STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G748	A. BUILDING 00 B. WING	02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	821 SUNSET DR FLORA, IN 46929

(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 the pre-determined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. This visit was in conjunction with the PCR (Post Certification Revisit) to the investigation of complaint #IN00366090 completed on 12/15/2021. Dates of Survey: 1/25, 1/26, 1/27, 1/31, 2/1, 2/2, and 2/3/2022. Facility number: 011602 Provider number: 15G748 AIM number: 200903760 These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/16/22.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 3 of 3 sample clients (clients A, B, and C) and 1 additional client (client D), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home and to ensure repackaged food was labeled and dated. Findings include:	W 0104	**Direct Support staff and House Coordinators have been retrained as of this date by the Program Director on Food Safety protocols for the labelling food if removed from its original container and repackaged for later use. Program Director will inspect any repackaged food items for**	03/18/2022

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

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	1. During the observation periods, on 1/25/2022 from 1:50pm until 4:25pm and on 1/26/2022 from 7:10am until 9:10am, clients A, B, C, and D were observed at the group home. On 1/26/2022 at 9:00am, DSP (Direct Support Professional) #5 indicated the group home was in need of repairs. DSP #5 stated clients A, B, C, and D "caused most all the damage" during their aggressive behaviors. DSP #5 stated the walls and damage throughout the group home "continued" to be repaired and clients A, B, C, and D "continued" to cause property damage. -DSP #5 stated four of four (4 of 4) dining room walls had "multiple unfinished dry wall patches, damage, and need repaired." -The dining room ceiling lights were damaged by client B during behaviors and he had damaged the connections to the lighting. -The dining room hallway had one of two (1 of 2) walls with holes in the wall and needed to be repaired. -The side A living room had three of four (3 of 4) living room walls with unfinished dry wall repairs which needed to be finished. -The side A living room was missing the television from the television cabinet and the television cabinet was broken. -DSP #5 stated clients A, B, C, and D's bedrooms were missing "closet doors because of behaviors." -DSP #5 stated there was a hole "four feet long by three feet wide" in the living room wall beside client C's bedroom. -DSP #5 indicated there were gaps between the door casings and the doors to both bathrooms, the storage room, the laundry room, client D's bedroom door, and the office door. DSP #5 indicated the damage was caused by behaviors		**labelling compliance weekly for the next 30 days and every other week for the following month.** **The Area Manager will also complete observation checks no less than twice per month to ensure corrective action is implemented.** **Dungarvin will ensure that maintenance repairs are completed no later than 3/18/2022**	

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	and the doors did not close to securely latch. On 2/3/2022 at 2:00pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The AD indicated clients A, B, C, and D's group home was in the process of being repaired. The AD indicated no further information was available for review. 2. During observations on 1/26/2022 at 7:20am, DSP #1 showed the surveyor the locked garage food storage area. DSP #1 opened the freezer which had repackaged food in clear zip lock bags. DSP #1 indicated the group home had purchased large quantities of meats and repackaged them into smaller sizes for meals. DSP #1 indicated the following repackaged foods did not have labels to identify the items and dates when repackaged and purchased to ensure meats and foods were not expired. The review indicated the facility failed to ensure food was labeled with a date on each package. -A package of 12 sausage patties. -A package of 10 sausage patties. -A package of 14 hot dogs. -A package of 4 precooked hamburger patties. -A package of 6 precooked hamburger patties. -A package of 10 hot dogs. -A package of 16 hot dogs. On 2/3/2022 at 2:00pm, an interview was conducted with the QIDP and the AD. The AD indicated staff had purchased large packages of meats and repackaged them into smaller sizes for clients A, B, C, and D's meals. The AD indicated the staff should have ensured each package was labeled and dated when the meat was repackaged.			

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	9-3-1(a)			
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview, for 2 of 3 sampled clients (clients B and C), the facility failed to ensure clients B and C's personal privacy when opportunities existed. Findings include: 1. During the observation period, on 1/25/2022 at 2:10pm, DSP (Direct Support Professional) #4 indicated DSP #5 had returned to the group home as a staff person. When asked where DSP #5 had been earlier during her scheduled shift, DSP #4 stated "She was at [name of another group home] because one of the ladies was having behaviors of attacking the staff there." At 2:10pm, DSP #5 was observed to enter the front door of the group home with Visitor #1, a female client from the other group home. At 2:10pm, Visitor #1 walked the distance from the front door of the group home, through the dining room, living room, down the hallway, to the medication room which had the door open, while DSP #4 was administering client C's medications. Visitor #1, without wearing a face mask, walked up to DSP #4, hugged her, and DSP #5 indicated to DSP #4 that she would administer medications. At 2:20pm, DSP #5 administered client C's medications with Visitor #1 encouraged to sit inside the medication room with client C and DSP #5. At 2:20pm, DSP #5 named client C's medication, client C took the medication with water, and client C was asked to	W 0130	All Direct Support staff have been retrained by the Program Director on Individual Rights with the focus on right to privacy in regards to personal care. Additionally, Staff were retrained on privacy included in the Medication Administration protocols with emphasis on all right to received medication in a private setting. The Program Director will ensure Medication Administration privacy and protocols are followed during his weekly visits for the next three months. The Area Manger will ensure the medication administration plan is implemented no less than twice month during routine site visits.	03/01/2022

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	leave the medication room. Visitor #1 stayed seated at the desk. and at 2:25pm, DSP #5 asked staff to bring client B into the medication room. DSP #5 administered client B's medications, stated the reasons for each medication, and administered client B's medications with Visitor #1 seated at the desk. During the medication administration for clients B and C the medication room door was left open to the hallway and clients A and C stood outside the medication room and were able to hear DSP #5 discuss each client's medications. 2. On 1/26/2022 at 7:50am, DSP #1 woke up client B, walked with him to the unlocked hallway bathroom, and left the door open to the living room area and hallway. DSP #1 stated to client B "Strip and you'll get a shower," and client B took off his clothing in full view of the living room and hallway. From 7:50am until 8:05am, client B was observed nude inside the bathroom, showered, and DSP #1 assisted him to dry his nude body with a towel in full view of the living room and hallway with the bathroom door open. On 2/3/2022 at 10:30am, an interview was conducted with the RN (Registered Nurse). The RN indicated clients B and C should have personal privacy when medications were administered. The RN indicated the client and the staff person should be the only people inside the medication room when medications were administered to ensure the client's personal privacy. The RN indicated the staff should have closed the door to ensure client B's personal privacy when bathing. The RN indicated the facility staff failed to ensure clients B and C's personal privacy when opportunities existed. On 2/3/2022 at 2:00pm, an interview was			

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	conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The AD and the QIDP both indicated the staff should have ensured clients B and C's personal privacy and taught the clients personal privacy when opportunities existed to close the medication room and the bathroom doors. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and B), the facility failed to ensure the implementation of their abuse/neglect prevention policy to prohibit client abuse and/or mistreatment and to immediately report an allegation of client abuse and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to State Law. Findings include: On 1/25/2022 from 1:50pm until 4:25pm, clients A, B, C, and D were observed at the group home. At 4:05pm, client A walked up to the surveyor, removed his jacket and his long sleeved shirt to show purple, dark red, and yellow teeth marks on his upper left arm. At 4:05pm, DSP (Direct Support Professional) #3 indicated the area was from a bite on 1/24/2022. DSP #3 stated "We were on the van, [client B] bit [client A] on the arm." At 4:05pm, DSP #3 stated the bite was "approximately five inches long. The bite marks in the dark red were the outline of	W 0149	All direct support staff have been retraining by the Program Director on abuse and neglect as it relates to peer to peer incidents. The Program Director also provided focused instruction on reporting whether incident were discovered at time of event or at later date, including injury of unknown origin and Peer to Peer incidents. All staff will ensure the individuals are seated with as much spacing as possible with on the Van and at least one staff will ensure they are riding in the back in efforts to quickly intervene should an individual served become aggressive. The Area manager will monitor all GER's to ensure all incidents are being reported to a live supervisor immediately. The review will occur	03/01/2022

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	[client B's] teeth." DSP #3 stated "It did not break the skin." When the surveyor asked if the teeth did not break the skin why were there dark red crusty scabs on the places where the teeth marks were, DSP #3 stated "Well I guess it might have broken the skin, but it didn't bleed." Client A's left upper arm had three areas that had fluid visible from the center of the teeth marks after client A had removed his shirt to show his injuries. Client A stated "It hurt" and indicated he tried not to cry. When asked if the staff had reported client A's injuries to the administrator, DSP #3 stated "I'm not sure. I think so." When asked if he reported client A's injuries to the administrator, DSP #3 stated, "No." DSP #3 indicated no incident report was available for review. On 1/26/2022 at 7:45pm, and on 1/27/2022 at 11:15am, the facility's Bureau of Developmental Disability Services (BDDS) reports from 7/1/2021 through 1/26/2022 were reviewed and did not indicate reports regarding allegations of abuse and/or mistreatment for client A. On 1/26/2022 at 11:15am, an interview was conducted with the AD (Area Director). The AD indicated he was not aware of the bite marks on client A's upper left arm and indicated he would look into it. On 1/31/2022 at 9:30am, the AD (Area Director) provided an additional BDDS report for an allegation of client to client physical abuse. -A 1/27/2022 BDDS report for an allegation of client abuse on 1/24/2022 at 12:00pm indicated "Date of knowledge 1/25/2022." The BDDS report indicated "It was reported on 1/26 (2022)		no less than three times weekly for the first 30 days and one time weekly thereafter.	

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	that [client A] mentioned in a conversation that he had been bitten by another individual while on a van ride several days earlier. It was reported that there was a visible mark, questionable as to whether or not skin was broken. Peer to peer investigation in progress." On 1/25/2022 at 12:10pm, an interview was conducted with the Area Director (AD). The AD indicated he was not aware of any allegations of abuse, neglect, and/or mistreatment. The AD indicated the agency followed the BDDS policy and procedure to prohibit abuse, neglect, and mistreatment, to immediately report incidents of failure to supervise clients according to their identified needs, client to client physical aggression, allegations of abuse, neglect, and/or mistreatment, and to complete thorough investigations into reported incidents. On 2/3/2022 at 2:00pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD. The AD indicated he reported the allegation to BDDS and in accordance with State Law when he became aware of the allegation. The AD indicated the staff had not reported the allegation immediately to the administrator. The AD stated "All allegations should be reported immediately." On 1/25/2022 at 12:10pm, the 4/2005 "BDDS Reportable Incidents to the Bureau of Developmental Disabilities Services" policy and procedure indicated "Reportable incidents are any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual or death of an individual...." On 1/25/2022 at 12:10pm, the facility's 4/2011			

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	"Policy and Procedure Concerning Consumer Abuse and Neglect" indicated the agency prohibited abuse, neglect, and/or mistreatment. The policy and procedure indicated "All persons working in this organization's homes or providing a service within these homes are mandated by law to report suspected abuse or neglect" and "It is the policy of this organization to inform appropriate agencies of suspected or actual abuse, neglect, or exploitation and to cooperate fully with the investigation of such." The policy indicated "Any suspected incidents" should be reported immediately. The policy indicated "Physical Abuse is defined as any act which constitutes a violation of the assault...Non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress...Neglect-the failure to provide appropriate care, supervision or training, failure to provide food and medical services as needed, failure to provide a safe, clean, and sanitary environment...as indicated in the Individual Support Plan (ISP)." 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and B), the facility failed to immediately report	W 0153	/p>	03/01/2022

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	an allegation of client abuse and/or mistreatment to the administrator and to BDDS (Bureau of Developmental Disabilities Services) in accordance to State Law. Findings include: On 1/25/2022 from 1:50pm until 4:25pm, clients A, B, C, and D were observed at the group home. At 4:05pm, client A walked up to the surveyor, removed his jacket and his long sleeved shirt to show purple, dark red, and yellow teeth marks on his upper left arm. At 4:05pm, DSP (Direct Support Professional) #3 indicated the area was from a bite on 1/24/2022. DSP #3 stated "We were on the van, [client B] bit [client A] on the arm." At 4:05pm, DSP #3 stated the bite was "approximately five inches long. The bite marks in the dark red were the outline of [client B's] teeth." DSP #3 stated "It did not break the skin." When the surveyor asked if the teeth did not break the skin why were there dark red crusty scabs on the places where the teeth marks were, DSP #3 stated "Well I guess it might have broken the skin, but it didn't bleed." Client A's left upper arm had three areas that had fluid visible after client A had removed his shirt to show his injuries. Client A stated "It hurt" and indicated he tried not to cry. When asked if the staff had reported client A's injuries to the administrator, DSP #3 stated "I'm not sure. I think so." When asked if he reported client A's injuries to the administrator, DSP #3 stated, "No." DSP #3 indicated no incident report was available for review. On 1/26/2022 at 7:45pm, and on 1/27/2022 at 11:15am, the facility's Bureau of Developmental Disability Services (BDDS) reports from 7/1/2021 through 1/26/2022 were reviewed and		The Area manager will monitor all GER's to ensure all incidents are being reported to a live supervisor immediately. The review will occur no less than three times weekly for the first 30 days and one time weekly thereafter.	

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	did not indicate reports regarding allegations of abuse and/or mistreatment for client A. On 1/26/2022 at 11:15am, an interview was conducted with the AD (Area Director). The AD indicated he was not aware of the bite marks on client A's upper left arm and indicated he would look into it. On 1/31/2022 at 9:30am, the AD (Area Director) provided an additional BDDS report for an allegation of client to client physical abuse. -A 1/27/2022 BDDS report for an allegation of client abuse on 1/24/2022 at 12:00pm indicated "Date of knowledge 1/25/2022." The BDDS report indicated "It was reported on 1/26 (2022) that [client A] mentioned in a conversation that he had been bitten by another individual while on a van ride several days earlier. It was reported that there was a visible mark, questionable as to whether or not skin was broken. Peer to peer investigation in progress." On 1/25/2022 at 12:10pm, an interview was conducted with the Area Director (AD). The AD indicated he was not aware of any allegations of abuse, neglect, and/or mistreatment. The AD indicated the agency followed the BDDS policy and procedure to prohibit abuse, neglect, and mistreatment, to immediately report incidents of failure to supervise clients according to their identified needs, client to client physical aggression, allegations of abuse, neglect, and/or mistreatment, and to complete thorough investigations into reported incidents. On 2/3/2022 at 2:00pm, an interview was conducted with the QIDP (Qualified Intellectual			

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	Disabilities Professional) and the AD. The AD indicated he reported the allegation to BDDS and in accordance with State Law when he became aware of the allegation. The AD indicated the staff had not reported the allegation immediately to the administrator. The AD stated "All allegations should be reported immediately." 9-3-2(a)			
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 (clients A, B, and C) and 1 additional client (client D), the facility failed to implement clients A, B, C, and D's ISP's (Individual Support Plans) and BSP's (Behavior Support Plans) to ensure chemicals were secured for the safety of the clients. Findings include: During the observation periods, on 1/25/2022 from 1:50pm until 4:25pm and on 1/26/2022 from 7:10am until 9:10am, clients A, B, C, and D were observed at the group home. During both observation periods, the connecting hallway from the garage to the kitchen was unlocked and inside the unlocked area were multiple shelves storing unlocked bottles and cans of laundry detergent, gallons of bleach, bottles of spot remover, liquid Lysol cleaner, oven cleaner, hand sanitizer, bug	W 0249	/p> All staff have been retrained on ensuring all chemicals are stored in accordance to regulation and individuals safety plan. The Program Director will monitor this weekly to ensure corrective action plan in being implemented. The Area Manage will monitor this no less than twice monthly to ensure compliance to protocols.	03/01/2022

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	spray, and rust remover. During both observation periods, clients A, B, C, and D walked into and out of the breeze way and the chemicals were unlocked inside the breeze way storage area. On 1/25/2022 at 2:50pm, the Residential Manager (RM) indicated clients A, B, C, and D should have chemicals and sharps locked inside the group home. The RM indicated clients had drunk chemicals in the past and each client's personal hygiene boxes with body wash and chemicals were kept inside the medication office. Client A's record was reviewed on 1/26/2022 at 10:45am and on 1/31/2022 at 12:45pm. Client A's 12/16/2021 ISP (Individual Support Plan) indicated an identified risk for misusing chemicals and the need for chemicals to be kept secured. Client A's 9/18/2021 BSP (Behavior Support Plan) indicated an identified need for locked chemicals inside the group home. Client B's record was reviewed on 1/26/2022 at 12:00pm and on 1/31/2022 at 1:05pm. Client B's 1/31/2021 ISP indicated an identified risk for misusing chemicals and the need for chemicals to be kept secured. Client B's 1/8/2021 BSP indicated an identified need for locked chemicals inside the group home. Client C's record was reviewed on 1/31/2022 at 2:00pm. Client C's 1/22/2021 ISP indicated an identified risk for misusing chemicals and the need for chemicals to be kept secured. Client C's 1/22/2021 BSP indicated an identified need for locked chemicals inside the group home. An interview with the BC (Behavior Consultant) was conducted on 1/25/2022 at 12:10pm. The			

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	15G748	A. BUILDING 00 B. WING	02/03/2022

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	BC indicated the facility had implemented restrictions at the group home to keep chemicals locked because of clients A, B, C, and D's identified behavioral needs. The BC indicated clients A, B, C, and D had misused chemicals in the past and stated "all chemicals" should be kept locked. The BC indicated the restriction of locked chemicals was documented in clients A, B, C, and D's ISPs and BSPs. An interview with the AD (Area Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/3/2022 at 2:00pm. At 2:00pm, the AD and the QIDP indicated the facility should have locked and/or secured chemicals inside the group home for the safety of clients A, B, C, and D. The AD and the QIDP stated client A, B, C, and D's records indicated a restriction for the group home to have "all" chemicals kept locked. The AD indicated the facility staff did not implement clients A, B, C, and D's ISPs and BSPs. 9-3-4(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview for 1 of 16 medications administered in the morning, the facility failed to ensure client C's medication was administered without error. Findings include: During the observation period, on 1/26/2022 at 8:05am, DSP (Direct Support Professional) #1	W 0369	Prior to exit, new labels were acquired for the medications noted and staff have been properly identified. Staff have been retrained on the proper medication administration and required triple checks of medication s against orders as outlined in Medcore A and B	03/01/2022

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	asked client C to come to the medication room. At 8:05am, DSP #1 took client C's medication bottle out of the product box and asked client C to administer his "Fluticasone (Flonase)" spray for allergies into client C's nose. Client C removed the cap on the bottle, administered one spray into each nostril, and DSP #1 stated "take another spray" equaling 2 sprays into each nostril. Client C then sprayed an additional spray of medication into each nostril. The pharmacy label on the medication indicated "Fluticasone spray, instill 1 spray into each nostril twice daily" (for allergies). DSP #1 did not indicate to client C the dosage amount to be administered. At 8:10am, client C's 1/2022 MAR (Medication Administration Record) indicated "Fluticasone Spray 50mcg (micrograms), instill 1 spray into each nostril twice daily." On 1/26/2022 at 8:10am, DSP #1 indicated the facility followed Core A/Core B medication administration training to teach clients about the medications. At 8:10am, client C stated he knew "some of my medications," did not know the names of his allergy medication, and the dosage for his allergy medication when administered. Client C stated "I did spray two sprays into each of my nostrils." Client C's record was reviewed on 1/31/2022 at 2:00pm. Client C's 10/14/2021 physician's orders indicated "Fluticasone Spray 50mcg (micrograms), instill 1 spray into each nostril twice daily" for allergies. On 2/3/2022 at 10:30am, an interview was conducted with the Registered Nurse (RN). The RN indicated she would consider client C's administration of his Flonase spray a medication error because the staff did not follow the		trainings. The Program Director will monitor at least one medication administration pass weekly to ensure compliance with protocol. The Area Manager will monitor at least one medication administration pass monthly to ensure compliance with protocol.	

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	physician's order to administer one spray twice a day. The RN indicated the facility followed Core A/Core B medication administration training to follow the physician's order. On 2/3/2022 at 2:00pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD (Area Director). The AD indicated staff should follow physician orders and the MAR when administering medications. The AD indicated client C's nasal spray was for allergies. The AD indicated he considered it a medication error since the staff did not follow physician's order. 9-3-6(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview for 3 of 3 sampled clients (clients A, B, and C) and 1 additional client (client D), the facility failed to ensure medications were kept locked when not being administered at the group home. Findings include: During the observation periods, on 1/25/2022 from 1:50pm until 4:25pm and on 1/26/2022 from 7:10am until 9:10am, clients A, B, C, and D were observed at the group home. On 1/25/2022 from 1:50pm until 2:20pm, the medication cart was not locked and the medication office was not locked or closed. During both observation periods, clients A, B, C, and D went into and out of the medication/office without facility staff	W 0382	All staff will be retrained on ensure all medication are locked up in accordance to regulation and protocol. This training will include all direct support staff being instructed to keep the keys on their person at all times during their work shift. The Program Director will monitor the implementation of this corrective action when completing week site visits. The Area Manager will monitor the implementation of this corrective action when completing week site visits.	03/18/2022

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	present. On 1/25/2022 at 2:10pm, an interview with DSP (Direct Support Professional) #5 was conducted. DSP #5 stated the facility "followed Core A/Core B" medication administration training regarding locking the medications. DSP #5 stated "No, the medication cart was not locked when I came into the medication room to administer medications." DSP #5 indicated the facility followed Core A/Core B medication administration training to keep medications locked except when administered. On 2/3/2022 at 10:30am, a review of the undated "Medication Administration" policy and procedure indicated the facility staff should ensure medications are kept locked when not being administered. On 2/3/2022 at 10:30am, a review of the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should ensure medications were kept locked when not being administered. On 2/3/2022 at 10:30am, an interview with the RN (Registered Nurse) was conducted. The RN indicated the facility followed Core A/Core B medication training. The RN indicated the medication cart should not have been left unlocked without staff present. The RN indicated clients A, B, C, and D's medications were stored inside the medication cart. The RN indicated the medication cart should be kept locked when medications were not administered. On 2/3/2022 at 2:00pm, an interview was			

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	conducted with the AD (Area Director) and the QIDP (Qualified Intellectual Disabilities Professional). The AD and the QIDP indicated medications should be locked when staff were not administering the medications. 9-3-6(a)			
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 1 additional client (client D), the facility failed to secure the medication keys at the group home. Findings include: During the observation periods, on 1/25/2022 from 1:50pm until 4:25pm and on 1/26/2022 from 7:10am until 9:10am, clients A, B, C, and D were observed at the group home. During both observation periods, the medication room/office door was open. and the medication keys hung on the wall beside the medication cart at eye level. During both observation periods, clients A, B, C, and D went into and out of the medication/office without facility staff present. On 1/25/2022 at 2:10pm, an interview with DSP (Direct Support Professional) #5 was conducted. DSP #5 stated the facility "followed Core A/Core B" medication administration training regarding the medication cabinet and medication cart keys. DSP #5 stated "We have always had the medication keys on the wall" beside the medication cart.	W 0383	All staff will be retrained on ensure all medication are locked up in accordance to regulation and protocol. This training will include all direct support staff being instructed to keep the keys on their person at all times during their work shift. The Program Director will monitor the implementation of this corrective action when completing week site visits. The Area Manager will monitor the implementation of this corrective action when completing week site visits.	03/18/2022

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	On 2/3/2022 at 10:30am, an interview with the RN (Registered Nurse) was conducted. The RN indicated the facility followed Core A/Core B medication training. The RN indicated the medication keys should not have been left hanging on the wall beside the medication cart. The RN indicated clients A, B, C, and D's medications were stored inside the medication cart. The RN indicated the medication keys should have been in the possession of a group home staff. On 2/3/2022 at 2:00pm, an interview with the AD (Area Director). The AD indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration. The AD indicated the medication keys should have been kept secured by the group home staff. On 2/3/2022 at 10:30am, a review was conducted of the facility's undated "Medication Administration" policy and procedure which indicated medication training of Core A/Core B should be followed and the medication cart keys should be kept secured. On 2/3/2022 at 10:30am, a review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication cart keys should be kept secured. 9-3-6(a)			
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing			

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	labels. Based on observation, record review, and interview, for 2 of 28 medications observed administered (clients A and D), the facility failed to ensure each medication was labeled with a legible pharmacy label. Findings include: 1. On 1/25/2022 at 2:30pm, DSP (Direct Support Professional) #5 asked client D to come into the medication room. At 2:30pm, DSP #5 selected client D's "Divalproex 500mg (milligrams) 2 tablets" and the remainder of the pharmacy label was unable to be read. DSP #5 indicated the pharmacy label on client D's medication card was unable to be read to verify the directions for client D's medication use. DSP #5 administered the medication to client D. At 2:35pm, client D's 1/2022 MAR (Medication Administration Record) indicated "Divalproex 500mg, 2 tablets daily for seizures." At 2:35pm, DSP #5 stated client D "had gone home on a leave of absence and that's how it was when he returned blacked out." DSP #5 stated client D's "family said they spilt something on the medication card and the ink ran together." On 2/3/2022 at 9:30am, client D's 12/2021 "Physician's Order" indicated "Divalproex 500mg, 2 tablets daily for seizures." On 2/3/2022 at 10:30am, an interview was conducted with the Registered Nurse (RN). The RN indicated the facility followed Core A/Core B policy and procedures for administering medications. The RN indicated she had not received a call from the facility regarding client D's Divalproex medication label. The RN indicated the facility's policy and procedure	W 0391	Prior to exit, new labels were acquired for the medications noted and staff have been properly identified. All Direct Support staff have been retrained by the Program Director on medication administration and the required triple checks of medication s against orders as outlined in Medcore A and B trainings. The Program Director will ensure Medication Administration privacy and protocols are followed during his weekly visits for the next three months. The Area Manger will ensure the medication administration plan is implemented no less than twice month during routine site visits.	03/01/2022

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	"Medication Administration" indicated medications should have a legible pharmacy label on each medication and when a pharmacy label was not able to have been read, the nurse should be contacted. The RN indicated if the label and the medication do not match the staff should not administer that medication. 2. On 1/26/2022 at 8:15am, DSP #1 asked client A to come into the medication room. At 8:15am, DSP #1 selected then administered from an unlabeled pharmacy bottle of "Polyethylene Glycol (Miralax)" for constipation, poured 17 grams of the powder into a glass of water, and client A stirred then drank the mixture. Client A's record was reviewed on 1/26/2022 at 10:45am and on 1/31/2022 at 12:45pm. Client A's 12/2021 "Physician's Order" indicated "Polyethylene (Miralax), 17gm (grams), given for constipation, dissolve 17gm in 8 ounces of liquid and drink twice daily." On 2/3/2022 at 10:30am, an interview was conducted with the Registered Nurse (RN). The RN indicated the facility followed Core A/Core B policy and procedures for administering medications. The RN indicated she had not received a call from the facility regarding client A's Polyethylene Glycol medication label. The RN indicated the facility's policy and procedure "Medication Administration" indicated medications should have a legible pharmacy label on each medication and when a pharmacy label did not include the client's name, the medication name, amount to be given, and directions for its use, the nurse should be contacted. The RN indicated if the label and the medication do not match the staff should not administer that			

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	medication. On 2/3/2022 at 10:30am, a review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated "Core Lesson 3: Principles of Administering Medication" indicated medications should have a legible pharmacy label on each medication administered and when/if the medication label does not match the MAR, the agency nurse should be contacted. 9-3-6(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 2 sampled clients (client C) who wore prescribed eye glasses, the facility failed to have available and encourage client C to wear his prescribed eye glasses. Findings include: During the observation periods, on 1/25/2022 from 1:50pm until 4:25pm and on 1/26/2022 from 7:10am until 9:10am, client C was observed at the group home. During both observation periods, client C did not wear his prescribed eyeglasses and was not asked to wear his prescribed eye glasses. During both observation periods client C watched television, talked on the telephone, walked around the	W 0436	Broken eyeglasses for the Individuals noted have been as of 2/26/2022. All staff will be sent an communication detailing all staff will report if any eyeglasses or other safety device is not properly functioning. The Program Director will monitor weekly to ensure they remain in good repair or are replaced immediately. The Area Manager will monitor monthly to ensure they remain in	03/01/2022

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	15G748	A. BUILDING 00 B. WING	02/03/2022

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	facility, completed medication administration, and played card games with the facility staff. Client C's record was reviewed on 1/31/2022 at 2:00pm. Client C's 1/22/2021 ISP indicated client C wore prescribed eye glasses to see. Client C's ISP indicated an objective for staff to encourage client C to wear his prescribed eye glasses. Client C's 4/8/2021 vision assessment indicated he wore prescribed eye glasses to see. An interview with the AD (Area Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/3/2022 at 2:00pm. At 2:00pm, the AD and the QIDP indicated the facility staff should have encouraged client C to wear his prescribed eye glasses. The QIDP indicated client C had a history of breaking his eye glasses during behaviors and was unsure if client C's prescribed eye glasses had been repaired. The AD and the QIDP indicated client C should have been taught and encouraged during formal and informal opportunities to wear his prescribed eye glasses. 9-3-7(a)		good repaid and or are replaced immediately.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview, for 3 of 3 sampled clients (clients A, B, and C) and 1 additional client (client D), the facility failed to ensure a completed evacuation drill was conducted at least every 90 days for the day shift (7:00 AM - 3:00 PM), evening shift (3:00pm-11:00pm), and night shift (11:00pm-7:00am) of personnel. Findings include:	W 0440	Effective 2/25/2022, Program Director has retrained all Direct Support staff on the necessity of completing one drill per shift/per quarter going forward. The Program Director will monitor compliance by completed weekly checks of the fire drill log.	03/01/2022

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	The facility's evacuation drills were reviewed on 1/26/2022 at 12:35pm, on 1/31/2022 at 9:15am, and on 1/31/2022 at 11:55am. The review indicated the facility had failed to conduct an evacuation drill every 90 days on the day shift and evening shift of personnel from 1/1/2021 through 8/10/2021 for clients A, B, C, and D. The review indicated no evacuation drill was completed for the day shift and evening shift personnel before 8/10/2021. The review indicated the facility failed to conduct an evacuation drill every 90 days on the night shift of personnel from 1/1/2021 through 1/26/2022 for clients A, B, C, and D. The review indicated no evacuation drill was completed for the night shift personnel from 1/1/2021 through 1/26/2022. On 2/3/2022 at 2:00pm, an interview was conducted with the AD (Area Director) and the QIDP (Qualified Intellectual Disabilities Professional). The AD stated the facility should conduct evacuation drills for each shift of personnel "at least quarterly." The AD indicated the agency's policy was to hold a drill for each shift of personnel quarterly. The AD stated the day shift, evening shift, and night shift evacuation drills were not held within "every 90 days" for the each shift personnel. The AD indicated the previous Residential Manager was responsible for conducting the drills and no additional drills were available for review. 9-3-7(a)		The Area Manager will monitor this monthly to ensure compliance with completing safety drills.	
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of			

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	infection and communicable diseases. Based on observation, record review, and interview for 3 of 3 sampled clients (clients A, B, and C) and 1 additional client (client D), the facility failed to implement the agency's infection control plan to prevent the spread of Covid-19 (Coronavirus Disease/respiratory illness) during a pandemic, to implement the agency's policy regarding: wearing a face mask, to ensure clients washed their hands when opportunities existed, to ensure visitors were screened and wore a face mask to prevent the spread of Covid-19 at the group home. Findings include: 1. During the observation periods, on 1/25/2022 from 1:50pm until 4:25pm and on 1/26/2022 from 7:10am until 9:10am, clients A, B, C, and D were observed at the group home. During both observation periods, clients A, B, C, and D touched the same areas of the sofas, tables, cards, game pieces, and the bathrooms to shower and bathe and no environmental cleaning was observed. During both observation periods, clients A, B, C, and D were provided snacks to eat with their fingers and no hand washing was encouraged by the facility staff. On 1/26/2022 from 7:10am until 9:10am, clients A, B, C, and D ate their breakfast of a cup of oatmeal, a slice of toast, and a glass of water. Clients A, B, C, and D ate their toast with their fingers and no handwashing was encouraged by the facility staff before the meal. During the observation period, clients were not asked to wash their hands before eating snacks and breakfast. 2. During the observation period, on 1/25/2022 at 2:10pm, DSP (Direct Support Professional) #4 indicated DSP #5 had returned to the group	W 0455	All staff was retrained on Dungarvin COVID protocols. The expectation will be reset for staff to ensure screening is complete prior to entering the home. Staff will also be retraining on ensure mask are worn at all times while in the home. All staff will ensure all individuals served practice good hygiene by washing their hand before all meal, medication administration and periodically throughout the day in efforts to reduce the risk of transmission of virus. Going forward any staff who fails to adhere to Dungarvin COVID and sanitation protocols will be written up to progressively up to up and including termination. The Program Director will be sure to observe hand sanitizing are completed weekly to ensure implementation of protocol. The Area Manager will monitor this during site visits to ensure compliance.	03/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G748	A. BUILDING 00 B. WING	02/03/2022

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	home as a staff person. When asked where DSP #5 had been earlier during her scheduled shift, DSP #4 stated "She was at [name of another group home] because one of the ladies was having behaviors of attacking the staff there." At 2:10pm, DSP #5 was observed to enter the front door of the group home with Visitor #1, a female client from the other group home. No screening was completed of Visitor #1, Visitor #1 did not wear a face mask, and no handwashing was completed. At 2:10pm, Visitor #1 walked the distance from the front door of the group home, through the dining room, living room, down the hallway, to the medication room which had the door open, and DSP #4 was administering client C's medications. Visitor #1, without wearing a face mask, walked up to DSP #4, hugged her, and DSP #5 indicated to DSP #4 that she would administer medications. At 2:20pm, DSP #5 administered client C's medications. From 2:20pm until 4:25pm, clients A, B, C, D, Visitor #1, and the facility staff played Uno (a card game), Visitor #1 used the same bathroom as clients A, B, C, and D without cleaning being completed. At 4:25pm, DSP #5 indicated clients A, B, C, D, Visitor #1, and the staff working at the group home were going out for dinner and picking up supplies in [name of town]. At 3:35pm, the shared hallway bathroom did not have hand soap, paper towels, and toilet paper available for clients to use. At 3:35pm, DSP #5 indicated clients A, B, C, and D did not have bowel movements in the front bathroom and did not need supplies in the unlocked hallway bathroom. At 4:25pm, clients A, B, C, D, and Visitor #1 got into the facility van without wearing face masks, and the staff and clients left on the facility van. During the observation period, Visitor #1 did not wear a face covering and sat on a chair next to clients A, C, and D, and			

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	was not socially distanced from people who had to walk by her to access the group home. On 1/26/2022 at 8:15am, clients A, C, and D stated "No, we didn't wear a face mask when we went out last night" on the van. Clients A and D stated "[Visitor #1] didn't wear a mask either." Client C indicated he did not have a face mask with him when they went out in the community on the van. On 2/3/2022 at 2:00pm, an interview was conducted with the AD (Area Director) and the QIDP (Qualified Intellectual Disabilities Professional). The AD stated "I want to inform you that all four clients (clients A, B, C, and D) are now positive for Covid-19. We completed an at home test on each and all were positive as of 1/27/2022 in the evening. We are currently waiting for the results of the formal test completed by [name of pharmacy]. We had a staff test positive on the morning of 1/27/2022 so we tested the clients. By the evening on 1/27/2022 all were positive. [Client D] has signs and symptoms only." The AD and QIDP indicated the facility should have followed the CDC guidelines and the agency's policy and procedures to ensure: clients A, B, C, and D wore face masks when in the community, Visitor #1 was screened and wore a face mask before entry to the group home, clients A, B, C, and D washed their hands when opportunities existed, and environmental cleaning was completed frequently by the facility staff. The AD indicated the facility failed to implement the agency's Covid-19 policy and procedures and CDC guidelines regarding handwashing, cleaning, and for clients A, B, C, D, and Visitor #1 not being encouraged to wear face masks when in the community.			

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	15G748	A. BUILDING 00 B. WING	02/03/2022

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DUNGARVIN INDIANA LLC	821 SUNSET DR FLORA, IN 46929

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	On 1/25/2022 at 12:50pm, the article "Coronavirus Disease 2019 (COVID-19): Protect Yourself" was reviewed from the website www.cdc.gov. The article indicated: " ...Everyone should: Wash your hands often: Wash your hands often with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing. If soap and water are not readily available, use a hand sanitizer that contains at least 60% (percent) alcohol. Cover all surfaces of your hands and rub them together until they feel dry. Avoid touching your eyes, nose, and mouth with unwashed hands. Avoid close contact: Avoid close contact with people who are sick, even if inside your home. If possible, maintain 6 feet between the person who is sick and other household members. Put distance between yourself and other people outside of your home. Remember that some people without symptoms may be able to spread virus. Stay at least 6 feet from other people. Do not gather in groups. Stay out of crowded places and avoid mass gatherings. Keeping distance from others is especially important for people who are at higher risk of getting very sick. Cover your mouth and nose with a cloth face cover when around others: You could spread COVID-19 to others even if you do not feel sick. Everyone should wear a cloth face cover when they have to go out in public, for example if they have to go to the grocery store or to pick up other necessities .... The cloth face cover is meant to protect other people in case you are infected .... Continue to keep about 6 feet distance between yourself and others. The cloth face cover is not a substitute for social distancing. Cover coughs and sneezes: If you are in a private setting and do not have on your cloth			

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	15G748	A. BUILDING 00 B. WING	02/03/2022

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DUNGARVIN INDIANA LLC	821 SUNSET DR FLORA, IN 46929

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	face covering, remember to always cover your mouth and nose with a tissue when you cough or sneeze or use the inside of your elbow. Throw used tissues in the trash. Immediately wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol. Clean and disinfect: Clean and disinfect frequently touched surfaces daily. This includes tables, door knobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets and sinks. If surfaces are dirty, clean them. Use detergent or soap and water prior to disinfection. Then, use a household disinfectant. Monitor your health: Be alert for symptoms. Watch for fever, cough, shortness of breath, or other symptoms of COVID-19. Especially important if you are running essential errands, going into the office or workplace, and in setting where it may be difficult to keep a physical distance of 6 feet. Take your temperature if symptoms develop .... Follow CDC (Center for Disease Control) guidance if symptoms develop." The guidelines indicated visitors should be screened before allowing entry to the group home for their temperature, screening questions, and encouraged to wash their hands. On 2/3/2022 at 10:30am, an interview was conducted with the RN (Registered Nurse). The RN indicated the facility followed Universal Precautions and the agency's pandemic plan to prevent the spread of Covid-19. The RN indicated clients and staff should "frequently wash their hands. They should wash their hands before and after meals and snacks, before medication administration, before and after using the bathroom." The RN indicated visitors should be screened before entry to the group home,			

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	their temperature taken then documented, and the visitor should wear a mask. The RN indicated anyone not living inside the group home was considered a visitor. The RN indicated the facility staff did not implement the agency's pandemic plan when handwashing was not completed and the visitor was not screened for Covid-19, documented the visitor's temperature, and the visitor wearing a face mask while at the group home. The RN stated when clients A, B, C, D, and Visitor #1 left on the facility van, "all clients should have worn a face mask" on the van. 9-3-7(a)			
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and for 1 additional client (client D), the facility failed to ensure clients A, B, C, and D received the recommended planned menu items for their breakfast meal. Findings include: On 1/26/2022 from 7:10am until 9:10am, clients A, B, C, and D were observed at the group home. From 8:45am until 9:10am, DSP (Direct Support Professional) #1 and DSP #2 prepared breakfast of a slice of toast with butter, one cup of cooked oatmeal, and a 12 ounce glass of water for clients A, B, C, and D. From 8:45am until 9:10am, clients A, B, C, and D ate their food at the dining room table. Clients A, B, C, and D were asked to refill their water glasses when the clients had requested more to drink. At 9:00am,	W 0460	All Direct Support staff will be retrained by the Program Director on ensuring the menu is followed to ensure all health protocol are adhered to. The House Coordinator will ensure all needed items are in the home prior to the each mealtime. The Program Director will monitor this area weekly during routine site visits to ensure implementation of menu. The Area Manager will monitor this area weekly during routine site visits to ensure implementation of menu.	03/18/2022

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	the group home refrigerator stored a partial opened gallon of milk, a container of grape jelly, and no orange juice, coffee, or other juices were inside the refrigerator. On 1/26/2022 at 9:10am, the facility's 1/26/2022 "1 Menu" was reviewed. The menu indicated "1/26 (2022) Wednesday: Hot cereal, whole wheat bread 1 slice, Margarine 1 tsp. (teaspoon), Skim milk 1 cup, Apple juice from concentrate 1/2 cup." Client A's record was reviewed on 1/26/2022 at 10:45am and on 1/31/2022 at 12:45pm. Client A's 12/16/2021 ISP (Individual Support Plan) and 12/2021 physician's order indicated a portion control regular diet. Client B's record was reviewed on 1/26/2022 at 12:00pm and on 1/31/2022 at 1:05pm. Client B's 1/31/2021 ISP and 12/2021 physician's order indicated a regular diet. Client C's record was reviewed on 1/31/2022 at 2:00pm. Client C's 1/22/2021 ISP and 12/2021 physician's order indicated a 1200 calorie diet. On 2/3/2022 at 10:30am, an interview was conducted with the RN (Registered Nurse). The RN indicated the staff at the group home should have followed the facility's menu to ensure clients received a healthy breakfast. An interview with the AD (Area Director) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted on 2/3/2022 at 2:00pm. At 2:00pm, the AD and the QIDP indicated the facility staff should follow the planned menu to serve during meal times for clients A, B, C, and D. The AD indicated the			

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	planned menu items should have been available and served for each meal. 9-3-8(a)			