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 PCR (Post Certification Revisit) to the investigation of complaint #IN00366090 completed on 12/15/2021. Complaint #IN00366090: Not Corrected. This visit was in conjunction with the pre-determined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey. 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.	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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	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. 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		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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	indicated the damage was caused by behaviors 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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	This federal tag relates to complaint #IN00366090. This deficiency was cited on 12/15/2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(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 1 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	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)		immediately. The review will occur no less than 3 times weekly for the first 30 days and 1 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)." This federal tag relates to complaint #IN00366090. This deficiency was cited on 12/15/2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 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			

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	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 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,	W 0153	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. 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 3 times weekly for the first 30 days and 1 time weekly thereafter.	03/01/2022

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	"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) 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			

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	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." This federal tag relates to complaint #IN00366090. This deficiency was cited on 12/15/2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 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	W 0249	A review of the chemical storage was completed and all chemicals have been secured as of this date. All staff have been retrained on ensuring all chemicals are stored	03/01/2022

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	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 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		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 then twice monthly to ensure compliance to protocols.	

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	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 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. This federal tag relates to complaint #IN00366090.			

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	This deficiency was cited on 12/15/2021. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			