STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00		00	COMPLETED		
15G479		B. WING		06/13/2022			
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP COD 422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
W 0000							
Bldg. 00	This visit was for the #IN00381404 and #	ne investigation of complaints #IN00381440.	W 0	000			
	_	81404: Substantiated, Federal v related to the allegation(s) is					
	Complaint #IN00381440: Unsubstantiated, due to lack of sufficient evidence.						
	Unrelated deficiencies cited.						
	Dates of Survey: 6/6/10/22 and 6/13/22	6/22, 6/7/22, 6/8/22, 6/9/22, 2.					
	Facility Number: 000993 Provider Number: 15G479 AIMS Number: 100244950						
	accordance with 46	also reflect state findings in 0 IAC 9. this report completed by #15068					
W 0104 Bldg. 00		DY dy must exercise general d operating direction over					
	sampled clients (A, clients (D, E, F and to exercise general	on and interview for 3 of 3 B, and C) and 4 additional G), the governing body failed policy, budget, and operating acility to ensure the home was	W 0	104	W 104 Governing Body (Standard) – Failed to exercise general poli budget, and operating direction over the facility to ensure the home was in good repair.	-	07/13/2022
	Findings include:				Corrective action for resident(s	s)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SQFZ11 Facility ID: 000993 If continuation sheet Page 1 of 6

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		00	COMPLETED		
15G479		B. WIN	B. WING		06/13/2022		
				CTD FFT A	ADDRESS SITY STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DUNIO A DV (IN IN IDIANA I I I O					RQUETTE TRAIL		
DUNGAR	RVIN INDIANA LLC	•		MICHIG	GAN CITY, IN 46360		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тс	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					found to have been affected		
	Observations were	conducted in the group home			All parts of the POC for the su	rvev	
		0 pm to 3:09 pm. Clients B, C, D,			with event ID SQFZ11 will be	•	
		resent in the group home for the			implemented, including the	·uny	
	duration of the obs				following specifics:		
		or annous positions			Maintenance staff completed	ı	
	-The ramp leading	into the group home had loose			repairs to the ramp leading to		
		own when walked on. The first			group home, stabilizing loose	uic	
		ed when walked on.			boards and replacing any war	ned	
	Seven bourds move	od when warked on.			or weak pieces of wood.	pcu	
	The ceiling in the	living room had an oval spot			The peeling and chipping are	a of	
		s peeling and chipping off. The			paint in the living room was	sa Ui	
	_	1/2 inches by 3 1/4 inches. This			scraped down and repainted.		
	_	B, C, D, E, F and G.			Program Director/QIDP has	hoon	
	affected chemis A,	B, C, D, E, F and G.			retrained on the process of	been	
	The Program Direct	etor (PD) was interviewed on			utilizing the Maintenance Req	uoot	
	_	n. The PD stated, "Ramp needs			Forms rather than the site visi		
		en writing it every week or					
	1 -	- ·			report which is not reviewed b	y ine	
	every other week o	on my house report."			Maintenance Department.	- d	
	Th. A Di	(AD) into mi 1			All DSPs, particularly the Lease to the Company of the Compan	au	
		(AD) was interviewed on  1. The AD stated, "The home			DSP along with the Program		
					Director have primary	d	
	should be in good	repair at all times.			responsibility to report day to	day	
	751 C 1 14 1	1: ////////////////////////////////////			concerns regarding the		
	I his federal tag rel	ates to complaint #IN00381404.			maintenance at the home. All		
	0.2.1()				these staff are being retrained	on	
	9-3-1(a)				the Maintenance Request		
					process.		
					How facility will identify other		
					residents potentially affected &	<b>X</b>	
					what measures taken		
					All residents potentially are		
					affected, and corrective meas		
					address the needs of all client	S.	
					Magaziroa ar avistoreis eksii ii	_	
					Measures or systemic change		
					facility put in place to ensure r	Ю	
					recurrence		
					Going forward, the QIDP is to		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2022 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G479	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/13/2022
	PROVIDER OR SUPPLIEI		422 M	ADDRESS, CITY, STATE, ZIP COD ARQUETTE TRAIL GAN CITY, IN 46360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				maintain a regular presence in home through scheduled and unscheduled visits multiple tirper week, to monitor for the organity of the maintenance and cleanliness of the home and of services being provided in the home. In addition, Maintenance to tour the home monthly for a concerns and the Area Direct to conduct look behind visits to the verify that concerns are being reported appropriately and the staff demonstrate competency monitoring the cleanliness and safety of the home.	nes verall d of the e ce is any or is o
W 0249 Bldg. 00	formulated a client each client must reatment prograr interventions and number and frequachievement of the individual program	terdisciplinary team has  It's individual program plan, receive a continuous active In consisting of needed services in sufficient rency to support the lie objectives identified in the	W 0249	W 249	07/13/2022
	interview for 1 of 3 facility failed to en	sample clients (client C), the sure client C's Pica (eating plan was implemented as	W 0249	Program Implementation (Standard) – Failed to ensure client C's Pica (eating inedible items) risk plan was implementation as written to meet his needs.	•
	Observations were on 6/6/22 from 1:30	conducted in the group home 0 pm to 3:09 pm. Clients B, C, D, esent in the group home for the		Corrective action for resident( found to have been affected All parts of the POC for the su with event ID SQFZ11 will be	ırvey

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SQFZ11 Facility ID: 000993

If continuation sheet Page 3 of 6

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
15G479		B. W	B. WING		06/13/	06/13/2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					RQUETTE TRAIL		
DUNGARVIN INDIANA LLC					GAN CITY, IN 46360		
			1		- , I	1	are:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	duration of the obse	ervation period.			implemented, including the		
	At 1.10 pm Stoff #1	brought out fruit and grain			following specifics:  • The IST reviewed the Pica ri	ol.	
		f #1 gave the snack and drink					
	· ·	and G. They all sat at the table		plan for client C and completed a			
		lled out client C's name and			new assessment, agreeing on several revisions to the plan.		
	1	for you." Client C came from			All facility staff are being train	ned	
	1	he dining room. Staff #2 was in			on the revised PICA plan.	ileu	
		th clients B, D, E, F and G. Staff			QIDP is being retrained on the second s	ne l	
	_	out of the doorway and			importance of staff training an		
		k trash and cups to the sink.			implementation of all high-risk		
		able to eat his snack and drank			plans as they are written in the		
	his juice. Staff #1 and #2 were not in arm's reach of				I ISP.		
	client C.				QIDP will be conducting		
					observations of the implement	tation	
	Client C's record wa	as reviewed on 6/7/22 at 11:34			of the PICA plan for client C d		
		nt C's Persistent Eating of			site visits at least 4 times per	3	
		re no nutritional value (Pica			week for 2 weeks following the	е	
	risk) plan dated 12-	15-21, updated by LPN			retraining. Staff will be coache		
	(Licensed Practical	Nurse) on 7/23/21 indicated			implementation of the plan du	ring	
	"Interventions: Staff will provide supervision at				all observations until all staff h	ave	
	All times, while the individual is awake Staff will				demonstrated compliance on the		
	remain at arms-length to enable retrieving				plan implementation.		
	non-edible items the	e individual is attempting to					
	consume"						
					How facility will identify other		
	_	tor (PD) was interviewed on			residents potentially affected a	<b>&amp;</b>	
		n. The PD stated, "I would			what measures taken		
	expect staff to follo	w the plan."			All residents potentially are		
					affected, and corrective meas		
		was interviewed on 6/10/22 at			address the needs of all client	S.	
		stated, "Staff should be			1		
	following the plan.'	•			Measures or systemic change		
					facility put in place to ensure r	10	
		rviewed on 6/10/22 at 12:43 pm.			recurrence		
		Absolutely, staff should follow			Going forward, the QIDP is to		
	the plan as written.'				maintain a regular presence in	n the	
	0.2.4(-)				home through scheduled and		
	9-3-4(a)				unscheduled visits multiple tin		
I	l		1		I per week. These visits are to I	ne in	

PRINTED: 07/22/2022 FORM APPROVED

	AID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
			00	COMPLETED	
	15G479	B. WING		06/13/2022	
ROVIDER OR SUPPLIER					
VIN INDIANA I I C					
			T	1	
			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
*		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
			sufficient number and length to allow the QIDP to model and coach staff on active treatment and risk plan implementation and naturally occurring opportunities. The nurse for the home id also be present at the home freque enough to monitor, model, and coach staff on the implementation of the Health Risk plans.	at all es. o to ently	
483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff. Based on observation, record review and interview for 1 of 3 sample clients (C), the facility failed to ensure staff did not use furniture to prevent client C from accessing the kitchen.  Findings include:  Observations were conducted in the group home on 6/6/22 from 1:30 pm to 3:09 pm. Clients B, C, D, E, and F were present in the group home for the duration of the observation.  -At 1:30 pm a dresser measuring 29 1/2 inches by 31 1/2 inches was blocking the doorway into the kitchenAt 1:38 pm Direct Support Professional (DSP) #2 moved the dresser to get into the kitchen and then moved it back into the doorway.		W 0287	W 287 Management of Inappropriate Client Behavior (Standard) – F to ensure staff did not use furr to prevent client C from acces the kitchen.  Corrective action for resident(s found to have been affected All parts of the POC for the su with event ID SQFZ11 will be implemented, including the following specifics:  • Maintenance has installed th half door as approved in the H restrictions for the home to pro the individuals with safety risk the kitchen area.  • All facility staff have reviewed this finding and been trained to	Failed niture sing s) rvey fully e IRC otect s in	
]	A83.450(b)(3) MGMT OF INAPP BEHAVIOR Techniques to ma behavior must new convenience of sta Based on observatio interview for 1 of 3 failed to ensure staf prevent client C from Findings include:  Observations were on 6/6/22 from 1:30 E, and F were prese duration of the observation of the observatio	ROVIDER OR SUPPLIER RVIN INDIANA LLC  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used for the convenience of staff. Based on observation, record review and interview for 1 of 3 sample clients (C), the facility failed to ensure staff did not use furniture to prevent client C from accessing the kitchen.  Findings include:  Observations were conducted in the group home on 6/6/22 from 1:30 pm to 3:09 pm. Clients B, C, D, E, and F were present in the group home for the duration of the observation.  -At 1:30 pm a dresser measuring 29 1/2 inches by 31 1/2 inches was blocking the doorway into the kitchenAt 1:38 pm Direct Support Professional (DSP) #2 moved the dresser to get into the kitchen and then	ABUILDING B. WING  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  483.450(b)(3)  MGMT OF INAPPROPRIATE CLIENT  BEHAVIOR  Techniques to manage inappropriate client behavior must never be used for the convenience of staff.  Based on observation, record review and interview for 1 of 3 sample clients (C), the facility failed to ensure staff did not use furniture to prevent client C from accessing the kitchen.  Findings include:  Observations were conducted in the group home on 6/6/22 from 1:30 pm to 3:09 pm. Clients B, C, D, E, and F were present in the group home for the duration of the observation.  -At 1:30 pm a dresser measuring 29 1/2 inches by 31 1/2 inches was blocking the doorway into the kitchen.  -At 1:38 pm Direct Support Professional (DSP) #2 moved the dresser to get into the kitchen and then moved it back into the doorway.  DSP #1 was interviewed on 6/6/22 at 1:34 pm. DSP	ROVIDER OR SUPPLIER  MIN INDIANA LLC  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  ABULLDING  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  ABULLDING  SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  ABULLDING  SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  ABULLDING  SUMMARY STATEMENT OF DEFICIENCIE  SUMMICHICAN THE PREFIX  ABION THE PREFIX  ABION TO FINAPPROPRIATE CLIENT BEHAVIOR  Techniques to manage inappropriate client behavior must never be used for the convenience of staff.  Based on observation, record review and interview for 1 of 3 sample clients (C), the facility failed to ensure staff did not use furniture to prevent client C from accessing the kitchen.  Findings include:  Observations were conducted in the group home on 6/6/22 from 1:30 pm to 3:09 pm. Clients B, C, D, E, and F were present in the group home for the duration of the observation.  At 1:30 pm a dresser measuring 29 1/2 inches by 31 1/2 inches was blocking the doorway into the kitchen.  -At 1:38 pm Direct Support Professional (DSP) #2 moved the dresser to get into the kitchen and then moved it back into the doorway.  DSP #1 was interviewed on 6/6/22 at 1:34 pm. DSP	

from getting food and choking on it."

is never appropriate to use

furniture to block access to any

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/13/2022 15G479 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **422 MARQUETTE TRAIL** DUNGARVIN INDIANA LLC MICHIGAN CITY, IN 46360 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE area of the home. DSP #2 was interviewed on 6/6/22 at 1:59 pm. DSP • The Program Director/QIDP has #2 stated, "Human Rights Committee (HRC) been retrained that furniture can approved a half door. [Client C] will touch the hot never be utilized to block stove and other individuals could grab food in the pathways in the home in place of kitchen and choke." an approved restriction in a behavior or high-risk plan. Client C's Behavior Management Plan (BMP) dated 11/1/2020 was reviewed on 6/7/22 at 11:34 am. The BMP did not include furniture blocking How facility will identify other access to kitchen as part of his plan. residents potentially affected & what measures taken Program Director (PD) was interviewed on 6/10/22 All residents potentially are at 11:39 am. PD indicated staff should not be affected, and corrective measures using a piece of furniture to block the doorway to address the needs of all clients. the kitchen. The PD stated, "It is not in anyone's plan to use a dresser." Measures or systemic changes facility put in place to ensure no Area Director (AD) was interviewed on 6/10/22 at recurrence 11:27 am. AD stated, "Use of furniture is Going forward, the QIDP is to inappropriate." maintain a regular presence in the home through scheduled and 9-3-5(a) unscheduled visits multiple times per week, to monitor for the overall quality of the programming and services being provided in the home. This includes monitoring that any restrictions in place in the current ISPs are implemented as written, in a way that does not impede safety in any way. The Area Director is to conduct look behind visits to verify that concerns are being reported appropriately and that staff demonstrate competency in implementing the programs in place.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

SQFZ11

Facility ID: 000993

If continuation sheet

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