STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G791	A. BUILDING 00 B. WING	01/02/2015

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

(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
W000000		W000000		

This visit was for the post certification revisit to the investigation of complaints #IN00158868 and #IN00158936.

This visit was done in conjunction with the full annual recertification and state licensure survey.

Complaint #IN00158868: Not corrected.

Complaint #IN00158936: Not corrected.

Dates of Surveys: December 29, 30 and 31, 2014 and January 2, 2015.

Facility number: 012557
Provider number: 15G791
AIM number: 201017960A

Surveyor: Christine Colon, QIDP

The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.
Quality Review completed 1/20/15 by Ruth Shackelford, QIDP.

W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement			

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

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	written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #3), the facility failed to implement written policy and procedures to prevent client to client aggression, client neglect, and to ensure investigations were conducted in regard to abuse/neglect. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 12/30/14 at 12:30 P.M. and indicated: -Investigation record dated 11/25/14 to 12/5/14 involving client #1 indicated: "...This investigation is being conducted due to a report from [client #1] to the QDDP (Qualified Developmental Disabilities Professional) that a staff member hit her in the legs, hit her in the stomach and slapped her in the face. The QDDP notified [Area Director]. The staff was suspended and an investigation started into the alleged allegation. Witness/Evidence:...[Maintenance Man #1] stated he saw [Staff #13] sit on the individual when trying to restrain her....	W000149	**W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS** The House Manager, QDDP, and maintenance Coordinator will review this Standard. The House Manager and QDDP have been retrained on this Standard. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. After investigation, the Maintenance Coordinator received disciplinary action for involvement in the restraint of client #1 and both maintenance personnel have been instructed by their supervisor not to assist staff in applying physical holds unless they have been trained in DCI and on the individuals' BSP. The QDDP is regularly meeting with client #2's IDT in order to address the clients' SIB and to develop and revise strategies/plans to assist client #2 in eliminating her target behavior of SIB. Upon notification of any allegation of client abuse, neglect, or exploitation, the QDDP will immediately notify the administrator,	02/01/2015

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	[Maintenance Man #2] stated he did see [Staff #13] sit on the individual...Conclusion Based on Facts: An (sic) proper DCI (crisis intervention) restraint was not done....Recommendation: I recommend [Staff #13] be terminated due to the use of an improper restraint." BDDS report dated 11/25/14 indicated: "On 11/25/14 [client #1] was in the kitchen loading the dishwasher and asked staff if she could have some tea. Staff informed her that she could ask the QDDP if she could have some tea. [Client #1] started to become agitated with staff and went out the front door. Staff then called the QDDP and told her what was going on. The QDDP then talked to [client #1] and she came back to the house and immediately begin (sic) kicking the hole in the wall that was there making it bigger. Staff asked her to stop and tried the (sic) verbally redirect her and asked her to use her coping skills. Then the maintenance man came and asked her to stop. She then punched him in his face and she continued to kick the holes in the wall and started to swing at the maintenance man again and he started using the DCI blocking technique to block her while staff continued to try and redirect her. [Client #1] then started throwing empty water jugs at staff and the maintenance man. Staff and the		will immediately implement sufficient/corrective action to prevent further possible occurrences, conduct a thorough investigation, notify the administrator of the results within 5 business days, then coordinate a meeting with the Individual's IDT to discuss the incident, develop and implement sufficient/effective corrective measures to ensure no future incidents. The QDDP and/or House Manager will conduct regular observations at the home, at least 3 times per week until compliance is demonstrated, and thereafter, at least weekly, to ensure staff are following all client protocol as written. The Area Director will follow-up with the QDDP during all investigations and ensure results are obtained within 5 business days and effective, corrective action has been implemented. **Will be completed by: 2/1/15** **Persons Responsible: Area Director, House Manager, and QDDP**	

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	maintenance man put her in a DCI hold. [Client #1] scratched staff's hand and the maintenance man (sic) hand. Staff and the maintenance man then had to gently take her to the ground. The maintenance man had one of her arms and her head (he placed his palm on her forehead to prevent her from biting) staff had her other arm and part of her leg and the other maintenance man had her other leg and we held her down till she became calm. Once she was calm staff and the maintenance men let her go and she was sitting Indian style as stated by staff. The QDDP then arrived and [client #1] made an allegation that staff slapped her. Staff was suspended and an investigation started." Further review of the record failed to indicate all staff and clients at the group home were interviewed. -BDDS report dated 12/2/14 involving clients #1 and #2 indicated: "[Client #2] was upset with [client #1] because [client #1] said it wasn't her night to do dishes. Staff then separated the two individuals. [Client #2] walked outside to talk with staff about how she felt while [client #1] walked to the common area. While in the common area [client #1] starred (sic) outside there (sic) door listening to [client #2] talking to staff about her. Staff used DCI approved blocking technique per her behavior support plan			

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	to stop [client #1] from hitting [client #2] and in the process [client #2] hit [client #1] once before walking away following verbal redirection. An approved DCI one person hold per her behavior support plan was then done to stop [client #1] from continuing to attacking(sic) [client #3]. Staff talked to the individual until they calmed down." -BDDS report dated 12/8/14 involving client #2 indicated: "On 12/8/14 [client #2] was in the kitchen then went to her room and said that she wanted to go to sleep because she was tired. At about 6:30 P.M. [client #2] came out of her room and told two staff members that she did something bad that she will regret. Both staff members asked what did she do and she replied that she put a (sic) earring in a scab on her arm and pushed it all the way down in her skin. Staff members looked at her arm but did not see anything. [Client #2] then wanted to talk to QDDP (Qualified Developmental Disabilities Professional) about it and after talking to QDDP she was sent to urgent care. At urgent care a small child stud earring was found under the surface of an old scab on her left arm. The doctor then prescribed antibiotics and [client #2] was sent home. When [client #2] comes in from all outings staff will check her for any items she may have			

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	acquired from any outings that can be used to self harm. Staff will continue to follow the individuals (sic) approved behavior plan which states a plan for the target behavior the individual has for self injurious behavior." Further review of the record failed to indicate an investigation was conducted in regard to this allegation of neglect. -BDDS report dated 12/11/14 involving clients #2 and #3 indicated: "When staff arrived they clocked in at 10:03 P.M.. and went into individual (sic) (client #3) room to talk to her because individual had spit on her. She was upset and needed to vent. Staff talked to individual and needed to go to restroom so staff let housemate go to restroom and housemate [client #2] came out of her room charging at housemate to attack her (client #3). Staff pulled them off of each other. When staff separated [client #2] then she began to tell staff that she was going to beat staff a-- because staff was a n----r b--h and that she was going to get staff fired. [Client #2] was redirected by staff multiple times to calm down and use her coping skills. [Client #2] became even more angry and then began to charge towards staff. [Client #2] attacked staff by hitting and scratching staff in the face and pulled staff hair. Staff intervened to help [client #2] let go of staff's hair and			

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	pulled [client #2] off staff." -BDDS report dated 12/26/14 involving clients #1 and #2 indicated: "On 12/26/14 [client #1] was in the van on an outing and wanted to know how much money she was getting today and staff did not know so staff told her they did not know. [Client #1] immediately began to start calling her housemate [client #2] out of her name. Staff attempted to redirect [client #1] to think about her outing and how much fun she was going to have. [Client #1] ignored redirecting while the van was in motion on the highway and [client #1] started to target her housemate. Staff pulled over on the side of the road. Staff used approved DCI blocking and verbal redirect to prevent [client #1] from hitting housemate [client #2] since she already reached over the seat and slapped housemate in the face as well as kicked housemate when staff was trying to remove the housemate [client #2] from the car. Staff then held her arms in a two person DCI hold. [Client #1] then calmed down and staff was able to drive her home. Once at home [client #1] attempted to run into her housemate's room to attack her but was redirected. [Client #1] the (sic) started to try to hit staff due to her not being able to get to her housemate but the approved BSP DCI blocking was used to redirect her...."			

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	A review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14 was conducted at the facility's administrative office on 12/31/14 at 1:00 P.M. and indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily life....Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional			

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	humiliation or distress...Neglect is defined as 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 and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)....The Supervisor, or Program Coordinator/Senior Director, or his/her delegate will conduct a thorough investigation of the reported incident. The investigation will include the following: 1. Review of witnesses. 2. Any evidence or previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the charge. ...The facility investigation will be completed within five (5) business days, and a summary of results of the investigation will be forwarded to the administrator within five (5) business days of the incident." An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 1/2/15 at 2:45 P.M.. The PD/QIDP indicated the facility's abuse/neglect policy should be followed			

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	at all times. The QIDP indicated daily house checks and every shift room sweeps are to be conducted by staff to prevent client #2 from gaining access to items to prevent SIB. The PD/QIDP indicated there was no written evidence an investigation was conducted in regard to the incident of neglect involving client #2. The PD/QIDP indicated clients #1 and #2's BSPs were not reviewed after the mentioned incidents. This deficiency was cited on 11/19/14. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaints #IN00158868 and #IN00158936. 9-3-2(a)			
W000154	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 2 of 2 sampled clients (clients #1 and #2), the facility failed to provide written	W000154	**W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS**	02/01/2015

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	evidence thorough investigations were conducted in regard to an unapproved physical restraint and an allegation of neglect. Findings include: A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and investigations was conducted on 12/30/14 at 12:30 P.M. and indicated: -BDDS report dated 12/8/14 involving client #2 indicated: "On 12/8/14 [client #2] was in the kitchen then went to her room and said that she wanted to go to sleep because she was tired. At about 6:30 P.M. [client #2] came out of her room and told two staff members that she did something bad that she will regret. Both staff members asked what did she do and she replied that she put a (sic) earring in a scab on her arm and pushed it all the way down in her skin. Staff members looked at her arm but did not see anything. [Client #2] then wanted to talk to QDDP (Qualified Developmental Disabilities Professional) about it and after talking to QDDP she was sent to urgent care. At urgent care a small child stud earring was found under the surface of an old scab on her left arm. The doctor then prescribed antibiotics and		The House Manager and QDDP will review this Standard. The House Manager and QDDP will be retrained on conducting thorough investigations into any allegation concerning suspected or actual abuse, neglect, and/or exploitation. The House Manager and QDDP will be retrained on the Agency's Policy on Abuse, Neglect, and Exploitation of Individual's served. Ongoing, the facility will conduct a thorough investigation, per Policy and this Standard, into any allegation or suspicion of abuse, neglect, or exploitation, and take appropriate/effective measures to ensure the individuals' safety and prevent any future recurrence. Ongoing, the Area Director will monitor and ensure all allegations concerning suspected or actual abuse, neglect, and/or exploitation are investigated thoroughly. **Will be completed by: 2/1/15** **Persons Responsible: Area Director, House Manager, and QDDP**	

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	[client #2] was sent home. When [client #2] comes in from all outings staff will check her for any items she may have acquired from any outings that can be used to self harm. Staff will continue to follow the individuals (sic) approved behavior plan which states a plan for the target behavior the individual has for self injurious behavior." Further review of the record failed to indicate an investigation was conducted in regard to this allegation of neglect. -Investigation record dated 11/25/14 to 12/5/14 involving client #1 indicated: "...This investigation is being conducted due to a report from [client #1] to the QDDP (Qualified Developmental Disabilities Professional) that a staff member hit her in the legs, hit her in the stomach and slapped her in the face. The QDDP notified [Area Director]. The staff was suspended and an investigation started into the alleged allegation. Witness/Evidence:...[Maintenance Man #1] stated he saw [Staff #13] sit on the individual when trying to restrain her.... [Maintenance Man #2] stated he did see [Staff #13] sit on the individual...Conclusion Based on Facts: An (sic) proper DCI (crisis intervention) restraint was not done....Recommendation: I recommend [Staff #13] be terminated due to the use			

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	of an improper restraint." BDDS report dated 11/25/14 indicated: "On 11/25/14 [client #1] was in the kitchen loading the dishwasher and asked staff if she could have some tea. Staff informed her that she could ask the QDDP if she could have some tea. [Client #1] started to become agitated with staff and went out the front door. Staff then called the QDDP and told her what was going on. The QDDP then talked to [client #1] and she came back to the house and immediately begin (sic) kicking the hole in the wall that was there making it bigger. Staff asked her to stop and tried the (sic) verbally redirect her and asked her to use her coping skills. Then the maintenance man came and asked her to stop. She then punched him in his face and she continued to kick the holes in the wall and started to swing at the maintenance man again and he started using the DCI blocking technique to block her while staff continued to try and redirect her. [Client #1] then started throwing empty water jugs at staff and the maintenance man. Staff and the maintenance man put her in a DCI hold. [Client #1] scratched staff's hand and the maintenance man (sic) hand. Staff and the maintenance man then had to gently take her to the ground. The maintenance man had one of her arms and her head (he placed his palm on her forehead to			

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	prevent her from biting) staff had her other arm and part of her leg and the other maintenance man had her other leg and we held her down till she became calm. Once she was calm staff and the maintenance men let her go and she was sitting Indian style as stated by staff. The QDDP then arrived and [client #1] made an allegation that staff slapped her. Staff was suspended and an investigation started." Further review of the record failed to indicate all staff and clients at the group home were interviewed. A review of client #2's record was conducted on 12/30/14 at 2:00 P.M.. Review of client #2's BSP (Behavior Support Plan) dated 3/14 indicated: "Self-Injurious Behavior: Actions performed by [client #2] in which she uses her body or a foreign object to inflict harm on a part of her body causing some damage to skin integrity, including cuts, bruises, burns or rashes. [Client #2] has a history of cutting on her arms and more recently has engaged in scratching her lower forearms and face to the point of skin breakdown." Further review of client #2's record indicated staff are to conduct daily house sweeps searching for any items she may harm herself with and to conduct sweeps of client #2's bedroom every shift to prevent client #2 from SIB.			

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

(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
	An interview with the Program Director/Qualified Intellectual Disabilities Professional (PD/QIDP) was conducted on 1/2/15 at 2:45 P.M.. The PD/QIDP indicated there was no written documentation to indicate all staff who worked at the group home and all clients who reside at the group home were interviewed in regard to the incident. The PD/QIDP further indicated an investigation was not conducted in regard to the allegation of neglect involving client #2. This deficiency was cited on 11/19/14. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaints #IN00158868 and #IN00158936. 9-3-2(a)			
W009999		W009999	No W999 citation found in survey report.	02/01/2015