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	04/14/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the PCR (Post Certification Revisit) to the pre-determined full recertification and state licensure survey and to the Covid-19 focused infection control survey completed on 2/3/2022. This visit was in conjunction with the PCR to the PCR completed on 2/3/2022 to the investigation of complaint #IN00366090 completed on 12/15/2021. Dates of Survey: 4/4, 4/5, 4/6, 4/7, 4/8, 4/11, and 4/14/2022. 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 4/29/22.	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 B, C, and D) and 1 additional client (client A), 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	All staff will be retrained by the Program Director. The training will include teaching staff how to properly store food items after meal preparation. Staff will also be taught how date and label and repackaged items prior to storing them. All training will be documented on a training record.	05/22/2022

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

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	1. During the observation period, on 4/4/2022 from 10:50am until 1:55pm, clients A, B, C, and D were observed at the group home. During the observation period, clients A, C, and D's bedrooms did not have closet doors. During the observation periods, the two living rooms had multiple dry wall patches which were not painted. On 4/4/2022 at 12:40pm, the RM (Residential Manager) indicated the group home was in need of repairs. The RM stated clients A, B, C, and D "caused most all the damage" during their aggressive behaviors. The RM stated clients A, C, and D's bedrooms were missing "closet doors because of behaviors." On 4/4/2022 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated clients A, B, C, and D's closet doors had not been replaced. On 4/14/2022 at 4:30pm, an interview was conducted with 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 4/4/2022 at 1:05pm, the RM showed the surveyor the locked garage food storage area. The RM opened the freezer which had repackaged food in clear zip lock bags. The RM indicated the group home had purchased large quantities of meats and repackaged them into smaller sizes for meals. The RM 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		The Program Director will monitor food packaging weekly during site visits to ensure all food items are labeled and stored properly. The Area Director will monitor food packaging weekly during site visits to ensure all food items are labeled and stored properly.	

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	package: -Two packages of hamburger patties. -A package of 5 hot dogs. -A package of 4 precooked sausage patties. This affected clients A, B, C and D. On 4/14/2022 at 4:30pm, an interview was conducted with 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. This deficiency was cited on 2/3/2022. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients B, C, and D) and 1 additional client (client A), the facility failed to provide sufficient staff at the group home to supervise clients A, B, C, and D based on the clients' identified needs.	W 0186	The Program Director will be retrained by the Area Director on appropriate staff levels and the importance of ensuring supervision levels are adequate. All staff will be retrained on the proper protocol to follow if they are left single staff.	05/22/2022

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	Findings include: Observations were completed at the group home on 4/4/2022 from 10:50am until 1:55pm. Clients A, B, C, and D were at the group home. From 10:50am until 12:10pm, the Residential Manager (RM) was the single staff on duty at the group home with clients A, B, C, and D. At 11:25am, the RM stated there should be "two to three staff on duty at the group home" to supervise clients A, B, C, and D. The RM stated "We are short staffed." At 12:10pm, the QIDP (Qualified Intellectual Disabilities Professional) entered the group home with visiting client #1 and indicated he came to the group home because the surveyor was present. The QIDP indicated he brought visiting client #1 to the group home with him because he was the staff assigned to supervise visiting client #1 at a different group home in another town. From 12:10pm until 1:55pm, two staff were at the group home with five clients. From 10:50am until 1:55pm, the RM assisted client B to dress and complete his hygiene. During the observation period, the RM assisted clients A, B, C, and D to complete medication administration, selecting a snack, cooked lunch, assisted clients to dress, and operated the television to select a movie to watch. On 4/4/2022 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The facility's staff schedule was requested. The QIDP stated there "should be two to three facility staff on duty" at the group home to supervise clients A, B, C, and D. The QIDP stated clients A, B, C, and D "had high behaviors of physical aggression, verbal aggression, property damage, and elopement behaviors." The QIDP indicated without the staffing ratio the staff will not always be able to		In the even this happens the Program Director will secure the appropriate supervision level ASAP. The schedule will be reviewed weekly by both the Program Director and Area Director to ensure all opening are filled. The Program Director will monitor this by completing unannounced visited to the home not les than twice per week on various shifts. The Area Director will monitor this by completing unannounced visits to home no less than monthly.	

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	implement clients A, B, C, and D's plans to intervene. On 4/4/2022 at 1:55pm, a review of the facility's posted "April, 2022" staff schedule was conducted with the RM. The schedule indicated from 7:00am to 7:00pm one staff was scheduled, from 8:00am to 8:00pm one staff was scheduled, and from 7:00pm to 7:00am one staff was scheduled to work 4/3/22, 4/5/22, 4/6/22, 4/7/22, 4/8/22, 4/10/22, 4/12/22, 4/13/22, 4/14/22, 4/15/22, 4/17/22, 4/19/22, 4/20/22, 4/21/22, 4/22/22, 4/24/22, 4/26/22, 4/27/22, 4/28/22, and 4/29/22. On 4/4/22, 4/11/22, 4/18/22, and 4/25/22 one facility staff was scheduled from 7:00am to 7:00pm and one facility staff was scheduled from 8:00am to 8:00pm. On 4/9/22, 4/16/22, 4/23/22, and 4/30/22 one facility staff was scheduled from 7:00am to 7:00pm. The RM stated when there was less than two staff on duty "I work too." When asked if the RM was already scheduled as the staff on duty on 4/3/22, 4/10/22, 4/17/22, and 4/24/22 from 7:00am to 7:00pm, the RM indicated she works as direct care when there was not enough staff to schedule. When asked when was the last time the group home had three staff during waking hours to supervise clients A, B, C, and D, the RM stated, "I can't remember when." On 4/14/2022 at 4:30pm, an interview was conducted with the Area Director (AD). The AD stated clients A, B, C, and D should have been supervised during waking hours by "at least three staff" on duty. Client A's record was reviewed on 4/8/2022 at 11:00am. Client A's 12/16/2021 ISP (Individual Support Plan) indicated client A needed staff supervision twenty-four hours a day/seven days a week. Client A's record indicated he was placed			

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	in an ESN (Extensive Support Needs) group home for the additional staff supervision. Client A's targeted behaviors included, but were not limited to property damage, physical aggression, elopement, and verbal aggression. Client B's record was reviewed on 4/8/2022 at 9:30am. Client B's 12/8/2021 ISP indicated client B needed staff supervision twenty-four hours a day/seven days a week. Client B's record indicated he was placed in an ESN group home for the additional staff supervision. Client B's targeted behaviors included, but were not limited to pica behaviors (eating non food items), property damage, physical aggression, elopement, fecal handling, food theft, and inappropriate social boundaries. Client C's record was reviewed on 4/8/2022 at 10:30am. Client C's 3/25/2022 ISP indicated client C needed staff supervision twenty-four hours a day/seven days a week. Client C's record indicated he was placed in an ESN group home for the additional staff supervision. Client C's targeted behaviors included, but were not limited to property damage, physical aggression, elopement, verbal aggression, and inappropriate social boundaries. Client D's record was reviewed on 4/8/2022 at 12:30pm. Client D's 12/16/2021 ISP indicated client D needed staff supervision twenty-four hours a day/seven days a week. Client D's record indicated he was placed in an ESN group home for the additional staff supervision. Client D's targeted behaviors included, but were not limited to property damage, physical aggression, elopement, self injurious behaviors, inappropriate social boundaries, homicidal/suicidal threats/ideation, and verbal aggression.			

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	9-3-3(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 B, C, and D) and 1 additional client (client A), 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 period, on 4/4/2022 from 10:50am until 1:55pm, clients A, B, C, and D were observed at the group home. During the observation period, 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 spray, and rust remover. During the observation period, 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 4/4/2022 at 11:25am, the Residential Manager indicated clients A, B, C, and D should have chemicals and sharps locked inside the group	W 0249	All staff will be retrained by the Program Director in how to properly store chemicals in the home in accordance to the BSP. The expectation will be reset for all staff in the home. The Program Director will monitor this weekly during site visits. The Area Director will monitor this monthly during site visits.	05/22/2022

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	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 and inside the storage area in the breezeway. On 4/4/2022 at 1:30pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated chemicals should have been kept locked and/or secured in the group home for the safety of clients A, B, C, and D. The QIDP indicated client A, B, C, and D needed the restriction for the group home. The QIDP indicated the facility staff did not implement clients A, B, C, and D's ISPs and BSPs. Client A's record was reviewed on 4/8/2022 at 11:00am. 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 3/2022 BSP (Behavior Support Plan) indicated an identified need for locked chemicals inside the group home. Client B's record was reviewed on 4/8/2022 at 9:30am. Client B's 12/8/2021 ISP indicated an identified risk for misusing chemicals and the need for chemicals to be kept secured. Client B's 3/25/2022 BSP indicated an identified need for locked chemicals inside the group home. Client C's record was reviewed on 4/8/2022 at 10:30am. Client C's 3/25/2022 ISP indicated an identified risk for misusing chemicals and the need for chemicals to be kept secured. Client C's 3/23/2022 BSP indicated an identified need for locked chemicals inside the group home. Client D's record was reviewed on 4/8/2022 at 12:30pm. Client D's 12/16/2021 ISP indicated an			

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	identified risk for misusing chemicals and the need for chemicals to be kept secured. Client D's 3/23/2022 BSP indicated an identified need for locked chemicals inside the group home. An interview with the AD (Area Director) was conducted on 4/14/2022 at 4:30pm. The AD indicated chemicals should have been kept locked and/or secured in the group home for the safety of clients A, B, C, and D. The AD 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. This deficiency was cited on 2/3/2022. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(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 period, on 4/4/2022 from 10:50am until 1:55pm, client C was observed at the	W 0436	The Program Director will create a eye glass goal. The goal will educate the individual on the importance of wearing his glasses. The goal will also include prompting and praise and documentation on all efforts. This will allow the team to review progress on a quarterly bases.	05/22/2022

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	group home. During the observation period, client C did not wear his prescribed eyeglasses and was not asked to wear his prescribed eye glasses. During the observation period client C watched television, walked around the facility, completed medication administration, and played games with the facility staff. Client C's record was reviewed on 4/8/2022 at 10:30am. Client C's 3/25/2022 ISP (Individual Support Plan) 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) was conducted on 4/14/2022 at 4:30pm. The AD indicated the facility staff should have encouraged client C to wear his prescribed eye glasses. The AD indicated client C should have been taught and encouraged during formal and informal opportunities to wear his prescribed eye glasses. This deficiency was cited on 2/3/2022. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)		The Program Director will visually monitor this weekly during site visits and will review monthly progress when completely monthly summaries. The Area Director will monitor this during monthly site visits.	
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, record review, and interview for 3 of 3 sampled clients (clients B, C, and D) and 1 additional client (client A), the	W 0455	The Program Director will retrain all staff on the COVID-19 protocol. This training will include the	05/22/2022

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	facility failed to implement the agency's infection control plan to prevent the spread of Covid-19 (Coronavirus Disease/respiratory illness), to implement the agency's policy regarding wearing a face mask and to ensure clients washed their hands when opportunities existed. Findings include: 1. During the observation period, on 4/4/2022 from 10:50am until 1:55pm, clients A, B, C, and D were observed at the group home. During the observation period, clients A, B, C, and D were provided snacks to eat with their fingers and no hand washing was encouraged by the facility staff. 2. On 4/4/2022 at 1:14pm, the RM (Residential Manager) prepared client B's medication. At 1:15pm, the RM took the medication she had dispensed out of the pill package into a medication cup inside the the medication room and carried it outside to the patio deck where client B was lying on the deck in the sunshine. The RM asked client B to sit up and he did. No handwashing was encouraged. The RM handed the medication cup to client B, he tilted the cup upright, and dropped the pill onto the wooden deck. The RM picked up the pill from the deck, did not verbalize anything to the client and while bent down to client B, held it between her pointer finger and thumb outward. Client B took the pill from the RM and swallowed the pill. No redirection was given. At 1:20pm, the RM stated "Well he took the pill from me and swallowed it." 3. During the observation period, on 4/4/2022 from 10:50am until 1:50pm, the RM did not wear a face mask while working at the group home with clients A, B, C, and D. At 10:50am, the RM		constant use of procedural mask while working with individuals served. Staff will also be retrained on the approved place to administer medication. This training will also include implementation of our universal precaution. All training will be recorded on a training record and place in the employee file. The Program will monitor that our systems are being implemented when completing weekly site visit. The Area Director will monitor that our systems are being inplemented when completing monthly site visits.	

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	indicated she had been trained on the agency's policy and procedure regarding wearing a face mask while working with clients and continued to not wear a face mask. At 1:50pm, the RM put on a face mask and sat in the living room. On 4/14/2022 at 4:30pm, an interview was conducted with the AD (Area Director). The AD indicated the facility should have followed the agency's policy and procedures to ensure staff wore a face mask while working with clients A, B, C, and D. The AD indicated clients A, B, C, and D should wash their hands when opportunities existed. The AD indicated the facility failed to implement the agency's Covid-19 policy and procedures. The AD indicated the facility followed Universal Precautions and Core A/Core B medication administration training. The AD indicated the staff should have redirected client B not to take the medication after it had been dropped on the wooden deck. On 4/5/2022 at 9:00am, a review of the facility's 2/1/2022 "Covid-19 Pandemic Guidelines Management" policy and procedure indicated staff should wear a face mask when with clients in the group home. The policy and procedure indicated clients and staff should wash their hands before eating and drinking. This deficiency was cited on 2/3/2022. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			