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	15G452	A. BUILDING 00 B. WING	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	52812 HIGHLAND DR SOUTH BEND, IN 46635

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W 0000 Bldg. 00	This visit was for a predetermined full recertification and state licensure survey. This visit included the COVID-19 focused infection control survey. Survey Dates: April 19, 20, 21, and 22, 2021. Facility Number: 000966 Provider Number: 15G452 AIMS Number: 100244770 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/6/21.	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 and interview for 3 of 3 sampled clients (#1, #2, and #3), plus 5 additional clients (#4, #5, #6, #7, and #8), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Findings include: Observations were conducted at the group home on 4/19/21 from 4:00 pm through 6:30 pm and on 4/20/21 from 6:00 am through 10:00 am. Clients #1, #2, #3, #4, #5, #6, #7, and #8 were present in the home for the duration of the observation periods.	W 0104	**W 104 (Standard)** Governing Body – Failure to ensure facility in good repair – repairs needed to front ramp and deck. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·The ramp and deck at the front of the facility were both completely rebuilt to code on 5/11/2021. ·All facility staff are receiving	05/22/2021

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

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	The front door of the group home opened onto a small wooden deck with an attached ramp. The deck shook when walked upon. When stepped on, individual boards came loose and rose as much as 4 inches on either end. House Manager (HM) #1 was interviewed on 4/20/21 at 9:31 am and stated, "Maintenance knows about the deck. I've told the Area Director as well. It needs to be replaced. It's not safe like this." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "I have talked to maintenance about the deck. They are in the process of working on it. I noticed it about a month ago." 9-3-1(a)		retraining on the Maintenance Request process to ensure they know the correct procedure to follow. ·Program Director and Lead DSP are receiving retraining on the Site Risk Management Checklist which is to be completed on a monthly basis and includes a review of the repair and safety of all entry/exit pathways from the facility. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** On a weekly basis, the Maintenance Director will meet with the Senior Director to review all outstanding Maintenance needs on the Maintenance Log in order to prioritize repairs like this ramp and deck, which constitute a health and safety risk. Senior Director will monitor compliance with deadlines set at these weekly meetings. **How corrective actions will be monitored to ensure no recurrence** Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the	

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			POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented. Going forward, the Program Director/QIDP is to continue weekly visits to monitor safety concerns and the Area Director and Senior Director will visit the facility on monthly and quarterly bases to verify that the home is being maintained in good repair.	
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 1 additional client (#4), the facility failed to ensure a full and complete accounting of client #4's purchases/expenditures. Findings include. On 4/20/21 at 8:55 am, Direct Support Professional (DSP) #5 counted client #4's house cash to be $6.09. Client #4's financial binder did not include a ledger. Client #4's cash was kept in a bank envelope dated 6/4/20. The envelope indicated $15.23. An enclosed receipt dated 6/4/20 indicated client #4 had spent $12.81. An undated	W 0140	**W 140 (Standard)** Client Finances – Cash on hand for client #4 not fully accounted for and balanced on a ledger at the home. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·Cash logs have been put back in place for all individuals who are keeping cash on hand at the	05/22/2021

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	note indicated an amount of $6.29. DSP #5 was interviewed on 4/20/21 at 9:00 am and stated, "The envelope on 6/4/20 says he should have $15.23. The receipt from [name of store] on 6/4/20 says he spent $12.81, but there's more money here than what would be left. The last time it was counted was 6/4/20. I don't know what [client #4] should have. There's this sticky note, but that doesn't match what's here either. I don't know what it should be." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "Staff should count the clients' change when there is a purchase or a change. Staff should balance the ledger to reflect the activity." QIDP #1 stated, "Everyone who has money should have a ledger. If [client #4] has any money being kept by staff, there should be a ledger." 9-3-2(a)		facility. ·The Lead DSP and Program Director are being retrained on the expectations regarding the use of the cash logs and the frequency of cash counts and audits. ·All facility staff are being retrained on Dungarvin policy and procedure regarding client finances and their responsibilities when assisting the persons served to spend their funds and the related documentation of all expenditure through retention of receipts and filling out expenditure slips. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Going forward, the Program Director/QIDP is responsible to conduct weekly spot audits on all client funds and to verify that regular audits are being conducted by the Lead DSP and any facility staff assisting with purchases in the home. **How corrective actions will be monitored to ensure no recurrence** Dungarvin has assigned an Area Director with over 20 years'	

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			experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented. The Area Director will be responsible to conduct quarterly audits during site visits to ensure that the Dungarvin system for accounting for client finances is correctly implemented and documented.	
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 record review and interview for 1 of 13 allegations of abuse, neglect, mistreatment, and exploitation reviewed, the facility failed to report 1 allegation of sexual misconduct of client by staff regarding client #6 to the appropriate state authority within 24 hours of the time of knowledge in accordance with state law. Findings include: The facility's shift notes were reviewed on 4/19/21 at 2:27 pm.	W 0153	**W 153 (Standard)** Staff Treatment of Clients – failure to report an incident of alleged abuse, neglect, or exploitation within 24 hours of knowledge **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics:	05/22/2021

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	A shift note dated 1/28/21 indicated the following: "When evening staff came in, [client #6] informed staff that another staff had come into his room and asked to have sex with him. An investigation showed that the staff in question had not worked on 1/26/21 as alleged and [client #6] had spent most of his time in his room calling the PD (Program Director) to report staff telling him he will be taken to the institution. The team met on 1/28/21 and discussed that [client #6] usually has such behavior issues when his injection is due. [Client #6] was due to receive injection on 1/26/21 but due to severe weather conditions, the doctor called to postpone the appointment to the following week. Staff are monitoring [client #6] for wellness, health, and safety." The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 4/20/21 at 11:42 am. - The review did not indicate the allegation of sexual misconduct was reported to BDDS. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "Allegations of sexual misconduct should be reported to BDDS." 9-3-2(a)		·All facility staff are being re-trained on Dungarvin's policy and procedure regarding Incident Reporting and the Abuse and Neglect policy, including the provision that all allegations of abuse and neglect must be reported immediately to the administrator and to BDDS within 24 hours. This re-training will include testing to competency for each staff member working at the facility. ·Program Director/QIDP is receiving re-training on the expectation regarding frequency of documentation review and check ins with the individuals served and the staff on duty to ensure that all concerns are being accurately documented and reported. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** ·QIDP is responsible to read the staff log notes, on call supervisor notes, and internal incident reports on a daily basis. ·Area Director is responsible to verify this review has been thorough and that no incidents requiring reporting or further	

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			investigation or review have been missed on a semi-weekly basis. ·All agency staff are required to be retrained on an annual basis on Policy B-2 regarding Abuse and Neglect and Policy A-7 regarding the Reporting and Documentation of Incidents, including the timelines required for reporting to the administrator or to other officials in accordance with State law through established procedures. **How corrective actions will be monitored to ensure no recurrence** Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 5 of 22 allegations of abuse, neglect, exploitation, and mistreatment reviewed, the facility failed to conduct thorough investigations regarding 1 injury of unknown origin for client #2, 1 injury of unknown origin for client #5, 1 injury of unknown	W 0154	**W 154 (Standard)** Staff Treatment of Clients – the facility failed to conduct thorough investigations. **Corrective action for resident(s)**	05/22/2021

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	origin for client #7, 1 allegation of peer to peer aggression for client #2, and one allegation of sexual misconduct for client #6. Findings include: The facility's Bureau of Developmental Disabilities Services were reviewed on 4/20/21 at 11:42 am. 1. A BDDS report dated 2/13/21 indicated the following: "Staff reported that while giving [client #2] a shower, staff noticed a bruise on her face on the nose between the eyes. The bruise is about 1 inch by 1 inch and yellow in color. When asked what happened, [client #2] could not remember how she got the bruise. She did not complain of pain. Staff followed protocol and informed the program director on call. The nurse was also notified. [Client #2] continued with her usual routine with no issues." The review included 2 witness statements dated 2/17/21. The review did not include a summary of the investigation or an interview with the client. 2. A BDDS report dated 2/25/21 indicated the following: "On 2/24/21, staff was assisting [client #5] (sic) use the bathroom when [client #5] stated that her arm hurt. Staff checked [client #5's] arm and noted a bruise the size of a dime on her upper left arm and another on her left elbow. [Client #5's] left ankle was swollen. Staff notified the nurse who instructed staff to have [client #5's] left ankle x-rayed." - The review did not include an investigation. 3. A BDDS report dated 3/9/21 indicated the following:		**found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·Program Director/QIDP is receiving re-training on the thorough and timely completion of investigations. ·Program Director/QIDP is implementing aggressive documentation review and check ins with the individuals served and the staff on duty to ensure that all concerns are being accurately documented and reported. ·Area Director is reviewing actions taken to fully implement this plan of correction during weekly supervision with the Program Director/QIDP. All issues reviewed and action taken are reviewed during this supervision meeting so that the Area Director can verify that appropriate measures are being taken to thoroughly investigate all allegations of abuse, neglect and mistreatment at the facility, including injuries of unknown origin, peer to peer aggression, and allegations of sexual misconduct. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.	

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	"On 3/9/21, [client #2] was sitting on the couch watching TV (television). Staff observed [client #4] standing over [client #2] and slapping her on the top of her right foot. [Client #2] was startled and started to cry. When the individual saw that [client #2] was crying, the individual tried consoling [client #2]." The review included 1 witness statement from staff dated 3/9/21 and 1 witness statement from client #4 dated 3/9/21. The review did not include statements from other clients, a review of client #4's plans, or a summary of findings. 4. A BDDS report dated 3/26/21 indicated the following: "Yesterday staff reported that they found [client #7] on the floor after he fell from his wheelchair while trying to transfer himself to the toilet seat. Staff followed protocol and reported incident to the supervisor. According to staff, [client #7] tried to use the bathroom by himself without asking for assistance from staff and fell to the floor when trying to transfer himself from the wheelchair to the toilet seat. Staff found him on the floor. He had a small cut 2 inches by 3 inches on the ridge of his nose. It was not bleeding, and it is suspected that he hit his nose on the toilet seat. Nurse advised that he be monitored for any swelling or any abnormal changes." - The review did not include an investigation. The facility's shift notes were reviewed on 4/19/21 at 2:27 pm. 5. A shift note dated 1/28/21 indicated the following: "When evening staff came in, [client #6] informed staff that another staff had come into his room and asked to have sex with him. An investigation		**Measures or systemic changes facility put in place to ensure no recurrence** ·Area Director is responsible to monitor that all allegations and concerns of possible abuse, neglect, and exploitation have been thoroughly investigated. All investigations are to be reviewed during weekly supervision meetings before the Area Director approves the internal incident report in the Therap documentation system. **How corrective actions will be monitored to ensure no recurrence** Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	showed that the staff in question had not worked on 1/26/21 as alleged and [client #6] had spent most of his time in his room calling the PD (Program Director) to report staff telling him he will be taken to the institution. The team met on 1/28/21 and discussed that [client #6] usually has such behavior issues when his injection is due. [Client #6] was due to receive injection on 1/26/21 but due to severe weather conditions, the doctor called to postpone the appointment to the following week. Staff are monitoring [client #6] for wellness, health, and safety." - The review did not include documentation of an investigation. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "We suspended the staff when he said they were advancing on [client #6]. Whatever he imagines becomes real to him. We did an investigation. The person accused wasn't working that day. We concluded it didn't happen because of the investigation. We cannot say that he is hallucinating unless there is an investigation. I don't know where the investigation is." QIDP #1 indicated allegations of abuse, neglect, and mistreatment should be investigated within 5 business days. QIDP #1 indicated injuries of unknown origin are investigated. QIDP #1 indicated the investigation includes a review of client plans when necessary and interviews with staff and clients. 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the			

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	comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview for 1 additional client (#7), the facility failed to develop a plan to address client #7's pattern of falls. Findings include: Observations were conducted at the group home on 4/19/21 from 4:00 pm through 6:30 pm and on 4/20/21 from 6:00 am through 10:00 am. Client #7 was present in the home for the duration of the observation period. At 5:50 pm, DSP #2 stated, "[Client #4] helps [client #7] get into his wheelchair." The wheels of the wheelchair were not locked. Client #4 held client #7's wheelchair still. Client #7 moved to the edge of his bed. Client #4 pushed the wheelchair close to the bed. Client #4 held the wheelchair handle with his left hand and held client #7's arm with his right hand. Client #7 put his arms on the seat of the wheelchair, and pivoted into the chair. Client #7 pushed himself into the dining room. Client #4 stated, "I always help." On 4/20/21 at 8:23 am, client #7 pushed himself in his wheelchair to his bedroom. Client #7 stated, "I can transfer myself from my chair to the bed. I have fallen several times because I don't lock the wheels, and the chair moves. [Client #4] helps me a lot of the time." DSP #5 pushed client #7's wheelchair to the edge of his bed. Client #7 began to transfer to his bed. DSP #5 stated, "What are you forgetting?" Client #7 locked the wheels on his wheelchair and transferred to his bed. The facility's staff shift notes were reviewed on 4/19/21 at 2:27 pm.	W 0227	**W 227 (Standard)** Individual Program Plan – facility failed to develop a plan to address client #7's pattern of falls. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·The Nurse, in conjunction with the QIDP, will develop a High-Risk Plan for falls/transfers for client #7. ·All facility staff will be trained on the new risk plan and will be retrained on the formal goal in the ISP for transfers as recommended by the PT. ·PT recommendations for client #7 will be reviewed to ensure they remain appropriate and if an updated evaluation is indicated, a referral will be procured from client #7's physician. ·QIDP is being retrained on the expectation that a Fall Analysis is to be completed after any reported fall to ensure that a pattern of falls is not developing, requiring a revision of high-risk plans or formal programs. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures	05/22/2021

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	A General Event Report (GER) dated 3/15/21 indicated the following: "[Client #7] was getting out of bed trying to sit on his wheelchair and the wheelchair moved and he did not noticed (sic) that the wheelchair moved and slid on the floor. Staff was approaching [client #7] to assist him with moving the wheelchair close to him but it was late to avoid him falling because he was already trying to sit on the wheelchair (sic) had already moved away from him. Therefore, he landed on his bottom and lay on the ground. Staff called for assistance to help get [client #7] off the ground. He was checked for injuries from head to toe. No injuries was (sic) noticed at that moment. Staff asked [client #7] if he was in pain, and he said he was okay." The facility's Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 4/20/21 at 11:42 am. A BDDS report dated 3/26/21 indicated the following: "Yesterday, staff reported that they found [client #7] on the floor after he fell from his wheel chair while trying to transfer himself to the toilet seat. Staff followed protocol and reported incident to the supervisor. According to staff, [client #7] tried to use the bathroom by himself without asking for assistance from staff and fell to the floor when trying to transfer himself from the wheelchair to the toilet seat. Staff found him on the floor. He had a small cut 2 inches by 3 inches on the ridge of his nose. It was not bleeding and it is suspected that he hit his nose on the toilet seat." Client #7's record was reviewed on 4/20/21 at 2:15 pm. Client #7's Individual Support Plan (ISP) dated		address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Going forward, the QIDP will be expected to complete a fall risk analysis after any fall and this will be reviewed with the Area Director during weekly supervision meetings. The QIDP will be expected to summarize actions taken in response to any pattern of falls in the Event Report follow up section as well as in an addendum to the IPP. **How corrective actions will be monitored to ensure no recurrence** Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	15G452	A. BUILDING 00 B. WING	04/22/2021

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	9/16/21 indicated the following goals: - "[Client #7] will complete recommended PT (physical therapy) exercises for health and wellness, [client #7] will complete all recommended exercises by OT (occupational therapy) to increase levels of upper body strength and flexibility, meal preparation, money management, self medication, laundry, and bathing. - Client #7's record did not include a high risk plan to address his falls and need for assistance when transferring to and from his wheelchair. DSP #2 was interviewed on 4/19/21 at 5:50 pm and indicated client #4 often assists client #7 to transfer into his wheelchair. DSP #5 was interviewed on 4/20/21 at 9:00 am and stated, "[Client #7] needs help getting into and out of his wheelchair. He's had some falls because he forgets to lock his brakes. Clients should not help him. Staff should help." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "[Client #7] does have a risk plan for transfers and falls. He should be assisted by staff. When he needs to use the bathroom, he should call staff to assist him. Sometimes he will try to transfer by himself, but he forgets to lock the wheels. Staff should not allow [client #4] to assist [client #7] with transfers." Registered Nurse (RN) #1 was interviewed by phone on 4/21/21 at 9:13 am and stated, "[Client #7] can transfer independently. He's supposed to have standby assist, but he tries to do it anyway. Staff should assist him. Staff should not ask other clients to assist him. He does not have a risk plan for transfers and falls, but he should."			

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	9-3-4(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 2 of 3 sampled clients (#1 and #2), plus 1 additional client (#7), the facility failed to implement clients #1, #2, and #7's plans when opportunities existed. Findings include: Observations were conducted at the group home on 4/19/21 from 4:00 pm through 6:30 pm and on 4/20/21 from 6:00 am through 10:00 am. Clients #1 and #2 were present in the home for the duration of the observation period. 1. On 4/19/21, client #1 was seated on a sofa in the living room watching television from 4:00 pm through 6:00 pm. Staff did not prompt client #1 to assist with the meal preparation, setting the table, or cleaning. At 6:00 pm, client #1 washed his hands and sat down at the table and ate his evening meal. After the evening meal, client #1 washed the dishes. On 4/20/21, client #1 was in his bedroom asleep from 6:00 am until 8:00 am. At 8:00 am, staff prompted client #1 to get wash his hands and go to breakfast. Client #1 ate breakfast and helped	W 0249	**W 249 (Standard)** Program Implementation – staff failed to implement programs when opportunities existed. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·All facility staff to be retrained on the programs currently in place in each individual's ISP. ·All facility staff will be retrained on how to utilize all teachable moments of the day to incorporate formal and informal learning opportunities for the individuals served. ·Once retraining is complete, the QIDP will be responsible to conduct active treatment observations at varying times of the day to ensure that facility staff demonstrate competency on	05/22/2021

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	wash the dishes and clean the kitchen until 9:00 am. From 9:00 - 9:15 am, client #1 painted a picture. From 9:15 am through 10:00 am, client #1 sat on a sofa in the living room and watched television. Client #1 was interviewed on 4/19/21 at 4:24 pm and stated, "I watched television today. Staff don't have anything for us to do." DSP #1 was interviewed on 4/19/21 at 5:29 pm and stated, "They just started [client #1's] goals. He moved in a month ago. He does his laundry, makes his bed, and helps with the dishes." Client #1's record was reviewed on 4/20/21 at 2:00 pm and indicated an admission date of 3/22/21. Client #1 did not yet have an established program. 2. On 4/19/21, client #2 was seated in a recliner in the living room watching television from 4:00 pm through 6:30 pm. Client #2 got out of her chair to take her medications at 5:00 pm and 6:00 pm. From 6:00 pm through 6:30 pm, client #2 sat alone in the living room watching television. - Staff did not prompt client #2 to participate in cooking, cleaning, or interactive activities. On 4/20/21, client #2 slept in a recliner in the living room from 6:00 am through 6:45 am. At 6:45 am, client #2 got dressed and took her medications. From 7:00 am through 10:00 am, client #2 sat in her recliner, slept, and watched television. - Staff did not prompt client #2 to participate in cooking, cleaning, or interactive activities. DSP #1 was interviewed on 4/19/21 at 5:29 pm and stated, "[Client #2's] goals are to brush her teeth, dress herself, wash herself in the shower, tell why she takes a medication, and to make her bed."		implementation of the programs for each individual. Initially these observations will be conducted 4 times per week for the first two weeks. If competency is shown in that time, observations may reduce to 3 times per week for the next two weeks and then titrate to 2 times per week for two weeks. Any observed concerns will be addressed through immediate retraining and coaching by the QIDP. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Going forward, the QIDP is expected to complete active treatment observations at a minimum of once per week at varying times of the day to ensure that programs are being implemented as written. **How corrective actions will be monitored to ensure no recurrence** Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will	

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	Client #2's record was reviewed on 4/20/21 at 7:48 am. Client #2's Individual Support Plan (ISP) dated 2/17/21 indicated goals in the following areas: - hand washing, putting shoes on, bathing, identifying the purpose of a medication, dental hygiene. 3. On 4/19/21, client #7 was sleeping on his bed with the door shut from 4:00 pm through 5:20 pm, client #7 was in his bedroom with the door shut and the lights off. At 5:20 pm, DSP #1 opened client #7's bedroom door and turned the lights on. Client #7 was lying on the edge of his bed with his legs hanging off the side. Client #7 was not dressed and appeared to be sleeping. DSP #1 called DSP #2 to assist client #7 to get dressed. After dressing, client #7 went back to sleep. At 5:50 pm, DSP #2 stated, "[Client #4] helps [client #7] get into his wheelchair." The wheels of the wheelchair were not locked. Client #4 held client #7's wheelchair still. Client #7 moved to the edge of his bed. Client #4 pushed the wheelchair close to the bed. Client #4 held the wheelchair handle with his left hand and held client #7's arm with his right hand. Client #7 put his arms on the seat of the wheelchair, and pivoted into the chair. Client #7 pushed himself into the dining room. Client #4 stated, "I always help." At 6:00 pm, client #7 was served pureed green beans, fish, and macaroni and cheese in a divided plate. Client #7 ate independently with a round handled spoon with a curved stem. On 4/20/21, client #7 was asleep in his room from 6:00 am through 8:00 am. At 8:00 am, DSP #5 woke client #7 for breakfast. Client #7 stated, "I have oatmeal for breakfast. I think it's peanut butter." House Manager (HM) #1 spoon fed client #7 with		be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented.	

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	a round handled spoon with a curved stem. Client #7 sat with his mouth open, and HM #1 put bites of food into his mouth. HM #1 stated, "Normally, [client #7] feeds himself, but he likes for me to do it. No one else will do it because they want everyone to be as independent as they can be." HM #1 continued to feed client #7 the rest of his oatmeal. At 8:23 am, client #7 pushed himself in his wheelchair to his bedroom. Client #7 stated, "I can transfer myself from my chair to the bed. I have fallen several times because I don't lock the wheels, and the chair moves. [Client #4] helps me a lot of the time." DSP #5 chose pants, socks, underwear, and a shirt for client #7. Client #7 took off his shirt and put on a clean one with staff assistance. DSP #5 gave client #7 a prepared toothbrush, and client #7 brushed his teeth. DSP #5 brushed client #7's teeth again. DSP #5 put deodorant on client #7. DSP #5 pushed client #7's wheelchair to the edge of his bed. Client #7 began to transfer to his bed. DSP #5 stated, "What are you forgetting?" Client #7 locked the wheels on his wheelchair and transferred to his bed. Client #7 stated, "I'm going to change my clothes then go back to sleep. I won't get up until lunch time." Client #7's record was reviewed on 4/20/21 at 2:15 pm. Client #7's ISP dated 9/16/20 indicated the following goals: - exercises recommended by PT (physical therapy), meal preparation, exercises recommended by OT (occupational therapy), money management, self medication, laundry, and bathing. Client #7 was interviewed on 4/20/21 at 8:23 am and stated, "I sleep and watch tv all day. Staff don't have anything for me to do that I enjoy. We don't go on outings. I used to work at [name of			

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	sheltered workshop]. I had a cat treat job. I liked it. I got money. I got to see other people. It gave me something to do. Now I just sleep all the time." QIDP #1 was interviewed on 4/20/21 at 2:49 pm and stated, "[Client #7] is able to feed himself. Staff should encourage him to eat. He knows how to eat by himself." Registered Nurse (RN) #1 was interviewed by phone on 4/21/21 at 9:13 am and stated, "[Client #7] is able to feed himself. Staff shouldn't be feeding him unless he's tired or sick." Direct Support Professional (DSP) #2 was interviewed on 4/19/21 at 5:25 pm and stated, "I asked them to sit and watch a movie, so I could clean. When they sit for a long time without anything to do, they get bored. They don't help clean because they might get hurt." DSP #5 was interviewed on 4/20/21 at 9:15 am and stated, "Everyone can help set the table, vacuum, or clean. They should all be active throughout the day." DSP #1 was interviewed on 4/20/21 at 4:09 pm and stated, "They can't go out right now. We don't have anywhere for them to go. It's hard to keep them busy. They can go for van rides, but we don't take them out very often." DSP #1 indicated there were no activities planned for the clients to do throughout the day. House Manager (HM) #1 was interviewed on 4/20/21 at 8:50 am and stated, "[The QIDP] doesn't give us activities to do during the day. She wants me to come up with activities on my own."			

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	QIDP #1 was interviewed on 4/20/21 at 2:49 pm and stated, "Clients need to be up and doing activities. We do have a problem with [client #7]. He doesn't want to leave his bed. Staff do encourage him and involve him with the activities that are going on at the house. Staff should encourage and prompt all of the clients to be involved in what is going on. If staff are doing anything, they should invite the individuals to participate. Staff should encourage them to help with cooking. There are clients who enjoy helping with cooking. The clients should be setting the table. Staff should encourage them to participate all the time." 9-3-4(a)			
W 0250 Bldg. 00	483.440(d)(2) PROGRAM IMPLEMENTATION The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure clients #2 and #3 had individual active treatment schedules. Findings include: 1. Client #2's record was reviewed on 4/20/21 at 7:48 am and did not include an active treatment schedule. 2. Client #3's record was reviewed on 4/20/21 at 8:11 am and did not include an active treatment schedule. Direct Support Professional (DSP) #5 was interviewed on 4/20/21 at 9:15 am and stated,	W 0250	**W 250 (Standard)** Program Implementation – facility failed to ensure clients #2 and #4 had individual active treatment schedules. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·The Program Director / QIDP will be retrained on the standard that an active treatment schedule be in place for all persons served in the home.	05/22/2021

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	"There used to be active treatment schedules a few years ago, but I don't about any now." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "There is a schedule for the whole house. The clients do not have individual active treatment schedules." 9-3-4(a)		·The Lead DSP and Program Director / QIDP will work together to develop an active treatment schedule for each individual residing in the facility. ·Facility staff will be trained on this deficiency and the updated individual active treatment schedules. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Going forward, the QIDP is responsible to ensure that individual active treatment schedules are reviewed and updated where needed on a quarterly basis. **How corrective actions will be monitored to ensure no recurrence** On a quarterly basis, file audits are to be completed by the QIDP in conjunction with the Area Director to ensure compliance with this standard. Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will	

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W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure clients #2 and #3's comprehensive functional assessments were reviewed at least annually. Findings include: 1. Client #2's record was reviewed on 4/20/21 at 7:48 am and included a comprehensive functional assessment dated 1/10/17. 2. Client #3's record was reviewed on 4/20/21 at 8:11 am and included a comprehensive functional assessment dated 12/1/16. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "The [comprehensive functional assessment] is done annually." 9-3-4(a)	W 0259	**W 259 (Standard)** Program Monitoring & Change – facility failed to ensure comprehensive functional assessments were reviewed annually for clients #2 and #3. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·The Comprehensive Functional Assessments for Clients #2 and #3 are being updated and placed in the client files. ·The Program Director/QIDP is receiving re-training regarding the expectation that the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed at least annually. **How facility will identify other**	05/22/2021

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			residents potentially affected & what measures taken All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** We have reviewed this deficiency for all other individuals residing at this facility to ensure that current Comprehensive Functional Assessments are in place. Any outdated assessments are being updated. **How corrective actions will be monitored to ensure no recurrence** On a quarterly basis, file audits are to be completed by the QIDP in conjunction with the Area Director to ensure compliance with this standard. Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented.	
W 0312	483.450(e)(2) DRUG USAGE			

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Bldg. 00	Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to develop a behavior support plan and a plan of reduction for client #3's psychotropic medications. Findings include: Client #3's record was reviewed on 4/20/21 at 8:11 am. Client #3's Medication Administration Record (MAR) for April 2021 indicated the following psychotropic medications: "Aripiprazole/Abilify 10 mg (milligrams), Indication/Purpose: To treat depression. Fluoxetine HCL 40mg, Indication/Purpose: Anti-depressant. Mirtazapine 7.5 mg, Indication/Purpose: Mood." Client #3's record did not include a Behavior Support Plan or a medication reduction plan. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 4/20/21 at 2:49 pm and stated, "[Client #3] should have a behavior support plan. We revised the BSP, but I don't have a copy right now." 9-3-5(a)	W 0312	**W 312 (Standard)** Drug Usage – facility failed to develop a Behavior Support Plan and a plan of reduction for client #3's psychotropic medications. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·The Behavior Support Plan for client #3 is being revised and updated to include the current medication regimen and a plan of reduction for his medications. ·The QIDP is being retrained on this standard and on the Q's responsibility to ensure that all psychotropic medication use is addressed in a Behavior Support Plan with a plan of reduction clearly delineated for the medication use. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. A systemic review of all behavior support plans in place at the home is being completed to ensure that	05/22/2021

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	15G452	A. BUILDING 00 B. WING	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	52812 HIGHLAND DR SOUTH BEND, IN 46635

(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
			all current psychotropic drug usage is being addressed and that medication reduction plans are in place in all plans.. **Measures or systemic changes facility put in place to ensure no recurrence** Going forward, the QIDP be responsible to ensure that all behavior support plans in place have all required elements, and that the drugs used for control of inappropriate behaviors are used only as an integral part of the client's individual program plan. **How corrective actions will be monitored to ensure no recurrence** On a quarterly basis, file audits are to be completed by the QIDP in conjunction with the Area Director to ensure compliance with this standard. Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented.	

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W 9999 Bldg. 00	State Findings 460 IAC 9-3-2(c)(3) Resident protections Authority: IC 12-28-5-19 Affected: IC 4-21.5;IC 5-2-55; IC 12-28-5-12; IC 22-12 (c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section. This State rule is not met as evidenced by: Based on record review and interview for 2 of 3 employee files reviewed, the facility failed to ensure House Manager (HM) #1 had 3 reference checks completed prior to employment at the group home. Findings include: The facility's employee files were reviewed on 4/20/21 at 11:06 am. HM #1's record did not include any references. Human Resources Specialist #1 was interviewed on 4/20/21 at 11:25 am and stated, "We require 3 references before hire." 9-3-2(c)(3)	W 9999	**W 9999 (State Finding)** Resident protections – facility failed to ensure that House Manager had 3 reference checks completed prior to employment at the group home. **Corrective action for resident(s) found to have been affected** All parts of the POC for the survey with event ID PGLV11 will be fully implemented, including the following specifics: ·Human Resources staff have been notified of this deficiency and retrained on this state rule. ·HR is responsible to ensure that 3 reference checks are completed and filed appropriately for each employee before they work at the facility. ·HR has completed an audit of all files for the facility staff and is ensuring that three reference checks for each employee have been completed and are filed in the correct place. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence**	05/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			Human Resources Director is implementing auditing practices to ensure that all employee files are compliant with this expectation and related state laws and statues. **How corrective actions will be monitored to ensure no recurrence** Dungarvin has assigned an Area Director with over 20 years' experience in residential services to monitor implementation of the POC. The Director will supervise implementation of this Plan of Correction. An evidence binder will be compiled with a tab for this citation. The binder will include documented evidence that the POC items are being fully implemented. The Area Director will work in conjunction with the Human Resources State Director to ensure references are completed and on file before the employee begins their on-site training at the facility.	