life Skills Profile Assessments (LSP), which include an assessment of specific behavioral needs, have been completed and entered into the client files for clients #1, 2 and 3. Further, the presence of current LSPs for all other individuals residing at the facility have been verified. ·The QIDP is being retrained on this standard and on the expectation that the Life Skills Profile must be completed for a newly admitted individual within the first 30 days of admission, prior to the IST meeting to develop the IPP/ISP. ·The QIDP is also being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the QIDP in ensuring that all requirements are met before and immediately after a new admission. How facility will identify other residents potentially affected & what measures taken	09/11/2021

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	the hose at the back of the washer, letting water spill onto the floor and into the basement. [Client #2] went into his room tore down the blinds, threw his clothes and his roommates (sic) from their closet onto the floor. He threatened to fight everyone in the house by using his roommate's colored pencils. Staff took the colored pencils and placed them in the medical cabinets for safety. [Client #2] picked up his cup of lemonade and threw it all over the living room and ran outside, kicking cars in the driveway. He threw an object and broke a window in the living room. [Client #2] came back inside and threw the computer and wall pictures down. He tipped over two large cabinets, and staff were able to restrain him." b. A BDDS report dated 7/13/21 indicated the following: "On 7/11/21, [client #2] asked staff to take him to the store, and staff agreed and prompted him to take a shower and brush his teeth before heading out to the store. He did not want to take a shower or brush his teeth, and, rather than discuss this with the staff, he immediately went into a destructive behavior. He threw an agency computer to the floor, went into his room and when he came out, he went in the kitchen, threw plates to the floor, and went back to his room and was throwing items around trying to break things. He got a fork and butter knife from the kitchen and went to his room. Staff followed [client #2] to his room, and when staff opened the door, [client #2] had the fork and knife to his chest saying that he wants to kill himself. Staff managed to convince [client #2] to turn over the fork and knife, and then [client #2] went outside by the driveway and started throwing stones around, cracking the windshield on a staff's car. He then attached staff and threw a stone directly		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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	at her foot. Dungarvin staff utilized a one person hold as trained in Dungarvin Crisis Intervention while another staff called the police. [Client #2] was in the restraint for approximately 3-4 minutes while staff were waiting for the police to arrive. Plan to Resolve (Immediate and Long Term). [Client #2] calmed down immediately when he saw the police approaching. He was immediately very apologetic and begged staff and the police to not put him in jail. The police talked to [client #2] and took statements from him. [Client #2] was taken to [name of hospital] for possible admission for a 24 hour observation and evaluation due to his threats of self harm. Staff followed him to the hospital. [Client #2] was evaluated and later discharged. [Client #2] returned to the group home via staff's vehicle. [Client #2] had calmed down and was ready to eat and put his room in order. The behavior specialist was on her way for an assessment visit when this incident occurred and was not able to complete the assessment as [client #2] was on his way to [name of hospital]. The behavior specialist will reschedule the assessment to update the behavior plan to help [client #2] with management and coping skills. A more structured activity schedule is being developed. All sharps, including forks and knives have been locked and emergency HRC (Human Rights Committee) approval is being obtained. All staff will be trained on the behavior plan in development as soon as possible and the IST (individual support team) will discuss immediate protocols to be put in place this week while the full plan with FBA (Functional Behavioral Analysis) is in development. Staff will continue to monitor [client #2] for health, safety, and wellness. The IST believes [client #2] is hoping			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	that he will be sent home to his parents if he acts out in this way. The team is committed to helping him through this transition to life at the group home." 2. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's record indicated an admission date of 7/2/21 and did not include a behavioral assessment or BSP. 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21 and did not include a behavioral assessment or BSP. Behavior Clinician Manager (BCM) #1 was interviewed on 8/11/21 at 11:46 am and stated, "I did an observation with [client #2] 2 weeks ago. I'm working on his FBA (Functional Behavioral Assessment) now. His BSP will be done by the end of the month. Staff in the home have not had any training from me on a plan for [client #2]." BCM #1 stated, "I'm not familiar with any of the other clients in the home. I haven't observed them." BCM #1 stated, "As far as I know, none of the other clients in the home have a behavior clinician." BCM #1 stated, "There is no plan to develop BSPs for the other clients. The Qualified Intellectual Disability Professional (QIDP) is responsible for writing those BSPs. They will write a support plan, so the staff can support the clients." 9-3-4(a)			
W 0226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the			

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	interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to develop Individual Service Plans (ISPs) for clients #1, #2, and #3 within 30 days of admission. Findings include: 1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's record indicated an admission date of 7/1/21 and did not include an ISP. 2. Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's record indicated an admission date of 7/2/21 and did not include an ISP. 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21 and did not include an ISP. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "The ISP should be done 30 days after they move in." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "The ISP should be done within 30 days." 9-3-4(a)	W 0226	W226 (Standard) Individual Program Plan – failed to develop Individual Service Plans (ISPs) for clients #1, 2, and 3 within 30 days of admission. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·The ISPs for clients #1, 2 and 3 have been completed and entered into the client files. Further, the ISPs for all other individuals residing at the facility have also been completed and entered. ·The QIDP is being retrained on the expectation that the ISP must be developed and implemented for a newly admitted individual within the first 30 days of admission. ·The QIDP is also being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the QIDP in ensuring that all requirements are met before and immediately after a new admission. 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	09/11/2021

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			facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to ensure clients #1, #2, and #3's active treatment programs were implemented during formal and informal training opportunities. Findings include: Observations were conducted at the group home on 8/3/21 from 1:24 pm through 3:30 pm and from 5:30 pm through 8:30 pm, and on 8/4/21 from 7:30 am through 9:00 am. Clients #1, #2, and #3 were present in the home for the duration of the observation period. 1. On 8/3/21 at 1:24 pm client #1 was playing video games in his bedroom, client #2 was	W 0249	W249 (Standard) Program Implementation – failed to ensure clients #1, 2 and 3's active treatment programs were implemented during formal and informal training opportunities. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·All facility staff to be retrained on the programs put in place in each individual's ISP. ·All facility staff will be retrained on how to utilize all teachable moments of the day to incorporate	09/11/2021

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	playing video games, and client #3 was sitting in the living room drinking an energy drink and using his cell phone. Direct Support Professionals (DSPs) #1, #2, and #3 were in the medication area talking. At 1:45 pm, clients #1 and #2 were playing video games. Client #3 was seated on a sofa in the living room. DSPs #1, #2, and #3 were standing in the kitchen talking to one another. At 2:00 pm, client #1 was playing video games. Client #2 came into the kitchen and wandered through the house. Client #3 was sitting on a sofa in the living room. At 2:16 pm, client #1 was playing video games. Client #2 left the home for a medical appointment. Client #3 went to the back yard with his housemate. At 2:22 pm, client #1 went on a walk with his housemate. Client #3 was in the back yard with his housemate. At 2:45 pm, clients #1 and #3 were outside. Client #2 was at a medical appointment. At 3:00 pm, client #1 was in his bedroom playing video games. Client #3 was seated on a sofa in the living room looking at his cell phone. Client #2 was at a medical appointment. House staff did not prompt clients #1 or #3 to participate in activities. On 8/3/21 at 5:30 pm, client #2 was seated at the dining table eating sausages and mixed vegetables. Client #1 was in the kitchen making toast. Client #3 was sitting on a sofa in the living		formal and informal learning opportunities for the individuals served. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on implementation of the programs for each individual. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching by the QIDP. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the	

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	room looking at his phone. DSP #4 offered to cook a pizza for client #7. DSP #6 was sitting in a desk chair in the medication area. DSP #5 was sitting in a rocking chair in the dining area with his eyes closed. At 5:37 pm, client #1 ate carrots. DSPs #5 and #6 were looking at their phones. DSP #4 was washing dishes. At 5:51 pm, clients #1 and #2 were in their bedrooms. Client #3 was seated on a sofa in the living room, looking at his cell phone. At 6:12 pm, client #3 was seated on a sofa in the living room, looking at his cell phone. Client #1 was using a computer in the living room. Client #2 was in his bedroom. At 6:19 pm, DSP #5 stated, "Their goals are written on the fridge. It says they need to clean their rooms and the bathrooms." - House staff did not prompt clients #1, #2, or #3 to engage in activities. At 6:22 pm, DSP #4 stated, "[Qualified Intellectual Disabilities Professional (QIDP #1)] wants them to eat at 5:00 pm. Other administrators say 7:00 pm. I don't know when they're supposed to eat. There is no schedule for clients to help with cooking." At 6:32 pm, DSP #6 was in the medication area, looking at his cell phone. At 6:36 pm, DSP #5 began passing medications. At 6:45 pm, DSP #4 prompted client #3 to clean the bathroom floor.		POC items are being fully implemented.	

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	At 6:49 pm, client #2 was in the kitchen asking DSP #4 for cookies. Client #1 was using his cell phone. Client #3 was in his bedroom. At 7:07 pm, client #3 was eating handheld microwaveable sandwiches in the living room. Client #2 was eating cookies and milk at the dining table. Clients #1 and #3 were drinking energy drinks. At 7:15 pm, DSP #6 was in the medication area looking at his cell phone. Client #1 warmed up 8 sausage links on a plate and poured syrup on the plate. Client #1 sat down in a recliner in the living room and began to eat the sausages with his fingers. Client #1 got up and got a plastic knife and fork from the kitchen. Client #1 sat back down in the recliner. Client #1 got up again and dumped the sausage links in the garbage. Client #1 got a frozen pizza out of the freezer and put it in the oven. Client #2 was using a computer in the living room. At 7:35 pm, client #1 refused to take his medications. At 7:42 pm, client #2 took his medications. At 8:00 pm, clients #1, #2, and #3 were in their bedrooms. On 8/4/21 at 7:30 am, clients #1, #2, and #3 were in their bedrooms. At 7:50 am, client #3 sat on a sofa in the living room. At 8:11 am, client #1 ate sausage patties at the dining table with his fingers. Client #3 returned to his bedroom.			

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	At 8:20 am, client #1 asked the surveyor to look at his video games. Client #1 asked the surveyor to sit in the living room to look at pictures he had colored. Client #1 stated, "I did graduate high school. I would like to get a job at [name of department stores]. I like coloring and playing video games. I also like cooking. I have 2 cookbooks in my room. They let me cook here sometimes. There isn't a schedule." Client #1 stated, "I don't know the names of my medications. I know one is for seizures, one is for anxiety, and one is for depression. I don't know what the others are." Client #1 stated, "I don't like being here. I get into arguments with some of the other clients. There are a lot of rules. I have to do chores. I do my own laundry, but only when I want to. We are going bowling on Friday, but staff don't have activities for us. I choose from things I brought with me." At 8:30 am, client #3 was in his bed. Client #2 was in his bedroom. Client #1 was playing video games. - Throughout the observation periods, staff did not engage clients in meaningful activities. Clients were not encouraged to help prepare meals or clean up the kitchen after meals. Staff did not make attempts to engage clients in conversations. 1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's record indicated an admission date of 7/1/21 and did not include an ISP. Client #1's undated active treatment schedule was not specific to his individual needs and interests and did not reflect his daily routine and schedule.			

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	2. Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's record indicated an admission date of 7/2/21 and did not include an ISP. Client #2's undated active treatment schedule was not specific to his individual needs and interests and did not reflect his daily routine and schedule. 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21 and did not include an ISP. Client #3's undated active treatment schedule was not specific to his individual needs and interests and did not reflect his daily routine and schedule. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Active treatment is getting the individuals to participate in their daily activities. Whatever is going on at the house. If they are preparing meals, having them to participate in those activities. Staff should invite clients to participate. Make sure they are engaged in whatever is going on in the house. Staff should model participation. Clients should be engaged in cooking and cleaning. Staff should not be in the med (medication) room on their phones. Staff should not be chatting by themselves. Even if the clients are watching a movie, staff should sit with them and talk to them about what is going on. They should participate in the activities with them. If the clients are in their rooms playing a game, staff should peek in to let the individual know they are in the house. Communicating with the individuals is very important. Staff should always be engaging them."			

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	Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Staff have done a chore chart to give some visual guidance. That works with these guys. They're all capable of helping with chores. If someone wants time to themselves, staff need to invite the client to participate every 15 minutes." 9-3-4(a)			
W 0250 Bldg. 00	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), the facility failed to ensure clients #1, #2, and #3's active treatment schedules were individualized to meet their needs. Findings include: 1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's undated active treatment schedule indicated the following: "Monday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Tuesday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast	W 0250	W250 (Standard) Program Implementation – failed to ensure clients #1, 2 and 3's active treatment schedules were individualized to meet their needs. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·The Program Director / QIDP will be retrained on the standard that an active treatment schedule must be individualized to reflect the actual day to day programs to be implemented by staff for each person served. ·The expectation has been set that the Lead DSP and Program Director / QIDP will work together to develop an active treatment schedule for each individual residing in the facility.	09/11/2021

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	8:45 - 12:00 pm: Day program activities 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Wednesday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Thursday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Friday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Saturday 8 am - 9am: Breakfast 10 am: Morning Programs/Activities 12:00 pm: Lunch		·Facility staff will be trained to competency on this deficiency and the updated individualized active treatment schedules. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	3p - 4 pm: Afternoon Program/Activities 5:30 pm: Dinner 6pm - 7 pm: Evening Program/Activities 8:30 pm: Bedtime Sunday 8 am - 9am: Breakfast 10 am: Morning Programs/Activities 12:00 pm: Lunch 3p - 4 pm: Afternoon Program/Activities 5:30 pm: Dinner 6pm - 7 pm: Evening Program/Activities 8:30 pm: Bedtime Free Time Preferences: Individual, 8:30 pm to 8:30 pm. Quarterly Objectives: [Client #1's] quarterly objectives are yet to be determined." 2. Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's undated active treatment schedule indicated the following: "Monday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Tuesday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime			

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	Wednesday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Thursday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Friday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Saturday 8 am - 9am: Breakfast 10 am: Morning Programs/Activities 12:00 pm: Lunch 3p - 4 pm: Afternoon Program/Activities 5:30 pm: Dinner 6pm - 7 pm: Evening Program/Activities 8:30 pm: Bedtime			

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	Sunday 8 am - 9am: Breakfast 10 am: Morning Programs/Activities 12:00 pm: Lunch 3p - 4 pm: Afternoon Program/Activities 5:30 pm: Dinner 6pm - 7 pm: Evening Program/Activities 8:30 pm: Bedtime Free Time Preferences: Individual, 8:30 pm to 8:30 pm. Quarterly Objectives: [Client #2's] quarterly objectives are yet to be determined." 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's undated active treatment schedule indicated the following: "Monday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Tuesday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Wednesday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities			

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	12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Thursday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Friday 7 a - 7:30 a: Morning wake-up 7:30 - 8 am: Breakfast 8:45 - 12:00 pm: Day program activities 12:00 pm Arrive home from placement 12:00 pm - 5:30 pm: Lunch/Leisure 5:30 pm - 6:00 pm: Dinner 6:30p - 8:30 pm: Prepare for bedtime 8:30 pm: Bedtime Saturday 8 am - 9am: Breakfast 10 am: Morning Programs/Activities 12:00 pm: Lunch 3p - 4 pm: Afternoon Program/Activities 5:30 pm: Dinner 6pm - 7 pm: Evening Program/Activities 8:30 pm: Bedtime Sunday 8 am - 9am: Breakfast 10 am: Morning Programs/Activities 12:00 pm: Lunch 3p - 4 pm: Afternoon Program/Activities			

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	5:30 pm: Dinner 6pm - 7 pm: Evening Program/Activities 8:30 pm: Bedtime Free Time Preferences: Individual, 8:30 pm to 8:30 pm. Quarterly Objectives: [Client #3's] quarterly objectives are yet to be determined." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Once we identify the day programs, 12:00 pm will be the time they come home from day program. We have an activity area with games. Staff can engage individuals while at the house." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Some clients are still school aged. As we get more active activity schedule it will help. We can have small groups." 9-3-4(a)			
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must 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 3 of 3 sample clients (#1, #2, and #3), the facility failed to ensure clients #1, #2, and #3's plans addressed the use of medications to manage their behaviors. Findings include:	W 0312	W312 (Standard) Drug Usage – failed to ensure clients #1, 2, and 3's plans addressed the use of medications to manage their behaviors. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021	09/11/2021

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	1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's Medication Administration Record (MAR) for August 2021 indicated the following medications were prescribed to address client #1's behaviors: "Depakote (mood disorder) 500 mg (milligram), 1 tablet by mouth daily, 7:00 am. Fluoxetine (mood disorder) 20 mg, 1 tablet by mouth daily, 7:00 am. Methylphenidate (ADHD) 36 mg, 1 tablet by mouth daily in the morning, 7:00 am. Risperidone (mood disorder) 1 mg, 1 tablet by mouth twice daily, 7:00 am and 8:00 pm." The review did not indicate a Functional Behavioral Assessment (FBA), system for tracking client #1's behaviors, or a medication reduction plan to address the use of medications to control client #1's behaviors. 2. Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's MAR for August 2021 indicated the following medications were prescribed to address client #2's behaviors: "Divalproex 250 mg, 1 tablet by mouth daily 7:00 am (with the 500 mg tablet to equal 750 mg). Divalproex 500 mg, 1 tablet by mouth twice daily, 7:00 am and 8:00 pm. Guanfacine (aggression and ADHD) 4 mg, 1 tablet by mouth every am, 7:00 am. Quetiapine Fumarate (agitation and aggression) 50 mg, 1 tablet by mouth at bedtime, 8:00 pm. Risperidone (mood disorder) 0.5 mg, take 1 tablet by mouth every morning, give with 3 mg tablet, 8:00 am. Risperidone 3 mg, take 1 tablet by mouth every day, 7:00 am.		Survey with Event ID GII011 will be fully implemented, including the following specifics: ·The BSPs for clients #1, 2 and 3 have been finalized and placed in the individual's files. The use of medication to manage behaviors is addressed in each BSP. ·Further, all ISPs for all individuals living at the home have been reviewed and all needed BSPs have been finalized and placed in the individual's files. ·All staff are being trained to competency on the BSPs in place for each individual, including the use of medications to manage behaviors. ·The QIDP is receiving retraining on this standard and on the expectation that all utilization of psychotropic medications for behavior control must be addressed within the program plan for each individual. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each	

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	Risperidone 4 mg, give 1 tablet by mouth every day at bedtime, 8:00 pm. Sertraline (depression) 100 mg, give 1 tablet by mouth every day, 7:00 am. Sertraline 25 mg, give 1 tablet by mouth every day, 7:00 am. PRN Medications: Trazodone (promote sleep) 25 mg, give 1/2 tablet by mouth at bedtime as needed for sleep." The review did not indicate an FBA, system for tracking client #2's behaviors, or a medication reduction plan to address the use of medications to control client #2's behaviors. 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's MAR for August 2021 indicated the following medications were prescribed to address client #3's behaviors: "Divalproex 250 mg, 1 tablet by mouth daily at bedtime, 8:00 pm. Guanfacine 1 mg, 1 tablet by mouth daily at bedtime, 8:00 pm. Lithium Carbonate (mood disorder) 300 mg, 2 tablets by mouth at bedtime, 8:00 pm. Olanzapine (mood disorder) 10 mg, dissolve 1 tablet in mouth daily, 8:00 pm." The review did not indicate an FBA, system for tracking client #3's behaviors, or a medication reduction plan to address the use of medications to control client #3's behaviors. Behavior Clinician Manager (BCM) #1 was interviewed on 8/11/21 at 11:46 am and stated, "Psychiatric medications used to manage behaviors do need HRC (Human Rights Committee) approval."		citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "The BSP (Behavior Support Plans) are still a work in progress. They are not complete, yet." 9-3-5(a)			
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), plus 3 additional clients (#4, #5, and #7), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure client #3 saw a primary care physician within 30 days of admission, to ensure clients #1, #2, and #3 had hearing exams completed within 30 days of admission and to ensure client #3 had a vision exam completed within 30 days of admission, to ensure client #3 had a tuberculosis test completed within 30 days of admission, to ensure client #3 had a dental exam completed within 30 days of admission, to provide adequate nursing oversight for clients #1, #2, #3, and #4's health care needs, to ensure client #4's medications were not prepared ahead of time, to ensure clients #1, #2, #3, #5, and #7's medications were administered without error, to ensure staff administering client #4's medications had completed Core A/Core B medication training, to ensure clients #1, #2, #3, #5, and #7's medications were secured when not in use, and to follow universal precautions in regards to hand washing for clients #1, #2, #3, #4, #5, and #7.	W 0318	W318 (Condition) Health Care Services – failed to ensure client #3 saw a PCP within 30 days of admission, to ensure clients 1, 2, and 3 had hearing exams completed and to ensure client #3 had a vision exam completed, to ensure client #3 had a TB test completed, to ensure client #3 had a dental exam completed, to provide nursing oversight for health care needs, to ensure clients' medications were not prepared ahead of time, to ensure medications were administered without error, to ensure staff administering medications had completed Core A/Core B medication training, to ensure medications were secured when not in use, and to follow universal precautions in regards to hand washing. Findings at W322, W323, W327, W351, W367, W368, W370, W382, W455. Corrective action for resident(s) found to have been affected Dungarvin Indiana has developed	09/11/2021

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	Findings include: 1. The facility's health care services failed to ensure client #3 saw a primary care physician within 30 days of admission. Please see W322. 2. The facility's health care services failed to ensure clients #1, #2, and #3 had hearing exams completed within 30 days of admission and to ensure client #3 had a vision exam completed within 30 days of admission. Please see W323. 3. The facility's health care services failed to ensure client #3 had a tuberculosis test completed within 30 days of admission. Please see W327. 4. The facility's health care services failed to provide nursing oversight for clients #1, #2, #3, #4's, #5's and #7's health care needs. 5. The facility's health care services failed to ensure client #3 had a dental exam completed within 30 days of admission. Please see W351. 6. The facility's health care services failed to ensure client #4's medications were not prepared ahead of time. Please see W367. 7. The facility's health care services failed to ensure clients #1, #2, #3, #5, and #7's medications were administered without error. Please see W368. 8. The facility's health care services failed to ensure staff administering client #4's medications had completed Core A/Core B medication training. Please see W370.		an aggressive action plan to come into full compliance with all Conditions of Participation established by the Secretary of Health and Human Services. Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Client #3 saw his primary care physician on 6/30/21 for his admission physical. A copy of this physical was obtained and placed in his medical record for review. His follow up appointment with a new local PCP is scheduled on 9/10/21. ·The new PCP has ordered hearing evaluations for clients #1, 2, and 3, and the referral coordinator within the PCP's provider system is finalizing the process. In reviewing the cause of the delay in getting this scheduled, it was reported that the previous provider who was completing all of the hearing evaluations for Dungarvin informed us that they could no longer accept Medicaid, which caused a delay finding a new provider who requires the referral document from the primary care physician's office. As soon as the referrals are processed, these appointments will be run at the first possible date. Dungarvin will regularly follow up with the PCP office to update status.	

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	9. The facility's health care services failed to ensure clients #1, #2, #3, #5, and #7's medications were secured when not in use. Please see W382. 10. The facility's health care services failed to follow universal precautions in regards to hand washing for clients #1, #2, #3, #4, #5, and #7. Please see W455. 9-3-6(a)		·Client #3 had a vision exam prior to admission. The optometrist's office is faxing a copy of the report from the visit and it is being placed into his medical file. ·Client #3 saw his primary care physician on 6/30/21 for his admission physical. His TB test was administered at this appointment. A copy of the reading of the TB is being obtained and placed in his medical record for review. His follow up appointment with a new local PCP is scheduled on 9/10/21. ·Client #3 saw his dentist on 6/10/2021 and is due to be seen again in December 2021. Written documentation of the appointment was obtained from the dental office and placed in his medical file. ·All facility staff to be retrained to competency on this finding and on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration, which reiterates the Medication Administration training that the staff member who prepares the medication must be the staff member who administers the medication and also states that staff in ICF-I/DDs must be trained	

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			in Med Core A and B before handling/passing medications. ·All supervisory staff to be retrained on the expectation that appropriate staffing must be arranged at all ICF/I-DD facilities, including staff trained in Med Core A and B on schedule to administer all medications. ·All facility staff receiving training to competency on this finding and on Dungarvin policy on handwashing, Policy C-17, Exposure Control Plan. ·All facility staff receiving training to competency on this standard and on Dungarvin's expectation that the medications at ICF/I-DD facilities are to be locked at all times that the trained staff is not immediately accessing the cabinet and supervising the immediate area. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment and/or medication pass observations at varying times of the day to ensure that facility staff demonstrate competency on all areas of retraining covered in this Plan of Correction. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to	

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			2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 sample clients (#3), the facility failed to ensure client #3 saw a primary care physician within 30 days of admission. Findings include: Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21. Client #3's medical record did not include documentation of a visit with a primary care	W 0322	W322 (Standard) Physician Services – failed to ensure client #3 saw a primary care physician within 30 days of admission. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Client #3 saw his primary care physician on 6/30/21 for his	09/11/2021

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	physician or a scheduled appointment. Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "[Client #3] wants to stay with his previous provider. His mom is encouraging him to allow us to get someone closer." LPN #1 indicated new clients should see a primary care provider within 30 days of admission. 9-3-6(a)		admission physical. A copy of this physical was obtained and placed in his medical record for review. His follow up appointment with a new local PCP is scheduled on 9/10/21. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and			

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	hearing. Based on record review and interview for 3 of 3 sample clients (#1, #2, and, #3), the facility failed to ensure clients #1, #2, and #3 had hearing exams completed within 30 days of admission and to ensure client #3 had a vision exam completed within 30 days of admission. Findings include: 1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's record indicated an admission date of 7/1/21. Client #1's medical record did not include documentation of a hearing exam or scheduled appointment. 2. Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's record indicated an admission date of 7/2/21. Client #2's medical record did not include documentation of a hearing exam or scheduled appointment. 3. Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21. Client #3's medical record did not include documentation of a hearing exam or scheduled appointment. Client #3's medical record did not include documentation of a vision exam or scheduled appointment. Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "Vision and hearing exams should be completed	W 0323	W323 (Standard) Physician Services – failed to ensure clients had hearing exams completed within 30 days, failed to ensure client #3 had a vision exam completed within 30 days of admission. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·The new PCP has ordered hearing evaluations for clients #1, 2, and 3, and the referral coordinator within the PCP's provider system is finalizing the process. In reviewing the cause of the delay in getting this scheduled, it was reported that the previous provider who was completing all of the hearing evaluations for Dungarvin informed us that they could no longer accept Medicaid, which caused a delay finding a new provider who requires the referral document from the primary care physician's office. As soon as the referrals are processed, these appointments will be run at the first possible date. Dungarvin will regularly follow up with the PCP office to update status. ·Client #3 had a vision exam prior to admission. The optometrist's office is faxing a copy of the report from the visit	09/11/2021

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	within 30 days of admission." LPN #1 stated, "[Client #3's] mom said he had recent hearing and vision tests. She couldn't remember the dates. She's going to get me the paperwork." 9-3-6(a)		and it is being placed into his medical file. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the			

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	15G573	A. BUILDING 00 B. WING	08/12/2021

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	American Academy of Pediatrics, or both. Based on record review and interview for 1 of 3 sample clients (#3), the facility failed to ensure client #3 had a tuberculosis test completed within 30 days of admission. Findings include: Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21. Client #3's medical record did not include documentation of a tuberculosis test. Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "The tuberculosis test should be completed within 30 days of admission." 9-3-6(a)	W 0327	W327 (Standard) Physician Services – failed to ensure client #3 had a TB test completed within 30 days of admission. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Client #3 saw his primary care physician on 6/30/21 for his admission physical. His TB test was administered at this appointment. A copy of the reading of the TB is being obtained and placed in his medical record for review. His follow up appointment with a new local PCP is scheduled on 9/10/21. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. 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.	09/11/2021

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			Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 3 of 3 sample clients (#1, #2, and #3), plus 3 additional clients (#4, #5 and #7), the facility's nursing services failed to provide oversight for clients #1, #2, #3, #4's, #5's and #7's health care needs. Findings include: 1. The nursing services failed to ensure client #3 saw a primary care physician within 30 days of admission. Please see W322. 2. The nursing services failed to ensure clients #1, #2, and #3 had hearing exams completed within 30 days of admission and to ensure client #3 had a vision exam completed within 30 days of admission. Please see W323. 3. The nursing services failed to ensure client #3 had a tuberculosis test completed within 30 days of admission. Please see W327. 4. The nursing services failed to ensure client #3	W 0331	W331 (Standard) Nursing Services – failed to provide oversight for clients' health care needs. Findings at W322, W323, W327, W351, W367, W368, W370, W382, W455. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Client #3 saw his primary care physician on 6/30/21 for his admission physical. His TB test was administered at this appointment. A copy of this physical was obtained and placed in his medical record for review. A copy of the reading of the TB is being obtained and placed in his medical record for review. His follow up appointment with a new	09/11/2021

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	had a dental exam completed within 30 days of admission. Please see W351. 5. The nursing services failed to ensure client #4's medications were not prepared ahead of time. Please see W367. 6. The nursing services failed to ensure clients #1, #2, #3, #5, and #7's medications were administered without error. Please see W368. 7. The nursing services failed to ensure staff administering client #4's medications had completed Core A/Core B medication training. Please see W370. 8. The nursing services failed to ensure clients #1, #2, #3, #5, and #7's medications were secured when not in use. Please see W382. 9. The nursing services failed to follow universal precautions in regards to hand washing for clients #1, #2, #3, #4, #5, and #7. Please see W455. 9-3-6(a)		local PCP is scheduled on 9/10/21. ·The new PCP has ordered hearing evaluations for clients #1, 2, and 3, and the referral coordinator within the PCP's provider system is finalizing the process. In reviewing the cause of the delay in getting this scheduled, it was reported that the previous provider who was completing all of the hearing evaluations for Dungarvin informed us that they could no longer accept Medicaid, which caused a delay finding a new provider who requires the referral document from the primary care physician's office. As soon as the referrals are processed, these appointments will be run at the first possible date. Dungarvin will regularly follow up with the PCP office to update status. ·Client #3 had a vision exam prior to admission. The optometrist's office is faxing a copy of the report from the visit and it is being placed into his medical file. ·Client #3 saw his dentist on 6/10/2021 and is due to be seen again in December 2021. Written documentation of the appointment was obtained from the dental office and placed in his medical file. ·All facility staff to be retrained to competency on this finding and	

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			on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration, which reiterates the Medication Administration training that the staff member who prepares the medication must be the staff member who administers the medication and also states that staff in ICF-I/DDs must be trained in Med Core A and B before handling/passing medications. ·All supervisory staff to be retrained on the expectation that appropriate staffing must be arranged at all ICF/I-DD facilities, including staff trained in Med Core A and B on schedule to administer all medications. ·All facility staff receiving training to competency on Dungarvin's expectation that the medications at ICF/I-DD facilities are to be locked at all times that the trained staff is not immediately accessing the cabinet and supervising the immediate area. ·All facility staff receiving training to competency on this standard and on Dungarvin's expectation that the medications at ICF/I-DD facilities are to be locked at all times that the trained staff is not immediately accessing the cabinet and supervising the immediate area.	

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			·All facility staff receiving training to competency on this finding and on Dungarvin policy on handwashing, Policy C-17, Exposure Control Plan. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment and medication pass observations at varying times of the day to ensure that facility staff demonstrate competency on all elements of staff training included in this Plan of Correction. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken	

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			All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0351 Bldg. 00	483.460(f)(1) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). Based on record review and interview for 1 of 3 sample clients (#3), the facility failed to ensure client #3 had a dental exam completed within 1 month of admission. Findings include: Client #3's record was reviewed on 8/4/21 at 2:42 pm. Client #3's record indicated an admission date of 7/2/21. Client #3's medical record did not include documentation of a dental exam or a scheduled	W 0351	W351 (Standard) Comprehensive Dental Diagnostic Service – failed to ensure client #3 had a dental exam completed within 1 month of admission. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·Client #3 saw his dentist on 6/10/2021 and is due to be seen	09/11/2021

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	appointment. Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "[Client #3's] mom said he had a dental appointment recently. It fell within the 6 month time span. She hasn't gotten me the paperwork, yet." LPN #1 stated, "They should have dental exams within 30 days of admission." 9-3-6(a)		again in December 2021. Written documentation of the appointment was obtained from the dental office and placed in his medical file. ·Facility nurse and QIDP are being retrained on the Dungarvin Pre/Post Admission Checklist in place to assist the oversight team in ensuring that all requirements are met before and immediately after a new admission, including obtaining proof of all required medical assessments/appointments. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0367 Bldg. 00	483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration. Based on observation, record review, and	W 0367	W367 (Standard)	09/11/2021

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	interview for 1 additional client (#4), the facility failed to ensure client #4's medications were not prepared ahead of time. Findings include: Observations were conducted at the group home on 8/4/21 from 7:30 am through 9:00 am. Client #4 was present in the home for the duration of the observation period. At 8:00 am, DSP #1 prepared client #4's 8:00 am medication. DSP #1 placed the medication in a medication cup and locked it in the medication cabinet. At 8:04 am, DSP #2 stated, "I haven't been trained to do it. I'm not supposed to." DSP #1 provided instructions and left the group home. At 8:12 am, client #4 came to the medication room. DSP #2 handed client #4 a medication cup, and client #4 took the medication with water. DSP #2 did not identify the medications or their purpose before client #4 took the medications. Client #4's Medication Administration Record (MAR) for August 2021 was reviewed on 8/3/21 at 2:23 pm and indicated the following 8:00 am medications: "Duloxetine (antidepressant) HCL (hydrochloric acid) DR (delayed release) 30 mg (milligram) cap (capsule). Give one capsule by mouth twice a day. Levetiracetam (anticonvulsant) 750 mg (milligrams) tablet. Give one tablet by mouth twice a day. Risperidone (antipsychotic) 1 mg tablet. Take one tablet by mouth twice a day. Vyvanse (stimulant). Give one capsule by mouth every morning."		Drug Administration – failed to ensure client #4's medications were not prepared ahead of time. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·All facility staff to be retrained to competency on this finding and on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct medication pass observations at varying times of the day to ensure that facility staff demonstrate competency on drug storage procedures. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other	

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	DSP #2 was interviewed on 8/3/21 at 2:25 pm and stated, "I don't pass meds (medications). I haven't been trained." Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "The client should be in the medication room. Staff would only have the one person's medications out and would involve them in the process. Staff should not prepare medications ahead of time." 9-3-6(a)		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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), plus 2 additional client (#5 and #7), the facility failed to ensure clients #1, #2, #3, #5, and #7's medications were administered without error. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 8/4/21 at 10:52 am. 1. A BDDS report dated 7/3/21 indicated the following: "On Friday, July 2, 2021 at about 8 pm, staff	W 0368	W368 (Standard) Drug Administration – failed to ensure medications were administered without error. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·All facility staff to be retrained to competency on this finding and on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding	09/11/2021

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	reported that [client #1] missed his morning medication. Reportedly, staff who worked in the morning forgot to give one medication and ear drops. The medication (sic) missed was (sic) ear drops for wax and Methylphenedate (sic) (a stimulant). Staff followed protocol and informed the Program Director on call. The nurse was also notified. [Client #1] is doing fine and nothing unusual has been noted." Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's MAR for July 2021 indicated the following: "Daily-vite (supplement), 1 tablet, 1 x daily, 7:00 am. 7/14/21 - Missed, This med is finished. 7/15/21 - Missed, This med is finished. 7/16/21 - Missed, This med is finished. 7/17/21 - Missed, Do not have. 7/18/21 - 7/31/21 - On Hold." "Loratadine (allergies), 1 tablet, 1 x daily, 7:00 am. 7/14/21 - Missed, This med is finished. 7/15/21 - Missed, This med is finished. 7/16/21 - Missed, This med is finished. 7/17/21 - Missed, Do not have. 7/18/21 - 7/31/21 - On Hold." "Methylphenidate, 1 tablet, daily am, 7:00 am. 7/2/21 - Missed, This med was not available." Client #1's MAR for August 2021 indicated the following: "Daily-vite, 1 tablet, 1 x daily, 7:00 am. 8/1/21 - 8/4/21 - On Hold." "Loratadine, 1 tablet, 1 x daily, 7:00 am. 8/1/21 - 8/4/21 - On Hold."		Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct medication pass observations at varying times of the day to ensure that facility staff demonstrate competency on medication administration procedures. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include	

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	"Melatonin (insomnia), 1 tablet 8:00 pm. 8/4/21 - Refused, [Client #1] refused to take this medication, claiming that it is not the one that he is used to. Staff conviction failed." Licensed Practical Nurse (LPN) #1 was interviewed by phone on 8/5/21 at 9:33 am and stated, "[Client #1] went to see his Nurse Practitioner (NP). He reviewed all of the medications, but when he wrote new scripts, he didn't include those two. I've contacted them twice trying to find out if he is supposed to have those medications or not. I haven't heard anything back." 2. A BDDS report dated 7/15/21 indicated the following: "Today around 7:25 pm, staff reported a medication error for [client #5] who missed his 2 pm dose of Quetiapine (antipsychotic) 50 mg yesterday. Staff are monitoring [client #5] for any side effects that may be caused by the missed dose and none has been noticed by the time this report is being written." Client #5's MAR for July 2021 was reviewed on 8/4/21 at 2:25 pm and indicated the following: "Quetiapine 50 mg, 1 tablet, twice daily, 8:00 am and 2:00 pm. 7/15/21 - Missed, Medication was found still in bubble pack, staff to be retrained." Client #5's MAR for July 2021 was reviewed on 8/4/21 at 2:25 pm and indicated the following: "Chlorpromazine (antipsychotic) 100 mg, 1 tablet, 1 x daily, 8:00 am. 8/2/21 - Missed, It's not home. 8/3/21 - Missed, Med is not here. 8/4/21 - None."		documented evidence that the POC items are being fully implemented.	

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"Gabapentin (To relieve nerve pain) 300 mg every day, 3 times a day, 8:00 am, 2:00 pm, 8:00 pm.
8/2/21, 8:00 am - Missed.
8/3/21, 2:00 pm - No documentation.
8/4/21, 2:00 pm - No documentation.
8/4/21, 8:00 pm - No documentation."

"Ibuprofen (pain reliever) 600 mg tablet, 1 tablet, 2 times a day, 8:00 am and 8:00 pm.
8/4/21, 8:00 pm - No documentation."

"Levetiracetam (anticonvulsant.) 500 mg, twice daily, 8:00 am and 8:00 pm.
8/4/21 - No documentation."

"Quetiapine 300 mg, 2 tablets, at bedtime, 8:00 pm.
8/4/21 - No documentation."

Quetiapine 50 mg, 1 tablet, twice daily, 8:00 am and 2:00 pm.
8/3/21 - No documentation.
8/4/21 - No documentation."

Trazodone (Depression) 100 mg, every day, 8:00 pm.
8/4/21 - No documentation."

LPN #1 was interviewed by phone on 8/5/21 at 9:33 am and stated, "I went through all of the medications on 8/2/21. I compared them to the MAR. They are all in the house. Staff should be documenting and reporting if something is wrong."

3. A BDDS report dated 7/17/21 indicated the following:
"This morning around 8 am, staff notified the on

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	call pager that when she was passing morning medications for [client #2], staff noticed that his Risperidone (antipsychotic) 0.5 mg (milligrams) was already popped out, and staff cannot tell when that tablet was given perhaps as an extra dose. Staff are monitoring [client #2] for any side effects that maybe (sic) due to a potential extra dose. Staff has not noticed any side effects by the time this report is being written." Client #2's record was reviewed on 8/4/21 at 2:37 pm. Client #2's MAR for July 2021 indicated the following: "Risperidone 0.5 mg tablet, 1 x daily. 8:00 am. Recorded Type: Administered. Administer Date: 7/17/21. Administer Time: 8:00 am. Administered By: [Program Director (PD) #1]. Recorded By: [PD #1] on 7/17/21, 7:21 am." 4. A BDDS report dated 7/22/21 indicated the following: "On 7/21/21, staff was helping other individuals and forgot to administer [client #3's] 9 am medications, Levothyroxine 50 mg for treating Hypothyroid. The nurse was informed." Client #3's record was reviewed on 8/4/21 at 12:40 pm. Client #3's MAR for July 2021 indicated the following: "Levothyroxine 50 mg, 1 tablet, 1 x daily. 7/16/21 - Missed, New staff missed med at 9:00 am and individual had eaten already. 7/21/21 - Missed, Medication missed." Client #3's MAR for August 2021 indicated the following: "Guanfacine (ADHD) 1 mg, 1 tablet, at bedtime, 8:00 pm.			

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	8/3/21 - Missed." 5. Client #7 was interviewed on 8/4/21 at 5:48 pm and stated, "They don't have my Trazodone. I've only slept 10 hours in 4 days. I think they forgot to order it or lost it." Client #7's MAR for August 2021 was reviewed on 8/4/21 at 1:24 pm and indicated the following: "Trazodone 100 mg, 1 tablet, every day, 8:00 pm. 8/1/21 - Missed, This med is missing! 8/2/21 - Missed, Missing medication. 8/3/21 - Missed." LPN #1 was interviewed by phone on 8/5/21 at 9:33 am and stated, "The medication was in the house. It has been in the house. It was there on 8/2/21 when I went to the house. I don't know what is up with that. Staff should report it immediately. They should call the on-call nurse if they have a problem or can't find something." LPN #1 was interviewed on 8/4/21 at 2:56 pm and stated, "There has been ongoing training with staff in the house. There is another training right now to talk about medication administration. I've talked with them about where medications should be kept, and I've told them to call the on-call nurse if there is a problem." LPN #1 indicated there are too many medications in the medication cabinets, making it difficult for staff to keep things organized. LPN #1 indicated medications clients brought from home should be destroyed and over-flow medications should be stored separately. LPN #1 indicated staff should pass meds according to the Medication Administration Record. 9-3-6(a)			

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W 0370 Bldg. 00	483.460(k)(3) DRUG ADMINISTRATION The system for drug administration must assure that unlicensed personnel are allowed to administer drugs only if State law permits. Based on observation, record review, and interview for 1 additional client (#4), the facility failed to ensure staff passing client #4's medications had completed Core A/Core B medication training. Findings include: Observations were conducted at the group home on 8/4/21 from 7:30 am through 9:00 am. Client #4 was present in the home for the duration of the observation period. At 8:00 am, DSP #1 prepared client #4's 8:00 am medication. DSP #1 placed the medication in a medication cup and locked it in the medication cabinet. At 8:04 am, DSP #2 stated, "I haven't been trained to do it. I'm not supposed to." DSP #1 provided instructions and left the group home. At 8:12 am, client #4 came to the medication room. DSP #2 handed client #4 a medication cup, and client #4 took the medication with water. DSP #2 did not identify the medications or their purpose before client #4 took the medications. Client #4's Medication Administration Record (MAR) for August 2021 was reviewed on 8/3/21 at 2:23 pm and indicated the following 8:00 am medications: "Duloxetine (antidepressant) HCL (hydrochloric acid) DR (delayed release) 30 mg (milligram) cap (capsule). Give one capsule by mouth twice a day. Levetiracetam (anticonvulsant) 750 mg	W 0370	W370 (Standard) Drug Administration – failed to ensure staff passing client #4's medications had completed Core A/Core B medication training. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·All facility staff to be retrained to competency on this finding and on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration, which reiterates the Medication Administration training that the staff member who prepares the medication must be the staff member who administers the medication and also states that staff in ICF-I/DDs must be trained in Med Core A and B before handling/passing medications. ·All supervisory staff to be retrained on the expectation that appropriate staffing must be arranged at all ICF/I-DD facilities, including staff trained in Med Core A and B on schedule to	09/11/2021

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	(milligrams) tablet. Give one tablet by mouth twice a day. Risperidone (antipsychotic) 1 mg tablet. Take one tablet by mouth twice a day. Vyvanse (stimulant). Give one capsule by mouth every morning." DSP #2's employee file was reviewed on 8/4/21 at 11:28 am. The review did not include evidence of Core A/Core B medication training for DSP #2. Human Resources Specialist #1 was interviewed on 8/4/21 at 11:44 am and stated, "[DSP #2] has not completed medication training." DSP #2 was interviewed on 8/3/21 at 2:25 pm and stated, "I don't pass meds (medications). I haven't been trained. Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "A person who hasn't completed training cannot pass medications. It also has to be the person who prepared the medication. That person has been told she cannot pass medications." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Staff passing medications should have completed Core A/Core B medication administration training. That staff knows she isn't supposed to pass medications. We've talked about it." 9-3-6(a)		administer all medications. 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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being			

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	prepared for administration. Based on observation, record review, and interview for 2 of 3 sample clients (#1 and #2), plus 2 additional clients (#5 and #7), the facility failed to ensure clients #1, #2, #5, and #7's medications were secured when not in use. Findings include: Observations were conducted on 8/3/21 from 5:30 pm through 8:30 pm and on 8/4/21 from 7:30 am through 9:00 am. Clients #1, #2, #5, and #7 were present in the home for the duration of the observation periods. 1. On 8/3/21 at 6:32 pm, Direct Support Professional (DSP) #5 took out client #7's medication cards. DSP #5 popped a pill into a medication cup and initialed the back of the medication packaging. DSP #5 put the medication cup in the medication cabinet and locked it. DSP #5 walked away. DSP #5 left client #7's medication cards sitting on the table in the medication room while he was away. The medication packaging indicated the following medications were left unattended until 6:40 pm: "Midorine (blood pressure) 5 mg (milligrams). Olanzapine (antipsychotic) 15 mg. Divalproex Sod (sodium) (anticonvulsant) 250 mg. Lithium Carb (carbonate) (mood disorder) 600 mg. Melatonin (insomnia) 5 mg." Client #7's MAR for August 2021 was reviewed on 8/4/21 at 1:24 pm and indicated client #7 takes the following medication at 7:00 pm. "Midorine 5mg, 1 tablet, 3 x a day, 7:00 am, 12:00 pm, and 7:00 pm."	W 0382	W382 (Standard) Drug Storage and Recordkeeping – failed to ensure clients' medications were secured when not in use. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·All facility staff receiving training to competency on this standard and on Dungarvin's expectation that the medications at ICF/I-DD facilities are to be locked at all times that the trained staff is not immediately accessing the cabinet and supervising the immediate area. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct medication pass observations at varying times of the day to ensure that facility staff demonstrate competency on drug storage procedures. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and	09/11/2021

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	2. On 8/3/21 at 7:25 pm, DSP #5 removed a grocery bag full of medication from the medication cabinet. DSP #5 sorted through the medications. DSP #5 stated, "I'm getting [clients #1 and #2's] medications ready." DSP #5 popped pills into a medication cup. The pharmacy packaging indicated the following medications for client #1: "Desmopressin Acetate (incontinence) 0.2 mg, 3 tablets at bedtime, 8:00 pm. Melatonin 5 mg, 1 tablet at bedtime, 8:00 pm. Risperidone (mood disorder) 1 mg, 1 tablet, twice daily, 8:00 pm." Client #2's pharmacy packaging indicated the following medications: "Risperidone 4 mg, 1 tablet at bedtime, 8:00 pm." "Quetiapine (antipsychotic) 500 mg, 1 tablet at bedtime, 8:00 pm." At 7:35 pm, DSP #5 left the medication area to look for client #1. At 7:38 pm, DSP #5 returned, wrote client #1's name on the medication cup, and put the medication cup in the medication cabinet. DSP #5 stated, "[Client #1] said he will take the medicine at 8:00 pm." DSP #5 was interviewed on 8/3/21 at 7:42 pm and stated, "The medication should be locked in the cabinet at all times." 3. On 8/4/21 at 7:54 am, DSP #1 prepared client #5's medications. DSP #1 popped client #5's medications from the pharmacy packaging into a medication cup. DSP #1 left the medication cup on the desk in the medication room and went to look for client #5. At 8:00 am, DSP #1 gave client #5 his medication. Client #5's pharmacy packaging indicated the		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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	following morning medications: "Benztropine (anti-tremor) 1 mg, 5 tablets, 2 times a day, morning. Gabapentin (anticonvulsant and nerve pain)v 300 mg, 1 tablet, 3 times a day, morning. Ibuprofen (pain reliever) 600 mg, 1 tablet, 2 times a day, morning, with food or milk. Levetiracetam (anticonvulsant) 500 mg, 1 tablet, 2 times a day, morning. Omeprazole (treats heart burn) 20 mg, 1 tablet, 1 time a day, morning. Quetiapine 50 mg, 1 tablet, 2 times a day, morning." DSP #1 was interviewed on 8/4/21 at 8:04 am and stated, "Medications should be kept locked in the medication cabinet." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Medications should be put back in the closet and locked up when staff need to walk away." Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "All medications should be locked up when staff are not present. If someone refuses a medication, staff should mark it as a Leave of Absence and put it in a container, so it is secure. It shouldn't be left where it can be mixed up with someone else's medication." LPN #1 stated, "Staff are taught to prepare each individual's medication, put those way, then go on to the next person." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "I would expect medications to be passed in the medication area. The individual should come to the medication area before the medications are prepared. The			

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	closets need to be locked anytime staff leave the area." 9-3-6(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 3 of 3 sample clients (#1, #2, and #3) plus 3 additional clients (#4, #5, and #7), the facility failed to follow universal precautions in regards to hand washing for clients #1, #2, #3, #4, #5, and #7. Findings include: Observations were conducted at the group home on 8/3/21 from 1:24 pm through 3:30 pm, from 5:30 pm through 8:30 pm, and on 8/4/21 from 7:30 pm through 9:00 pm. Clients #1, #2, #3, #4, #5, and #7 were present in the home for the duration of the observation periods. 1. On 8/3/21 at 1:49 pm, client #5 asked, "Can I get a bowl of cereal?" Direct Support Professional (DSP) #1 stated, "Didn't you eat lunch?" Client #5 indicated he had not eaten lunch. DSP #1 did not respond to client #5. Client #5 went to the kitchen, got out a cup, and poured a cup of milk. Client #5 took his drink to the living room and sat in a recliner. Client #5 did not wash his hands before preparing his drink. Staff did not prompt client #5 to wash his hands. 2. On 8/3/21 at 2:00 pm, client #6 prepared a sandwich and poured a cup of milk. Client #6 did not wash his hands before preparing his	W 0455	W455 (Standard) Infection Control – failed to follow universal precautions in regards to hand washing. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·All facility staff receiving training to competency on this finding and on Dungarvin policy on handwashing, Policy C-17, Exposure Control Plan. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on the handwashing policy. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two	09/11/2021

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	sandwich. Staff did not prompt client #6 to wash his hands. 3. On 8/3/21 at 5:30 pm, client #1 made toast. Client #1 opened a can of carrots, put them in a bowl and warmed them in the microwave. Client #1 sat at the table and ate his toast and carrots. At 6:12 pm, client #1 was at the computer. At 6:49 pm, client #1 was using his cell phone. At 7:00 pm, client #1 used his fingers to put 8 sausage links on a plate. Client #1 warmed the sausage links in the microwave then put syrup on his plate. Client #1 took his plate to the living room and sat in a recliner. Client #1 began eating the sausage links with his fingers. Client #1 got up from the chair, went into the kitchen and got a plastic knife and fork. Client #1 sat back down. Client #1 got up from the recliner, dumped his plate in the garbage and put his plate in the sink. At 7:25 am, client #1 put a pizza in the oven. Client #1 did not wash his hands before eating or preparing food. Staff did not prompt client #1 to wash his hands. 4. On 8/3/21 at 6:30 pm, DSP #4 followed the surveyor to the bathroom to answer a question. DSP #4 went to the kitchen and opened a frozen pizza. DSP #4 washed her hands after removing the plastic wrapping from the pizza. 5. On 8/3/21 at 6:36 pm, DSP #5 began to prepare medications. DSP #5 took out a medication card and used his bare hands to pop the pill into a medication cup. DSP #5 called client #7 to the medication room and gave him his medication. DSP #5 did not wash his hands before preparing client #7's medication and did not prompt client #7 to wash his hands. 6. On 8/3/21 at 7:07 pm, client #3 opened 2		weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	frozen hand held microwaveable sandwiches and cooked them in the microwave. Client #3 sat on the sofa in the living room and ate the sandwiches with his hands. Client #3 did not wash his hands before cooking or eating. Staff did not prompt client #3 to wash his hands. 7. On 8/3/21 at 7:07 pm, client #2 asked for cookies and milk. DSP #4 poured a cup of milk for client #1 and gave him 2 packages of chocolate chip cookies. Client #2 sat at the dining table and ate his cookies dipped in milk. Client #2 did not wash his hands before eating. DSP #4 did not prompt client #2 to wash his hands. 8. On 8/3/21 at 7:07 pm, DSP #4 took 2 slices of pizza to client #7 while he sat in a swing on the screened porch. Client #7 did not wash his hands. DSP #4 did not prompt client #7 to wash his hands before eating. 9. On 8/3/21 at 7:25 pm, DSP #5 prepared clients #1 and #2's medications. DSP #5 did not wash his hands before preparing clients #1 or #2's medications. At 7:42 pm, DSP #5 administered client #2's medications. Client #2 picked the pills out of the medication cup one at a time and took them with water. Client #2 did not wash his hands prior to taking his medications. DSP #5 did not prompt client #2 to wash his hands. At 7:53 pm, DSP #5 prepared client #4's medications. DSP #5 did not sanitize the work surface before preparing medications. DSP #5 dropped one of client #4's medications onto the work surface, picked it up, and put it into the medication cup. DSP #5 directed client #4 to wash his hands before receiving his medications.			

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	DSP #5 was interviewed on 8/3/21 at 7:44 pm and stated, "[Clients] should wash their hands before they take their medications. I forgot to tell [client #1]. Staff should wash their hands, too." At 7:53 pm, DSP #5 stated, "I made a mistake today. I should have put a paper towel down on the desk before I began to do the medication." DSP #5 indicated he did not sanitize the work surface or wash his hands before preparing and administering medications. 10. On 8/4/21 at 7:54 am, DSP #1 prepared client #5's medications. DSP #1 did not wash her hands. Client #5 took his medications. Client #5 did not wash his hands before taking his medications. DSP #1 was interviewed on 8/4/21 at 8:04 am and stated, "Clients and staff should wash their hands before they take their medications. I didn't today." 11. On 8/4/21 at 8:11 am, client #1 took prepared sausages out of the microwave and put them on a plate. Client #1 ate the sausages with his fingers at the dining table. Client #1 did not wash his hands. Staff did not prompt client #1 to wash his hands. 12. On 8/4/21 at 8:12 am, DSP #2 handed client #4 prepared medications in a medication cup. Client #4 took the medication. DSP #2 did not wash her hands. DSP #2 did not prompt client #4 to wash his hands. Licensed Practical Nurse (LPN) #1 was interviewed on 8/4/21 at 2:56 pm and stated, "Hand washing during medication pass should happen before staff touch anything. Staff should encourage clients to wash their hands before they			

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	touch anything. Medication preparation surfaces should be sanitized." LPN #1 stated, "Everybody needs to be washing their hands. When staff prepare food, they should wash their hands and encourage clients to wash their hands prior to eating." 9-3-7(a)			
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview for 1 additional client (#7), the facility failed to ensure client #7's food was served in a manner consistent with his dining plan. Findings include: Observations were conducted on 8/3/21 from 5:30 pm through 8:30 pm. Client #7 was present in the home for the duration of the observation period. At 7:45 pm, client #7 was sitting in a hammock like swing on the back screened porch. Direct Support Professional (DSP) #4 brought client #7 a paper plate with 2 whole slices of pizza. Client #7 ate the pizza with a 2 liter bottle of root beer while sitting in the swing. DSP #4 left client #7 outside and went back into the house. Client #7's record was reviewed on 8/4/21 at 12:00 pm. Client #7's Health Risk: Dining Plan for Cut-up Food Consistency dated 7/1/21 indicated the following: "Assist the individual to cut all food into bite size	W 0474	W474 (Standard) Meal Services – failed to ensure client #7's food was served in a manner consistent with his dining plan. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: ·All facility staff receiving training to competency on this finding and on all dining risk plans for the individuals at the facility. ·Once retraining is complete, the QIDP, Nurse, Area Director or other qualified senior level supervisory staff will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on implementation of the risk plans for each individual. Initially these observations will be conducted 4 times per week for	09/11/2021

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	pieces - 1/2 inch x 1/2 inch x 1/2 inch. Always provide an environment with least amount of distraction and TV (television). Always sit in an upright position. Eat and drink slowly, taking small bites/sips. Chew food thoroughly. Clean mouth regularly. Have family member or staff who is familiar with the swallow precautions be present to give reminders. Provide supervision to give verbal cues to take small bites and chew thoroughly as needed. Verbal cues to take a drink to clear food from mouth as needed. Mealtimes should be relaxed and not rushed. Remind the individual not to talk while chewing as needed. Sit upright at the table 90-degree angle." DSP #4 was interviewed on 8/3/21 at 6:18 pm. DSP #4 indicated she was trained on the clients high risk plans. DSP #4 stated, "I don't know if anyone has special plans for eating." Licensed Practical Nurse (LPN #1) was interviewed on 8/4/21 at 2:56 pm and stated, "[Client #7's] food is supposed to be in bite size pieces. Whole slices of pizza is not ok." 9-3-8(a)		the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching. How facility will identify other residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. Measures or systemic changes facility put in place to ensure no recurrence Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 9999 Bldg. 00	State Findings 1. 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the	W 9999	W9999 (State Findings) Governing Body – failed to submit incident reports to BDDS regarding medication errors. Resident Protections – failed to	09/11/2021

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	following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 16) A medication error or medical treatment error as follows: c. missed medication - not given. This state rule was not met as evidenced by: Based on interview and record review for 2 of 3 sample clients (#1 and #3), plus 2 additional clients (#5 and #7), the facility failed to submit incident reports to the BDDS (Bureau of Developmental Disabilities Services) regarding medication errors. Findings include: The facility's BDDS reports were reviewed on 8/4/21 at 10:52 am. The review did not indicate the following medication errors were reported to BDDS. 1. Client #1's record was reviewed on 8/4/21 at 12:40 pm. Client #1's MAR for July 2021 indicated the following: "Daily-vite (supplement), 1 tablet, 1 x daily, 7:00 am. 7/14/21 - Missed, This med is finished. 7/15/21 - Missed, This med is finished. 7/16/21 - Missed, This med is finished. 7/17/21 - Missed, Do not have. 7/18/21 - 7/31/21 - On Hold." "Loratadine (allergies), 1 tablet, 1 x daily, 7:00 am. 7/14/21 - Missed, This med is finished. 7/15/21 - Missed, This med is finished. 7/16/21 - Missed, This med is finished.		ensure DSPs had 3 reference checks completed prior to employment at the group home. Health Care Services – failed to ensure DSP #2 received Core A and B medication administration training prior to administering medications to client #4. Corrective action for resident(s) found to have been affected Each POC item from 8/12/2021 Survey with Event ID GII011 will be fully implemented, including the following specifics: Governing Body ·All facility staff being retrained on this finding and on Dungarvin policies regarding Incident Reporting and Medication Administration. All medication errors, including missing medications, are high level incidents requiring submission of an internal incident report (GER) and direct reporting to the nurse and supervisor. ·All supervisory/QIDP level staff receiving retraining on the Dungarvin policy on Incident Reporting, including the requirement that missing medications/medications not available must be reported to BDDS in accordance with 460 IAC 9-3-1. ·Nurse and QIDP hold a weekly nursing meeting which will include a review of the facility MARs to	

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	7/17/21 - Missed, Do not have. 7/18/21 - 7/31/21 - On Hold." "Methylphenidate, 1 tablet, daily am, 7:00 am. 7/2/21 - Missed, This med was not available." Client #1's MAR for August 2021 indicated the following: "Daily-vite, 1 tablet, 1 x daily, 7:00 am. 8/1/21 - 8/4/21 - On Hold." "Loratadine, 1 tablet, 1 x daily, 7:00 am. 8/1/21 - 8/4/21 - On Hold." "Melatonin (insomnia), 1 tablet 8:00 pm. 8/4/21 - Refused, [Client #1] refused to take this medication, claiming that it is not the one that he is used to. Staff conviction failed." Licensed Practical Nurse (LPN) #1 was interviewed by phone on 8/5/21 at 9:33 am and stated, "[Client #1] went to see his Nurse Practitioner (NP). He reviewed all of the medications, but when he wrote new scripts, he didn't include those two. I've contacted them twice trying to find out if he is supposed to have those medications or not. I haven't heard anything back." 2. Client #5's MAR for July 2021 was reviewed on 8/4/21 at 2:25 pm and indicated the following: "Chlorpromazine (antipsychotic) 100 mg, 1 tablet, 1 x daily, 8:00 am. 8/2/21 - Missed, It's not home. 8/3/21 - Missed, Med is not here. 8/4/21 - None." "Gabapentin (To relieve nerve pain) 300 mg every day, 3 times a day, 8:00 am, 2:00 pm, 8:00		ensure that no medication errors have been missed by facility staff. Resident Protections ·Completed reference checks for DSPs #2 and #3 have been provided to the Area Director by Human Resources. The originals have been placed in the Human Resource files for each employee. ·Human Resources staff has been retrained on this finding and on the expectation that newly hired DSPs are not to be released to go and work at the location until all three reference checks have been completed. Health Care Services ·All facility staff to be retrained to competency on this finding and on appropriate medication passing procedures, including Policies C-1 regarding Medication Administration, C-3 regarding Medication Administration and Documentation, and Dungarvin's Organized System of Medication Administration, which reiterates the Medication Administration training that the staff member who prepares the medication must be the staff member who administers the medication and also states that staff in ICF-I/DDs must be trained in Med Core A and B before handling/passing medications. How facility will identify other residents potentially affected & what measures taken	

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	pm. 8/2/21, 8:00 am - Missed. 8/3/21, 2:00 pm - No documentation. 8/4/21, 2:00 pm - No documentation. 8/4/21, 8:00 pm - No documentation." "Ibuprofen (pain reliever) 600 mg tablet, 1 tablet, 2 times a day, 8:00 am and 8:00 pm. 8/4/21, 8:00 pm - No documentation." "Levetiracetam (anticonvulsant.) 500 mg, twice daily, 8:00 am and 8:00 pm. 8/4/21 - No documentation." "Quetiapine 300 mg, 2 tablets, at bedtime, 8:00 pm. 8/4/21 - No documentation." Quetiapine 50 mg, 1 tablet, twice daily, 8:00 am and 2:00 pm. 8/3/21 - No documentation. 8/4/21 - No documentation." Trazodone (Depression) 100 mg, every day, 8:00 pm. 8/4/21 - No documentation." LPN #1 was interviewed by phone on 8/5/21 at 9:33 am and stated, "I went through all of the medications on 8/2/21. I compared them to the MAR. They are all in the house. Staff should be documenting and reporting if something is wrong." 3. Client #3's record was reviewed on 8/4/21 at 12:40 pm. Client #3's MAR for August 2021 indicated the following: "Guanfacine (ADHD) 1 mg, 1 tablet, at bedtime, 8:00 pm.		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 Dungarvin has assigned an Area Director to monitor implementation of the POC. An evidence binder will be compiled with tabs for each citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	8/3/21 - Missed." 4. Client #7 was interviewed on 8/4/21 at 5:48 pm and stated, "They don't have my Trazodone. I've only slept 10 hours in 4 days. I think they forgot to order it or lost it." Client #7's MAR for August 2021 was reviewed on 8/4/21 at 1:24 pm and indicated the following: "Trazodone 100 mg, 1 tablet, every day, 8:00 pm. 8/1/21 - Missed, This med is missing! 8/2/21 - Missed, Missing medication. 8/3/21 - Missed." LPN #1 was interviewed by phone on 8/5/21 at 9:33 am and stated, "Staff should report immediately if there is a problem, or they can't find something. They should call the on-cal nurse. Medication errors should be reported to BDDS. It's an automatic report to BDDS." 9-3-1(b) 2. 460 IAC 9-3-2(c)(3) Resident protections Authority: IC 12-28-5-19 Affected: IC 4-21.5;IC 5-2-55; IC 12-28-5-12; IC 22-12 (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This State rule is not met as evidenced by: Based on record review and interview for 2 of 3 employee files reviewed, the facility failed to			

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	ensure Direct Support Professionals (DSPs) #2 and staff #3 had 3 reference checks completed prior to employment at the group home. Findings include: 1. DSP #2's employee record was reviewed on 8/4/21 at 11:28 am. DSP #2's record indicated a start date of 7/12/21. DSP #2's record did not include documentation of any verified references. 2. DSP #3's employee record was reviewed on 8/4/21 at 11:28 am. DSP #3's record indicated a start date of 7/12/21. DSP #3's record did not indicate documentation of any verified references. Human Resources Specialist #1 was interviewed on 8/4/21 at 11:44 am and stated, "Each employee should have 3 reference checks completed in the first week of orientation. It should be done before they begin working in the group home." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Staff should have 3 references before they begin working with clients." 9-3-2(c)(3) 3. 460 IAC 9-3-6(b) Health Care Services (b) All personnel who administer medication to residents or observe residents self-administering medication shall have received and successfully completed training using materials approved by the council.			

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	This state rule is not met as evidenced by: Based on record review and interview for 1 of 3 staff files, the facility failed to ensure Direct Support Professional (DSP) #2 received Core A and B medication administration training prior to administering medications to client #4. Findings include: Observations were conducted at the group home on 8/4/21 from 7:30 am through 9:00 am. Client #4 was present in the home for the duration of the observation period. At 8:00 am, DSP #1 prepared client #4's 8:00 am medication. DSP #1 placed the medication in a medication cup and locked it in the medication cabinet. At 8:04 am, DSP #2 stated, "I haven't been trained to do it. I'm not supposed to." DSP #1 provided instructions and left the group home. At 8:12 am, client #4 came to the medication room. DSP #2 handed client #4 a medication cup, and client #4 took the medication with water. DSP #2 did not identify the medications or their purpose before client #4 took the medications. Client #4's Medication Administration Record (MAR) for August 2021 was reviewed on 8/3/21 at 2:23 pm and indicated the following 8:00 am medications: "Duloxetine (antidepressant) HCL (hydrochloric acid) DR (delayed release) 30 mg (milligram) cap (capsule). Give one capsule by mouth twice a day. Levetiracetam (anticonvulsant) 750 mg (milligrams) tablet. Give one tablet by mouth twice a day. Risperidone (antipsychotic) 1 mg tablet. Take			

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	one tablet by mouth twice a day. Vyvanse (stimulant). Give one capsule by mouth every morning." DSP #2's employee file was reviewed on 8/4/21 at 11:28 am. The review did not include evidence of Core A/Core B medication training for DSP #2. Human Resources Specialist #1 was interviewed on 8/4/21 at 11:44 am and stated, "[DSP #2] has not completed medication training." DSP #2 was interviewed on 8/3/21 at 2:25 pm and stated, "I don't pass meds (medications). I haven't been trained." Area Director (AD) #1 was interviewed on 8/4/21 at 4:00 pm and stated, "Staff passing medications should have completed Core A/Core B medication administration training. That staff knows she isn't supposed to pass medications. We've talked about it." 9-3-6(b)			