STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G479	A. BUILDING 00 B. WING	06/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DUNGARVIN INDIANA LLC	422 MARQUETTE TRAIL MICHIGAN CITY, IN 46360

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W 0000 Bldg. 00	This visit was for the investigation of complaints #IN00381404 and #IN00381440. Complaint #IN00381404: Substantiated, Federal and state deficiency related to the allegation(s) is cited at W104. Complaint #IN00381440: Unsubstantiated, due to lack of sufficient evidence. Unrelated deficiencies cited. Dates of Survey: 6/6/22, 6/7/22, 6/8/22, 6/9/22, 6/10/22 and 6/13/22. Facility Number: 000993 Provider Number: 15G479 AIMS Number: 100244950 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/23/22.	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 and interview for 3 of 3 sampled clients (A, B, and C) and 4 additional clients (D, E, F and G), 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:	W 0104	W 104 Governing Body (Standard) – Failed to exercise general policy, budget, and operating direction over the facility to ensure the home was in good repair. Corrective action for resident(s)	07/13/2022

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

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	Observations were conducted in the group home on 6/6/22 from 1:30 pm to 3:09 pm. Clients B, C, D, E, F and G were present in the group home for the duration of the observation period. -The ramp leading into the group home had loose boards and sunk down when walked on. The first seven boards moved when walked on. -The ceiling in the living room had an oval spot where the paint was peeling and chipping off. The spot measured 14 1/2 inches by 3 1/4 inches. This affected clients A, B, C, D, E, F and G. The Program Director (PD) was interviewed on 6/10/22 at 11:39 am. The PD stated, "Ramp needs repaired. I have been writing it every week or every other week on my house report." The Area Director (AD) was interviewed on 6/10/22 at 11:27am. The AD stated, "The home should be in good repair at all times." This federal tag relates to complaint #IN00381404. 9-3-1(a)		found to have been affected All parts of the POC for the survey with event ID SQFZ11 will be fully implemented, including the following specifics: • Maintenance staff completed repairs to the ramp leading to the group home, stabilizing loose boards and replacing any warped or weak pieces of wood. • The peeling and chipping area of paint in the living room was scraped down and repainted. • Program Director/QIDP has been retrained on the process of utilizing the Maintenance Request Forms rather than the site visit report which is not reviewed by the Maintenance Department. • All DSPs, particularly the Lead DSP along with the Program Director have primary responsibility to report day to day concerns regarding the maintenance at the home. All of these staff are being retrained on the Maintenance Request process. 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 to	

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			maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week, to monitor for the overall quality of the maintenance and cleanliness of the home and of the services being provided in the home. In addition, Maintenance is to tour the home monthly for any concerns and the Area Director is to conduct look behind visits to verify that concerns are being reported appropriately and that staff demonstrate competency in monitoring the cleanliness and safety of the home.	
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 1 of 3 sample clients (client C), the facility failed to ensure client C's Pica (eating inedible items) risk plan was implemented as written to meet his needs. 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, F and G were present in the group home for the	W 0249	W 249 Program Implementation (Standard) – Failed to ensure client C's Pica (eating inedible items) risk plan was implemented as written to meet his needs. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID SQFZ11 will be fully	07/13/2022

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	duration of the observation period. At 1:10 pm Staff #1 brought out fruit and grain bars and juice. Staff #1 gave the snack and drink to clients B, D, E, F and G. They all sat at the table and ate. Staff #1 yelled out client C's name and said, "I have snack for you." Client C came from another room into the dining room. Staff #2 was in the dining room with clients B, D, E, F and G. Staff #2 moved a dresser out of the doorway and clients F and G took trash and cups to the sink. Client C sat at the table to eat his snack and drank his juice. Staff #1 and #2 were not in arm's reach of client C. Client C's record was reviewed on 6/7/22 at 11:34 am. Review of client C's Persistent Eating of Substances that have no nutritional value (Pica risk) plan dated 12-15-21, updated by LPN (Licensed Practical Nurse) on 7/23/21 indicated "...Interventions: Staff will provide supervision at All times, while the individual is awake. - Staff will remain at arms-length to enable retrieving non-edible items the individual is attempting to consume...." The Program Director (PD) was interviewed on 6/10/22 at 11:39 am. The PD stated, "I would expect staff to follow the plan." The Area Director was interviewed on 6/10/22 at 11:27 am. The AD stated, "Staff should be following the plan." The Nurse was interviewed on 6/10/22 at 12:43 pm. The nurse stated, "Absolutely, staff should follow the plan as written." 9-3-4(a)		implemented, including the following specifics: • The IST reviewed the Pica risk plan for client C and completed a new assessment, agreeing on several revisions to the plan. • All facility staff are being trained on the revised PICA plan. • QIDP is being retrained on the importance of staff training and implementation of all high-risk plans as they are written in the ISP. • QIDP will be conducting observations of the implementation of the PICA plan for client C during site visits at least 4 times per week for 2 weeks following the retraining. Staff will be coached on implementation of the plan during all observations until all staff have demonstrated compliance on the plan implementation. 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 to maintain a regular presence in the home through scheduled and unscheduled visits multiple times per week. These visits are to be in	

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			sufficient number and length to allow the QIDP to model and coach staff on active treatment and risk plan implementation at all naturally occurring opportunities. The nurse for the home id also to be present at the home frequently enough to monitor, model, and coach staff on the implementation of the Health Risk plans.	
W 0287 Bldg. 00	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 #1 stated, "It's for their safety to prevent them from getting food and choking on it."	W 0287	W 287 Management of Inappropriate Client Behavior (Standard) – Failed to ensure staff did not use furniture to prevent client C from accessing the kitchen. Corrective action for resident(s) found to have been affected All parts of the POC for the survey with event ID SQFZ11 will be fully implemented, including the following specifics: • Maintenance has installed the half door as approved in the HRC restrictions for the home to protect the individuals with safety risks in the kitchen area. • All facility staff have reviewed this finding and been trained that it is never appropriate to use furniture to block access to any	07/13/2022

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	DSP #2 was interviewed on 6/6/22 at 1:59 pm. DSP #2 stated, "Human Rights Committee (HRC) approved a half door. [Client C] will touch the hot stove and other individuals could grab food in the kitchen and choke." 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 access to kitchen as part of his plan. Program Director (PD) was interviewed on 6/10/22 at 11:39 am. PD indicated staff should not be using a piece of furniture to block the doorway to the kitchen. The PD stated, "It is not in anyone's plan to use a dresser." Area Director (AD) was interviewed on 6/10/22 at 11:27 am. AD stated, "Use of furniture is inappropriate." 9-3-5(a)		area of the home. • The Program Director/QIDP has been retrained that furniture can never be utilized to block pathways in the home in place of an approved restriction in a behavior or high-risk plan. . 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 to maintain a regular presence in the home through scheduled and 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.	