STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G793	A. BUILDING 00 B. WING	06/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNGARVIN INDIANA LLC	113 S 325 E VALPARAISO, IN 46385

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for an annual recertification and state licensure survey. Dates of Survey: June 3, 4, 6, 9 and 13, 2014. Facility number: 012584 Provider number: 15G793 AIM number: 201018520 Surveyor: Christine Colon, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/26/14 by Ruth Shackelford, QIDP.	W000000		
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed for 2 of 2 sampled clients and 1 additional client (clients #1, #2 and #4), to exercise general operating direction over the facility to ensure clients did not pay for	W000104	**W104 483.410(a)(1) GOVERNING BODY** The three Individuals who paid for their haircuts will be reimbursed by the Agency. House Manager will review all client financial records to	07/13/2014

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

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	hair cuts. Findings include: A financial record review was conducted on 6/6/14 at 2:30 P.M.. A review of client #1's financial record indicated he paid for a haircut on 5/15/14 in the amount of $6.00. Further review of the record failed to indicate he had been reimbursed for the expenditure. A review of client #2's financial record indicated he paid for a haircut on 5/15/14 in the amount of $6.00. Further review of the record failed to indicate he had been reimbursed for the expenditure. A review of client #4's financial record indicated he paid for a haircut on 4/8/14 in the amount of $9.00 and on 5/15/14 in the amount of $6.00. Further review of the record failed to indicate he had been reimbursed for the expenditures. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/9/14 at 4:20 P.M.. The QIDP indicated clients should not pay for haircuts. 9-3-1(a)		ensure that the clients have not paid for any other items that are the responsibility of the Agency. If other items are found, the Individuals will be reimbursed by the Agency for the items purchased. QDDP, House Manager, and Lead DSP will be retrained to ensure the Individuals do not pay for their haircuts. Immediately and for one month, or until compliance has been demonstrated, the House Manager or QDDP will complete weekly audits of each Individual's finances to ensure no items have been purchased, that are the responsibility of the Agency. If any are found, the Individuals will be immediately reimbursed and responsible staff retrained on the allowable uses of the Individuals finances. After compliance has been demonstrated, these audits will be completed at random, and at least monthly. System wide, all Program Directors, QDDPs, and House Managers will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/13/14** **Persons Responsible: QDDP, House Manager, and Lead DSP**	

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W000140	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 upon record review and interview, the facility failed to maintain an accurate accounting system for 4 of 4 clients who reside at the group home (clients #1, #2, #3 and #4), for whom the facility managed their personal funds accounts. Findings include: A review of the facility's records was conducted on 6/6/14 at 10:00 A.M.. A review of client #1, #2, #3 and #4's personal petty cash financial records was conducted. There was no financial ledger to indicate the facility kept track of how much money was available for clients #1, #2, #3 and #4's use at the group home and to indicate the facility was retaining an individual financial record, banking statements, reconciliations and receipts of their personal funds for the months of 6/13, 7/13, 8/13, 9/13, 10/13, 11/13 and 12/13. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/6/14 at 4:20	W000140	**W140 483.420(b)(1)(i) CLIENT FINANCES** **House Manager, QDDP, and Lead DSP will review this standard; to maintain an accurate accounting of clients' funds and ensure the records are available for review upon request of authorized personnel. All staff have been trained on the procedure and importance of maintaining an always current, accurate count of each client's checking account and petty cash, and that these records must be maintained in the home and available for review upon request. Initially, and for one month until compliance is ensured, QDDP and/or House Manager will complete weekly audits of each client's checking account ledger and petty cash ledger to ensure the records are available in the home, and have up-to-date and accurate accounting of all funds. After compliance is demonstrated, the House Manager and/or QDDP will complete monthly and random audits of each client's checking account ledger and petty cash ledger. Random audits will be completed at any time and without notice to staff at home.**	07/13/2014

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	P.M.. The QIDP indicated the facility managed clients #1, #2, #3 and #4's finances and further indicated the facility was to keep an accurate account of their finances at all times. The QIDP further indicated each client should have a financial ledger which should reflect the clients' expenditures and balances to ensure they kept an accurate accounting of their petty cash funds by staff at the group home. The QIDP further indicated there was no documentation to indicate the facility kept an accurate accounting system of clients #1, #2, #3 and #4's personal finances prior to 1/1/14. 9-3-2(a)		**System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's.** **Completed: 7/13/14** **Persons Responsible: House Manager, QDDP, and Lead DSP**	
W000149	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 record review and interview for 2 additional clients (clients #3 and #4) residing at the group home, the facility failed to implement written policy and procedures to report an allegation of verbal abuse, prevent abuse and neglect by staff and to address a pattern of elopement. Findings include:	W000149	**W 149 483.420(d)(1) STAFF TREATMENT OF CLIENTS** The House Manager and QDDP will review this Standard. Dungarvin has a written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. 1. All staff have been retrained on the Agency's reporting policy and policy on abuse, neglect, and exploitation, with a focus on the fact that this Policy specifically states that any	07/01/2014

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	A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 6/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated: 1. -Investigation Report: "Allegation that [Staff #13] verbally abused individuals served....Date and Time of alleged incident: 2/25/14 Exact time could not be determined....Persons involved: [Client #3] and [Client #4]...Dates of Investigation: 3/7/14-3/24/14...This allegation of verbal abuse was substantiated based on evidence collected." Further review of the record indicated the investigation was concluded on 3/24/14. Further review of the record did not indicate the results of the investigation were reported to the administrator within 5 days. Further review of the report failed to indicate the incident of verbal abuse was immediately reported to the administrator and BDDS. 2. -BDDS report dated 2/24/14 indicated client #4 ran out of the van and ran into a store while out in the community with his staff and housemates. Staff followed him into the store and lost sight of him in the store and then found him. -BDDS report dated 4/3/14 indicated		suspicion of, or actual abuse neglect must be immediately reported to the supervisor, who will in turn report to the administrator. 2. The Area Director has retrained the House Manager and QDDP on the need to monitor, and immediately and effectively address any pattern of behavior that may risk the health and safety of any Individual Served. For the Individual who has been exhibiting a pattern of elopement, the IDT has developed and implemented a plan for one-on-one staffing including constant supervision except for private time. All staff have been trained on this protocol and at this time, the protocol appears to be effective. Immediately and for one month, or until compliance has been demonstrated, the House Manager, QDDP, Nurse, or Behaviorist will complete daily observations to ensure this protocol is being followed. Once compliance has been demonstrated and ongoing, the QDDP or House Manager will complete weekly observations to ensure this protocol is being followed. Furthermore, the IDT will regularly review the effectiveness of this protocol and his BSP and make changes as necessary to best support the Individual in preventing additional incidents of elopement. System wide, all House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.	

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	staff was preparing client #4's 11:00 P.M. medications in the office. When staff went to client #4's bedroom to administer the medications client #4 was gone. Staff noticed him walking down the road and followed him to a gas station where client #4 entered. Once back at the group home it was found that client #4 had stolen two energy drinks and two sodas. Further review of the report failed to indicate the group home is located on a country road approximately 2 miles from the gas station which is located on a major rural divided highway. A review of client #4's record was conducted on 6/6/14 at 2:15 P.M.. Review of client #4's Behavior Support Plan (BSP) dated 4/14 indicated staff should follow him and keep him within eye sight at all times. The record failed to indicate staff documented 15 minute checks on client #4 at all times. A review of the facility's records was conducted at the facility's administrative office on 6/6/14 at 7:30 P.M.. Review of the facility's "Policy and Procedure Concerning Abuse, Neglect and Exploitation", dated 2/27/14, indicated, in part, the following: "Dungarvin believes that each individual has the right to be free from mental, emotional and physical abuse in his/her daily		**Will be completed by: 7/1/14** **Persons Responsible: Area Director, House Manager, and QDDP**	

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	life....Abuse, neglect or exploitation of the individuals' served is strictly prohibited in any Dungarvin service delivery setting....Physical abuse is defined as any act which constitutes a violation of the assault, prostitution or criminal sexual conduct statutes including intentionally touching another person in a rude, insolent or angry manner, willful infliction of injury, unauthorized restraint/confinement resulting from physical or chemical intervention....Emotional/verbal abuse is defined as non-therapeutic conduct which produces or could reasonably be expected to produce pain or injury and is not accidental, or any repeated conduct which produces or could reasonably be expected to produce mental or emotional distress, including communicating with words or actions in a individual's presence with intent to cause fear of retaliation, fear of confinement or restraint, cause an individual to experience emotional humiliation or distress...Neglect is defined as failure to provide appropriate care, supervision, or training, failure to provide food and medical services as needed, failure to provide a safe, clean and sanitary environment and failure to provide medical supplies/safety equipment as indicated in the individual's Individual Support Plan (ISP)....The Supervisor, or Program			

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	Coordinator/Senior Director, or his/her delegate will conduct a thorough investigation of the reported incident. The investigation will include the following: 1. Review of witnesses. 2. Any evidence or previous abuse or neglect. 3. All other evidence to determine the veracity and seriousness of the charge. ...The facility investigation will be completed within five (5) business days, and a summary of results of the investigation will be forwarded to the administrator within five (5) business days of the incident." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/9/14 at 4:20 P.M.. The QIDP indicated the facility's abuse/neglect policy should be followed at all times. The QIDP indicated staff did not immediately report the incident of staff verbal abuse towards clients #3 and #4. The QIDP further indicated the results of investigations are to be reported with in 5 days. The QIDP indicated client #4's BSP was not reviewed after the mentioned incidents. The QIDP indicated staff are to do 15 minute checks on client #4 and keep him in sight at all times. The QIDP further indicated there			

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	was no documentation available for review to indicate any measures were put in place to prevent recurrence of client #4's elopement. 9-3-2(a)			
W000153	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, the facility failed for 2 additional clients (clients #3 and #4), to report an allegation of verbal abuse immediately to the administrator and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law. Findings include:	W000153	**W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS** In conjunction with the Plan of Correction for W149, the House Manager and QDDP will review this Standard. Dungarvin has written policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. These policies require all staff to	07/01/2014

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	A review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 6/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated: -Investigation Report: "Allegation that [Staff #13] verbally abused individuals served....Date and Time of alleged incident: 2/25/14 Exact time could not be determined....Persons involved: [Client #3] and [Client #4]...Dates of Investigation: 3/7/14-3/24/14...This allegation of verbal abuse was substantiated based on evidence collected." Further review of the report failed to indicate the incident of verbal abuse was immediately reported to the administrator and BDDS. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/9/14 at 4:20 P.M.. The QIDP indicated this incident of staff verbal abuse was not immediately reported to the administrator or BDDS. The QIDP further indicated the incidents should have been immediately reported to the administrator and within 24 hours to BDDS. 9-3-2(a)		immediately report any suspicion of, or actual abuse neglect to the supervisor, who will in turn report to the administrator and BDDS. All staff have been retrained on the Agency's reporting policy and policy on abuse, neglect, and exploitation, with a focus on the fact that this Policy specifically states that any suspicion of, or actual abuse neglect must be immediately reported to the supervisor, who will in turn report to BDDS and the administrator. Immediately and for one month, or until compliance has been demonstrated, the House Manager, QDDP, Nurse, or Behaviorist will complete daily documentation reviews and observations to ensure these policies and procedures are followed. Any staff person who fails to adhere to these policies and procedures will receive prompt disciplinary action up to, and including termination from employment. Once compliance has been demonstrated and ongoing, the QDDP or House Manager will complete weekly documentation reviews and observations to ensure this protocol continues to be in compliance. System wide, all House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/1/14** **Persons Responsible: House**	

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			Manager, QDDP, Nurse, and Behaviorist	
W000156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview, the facility failed to report the results of 1 of 1 reviewed investigation, involving 2 additional clients (clients #3 and #4), to the administrator within five business days. Findings include: A review of the facility's Bureau Of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 6/3/14 at 1:45 P.M.. Review of the facility's investigation records indicated: -Investigation Report: "Allegation that [Staff #13] verbally abused individuals served....Date and Time of alleged incident: 2/25/14 Exact time could not be determined....Persons involved: [Client #3] and [Client #4]...Dates of	W000156	**W 156 483.420(d)(4) STAFF TREATMENT OF CLIENTS** In conjunction with the Plan of Corrections for W149, and W153, the House Manager and QDDP will review this Standard. The Area Director has retrained the QDDP and House Manager on the expectation that the results of any investigation concerning abuse, neglect, and/or exploitation be reported to the administrator within 5 business days. Going forward, and until compliance is demonstrated, once the Area Director is notified an investigation into abuse/neglect/exploitation has begun, the Area Director will follow-up with the investigator as to the results every 5 days. System wide, all Area Directors, House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin	07/13/2014

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	Investigation: 3/7/14-3/24/14...This allegation of verbal abuse was substantiated based on evidence collected." Further review of the record indicated the investigation was concluded on 3/24/14. Further review of the record did not indicate the results of the investigation were reported to the administrator within 5 days. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/9/14 at 4:20 P.M.. The QIDP the investigation was not completed within 5 days. The QIDP further indicated results from investigations are to be reported to the administrator within 5 days. 9-3-2(a)		ICF-MR's. **Will be completed by: 7/13/14** **Persons Responsible: House Manager, QDDP, Nurse, and Behaviorist**	
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 1 additional client (client #4), the facility failed to take sufficient/effective corrective measures to address and/or prevent client #4's elopement.	W000157	**W 157 483.420(d)(4) STAFF TREATMENT OF CLIENTS** In conjunction with the Plan of Correction for W149, the House Manager and QDDP will review this Standard. Dungarvin has a written	07/01/2014

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	Findings include: A review of the facility's Bureau Of Developmental Disabilities Services (BDDS) reports, Internal Reports (IR) and investigation records was conducted on 6/3/14 at 1:45 P.M.. Review of the records indicated: -BDDS report dated 2/24/14 indicated client #4 ran out of the van and ran into a store while out in the community with his staff and housemates. Staff followed him into the store and lost sight of him in the store and then found him. -BDDS report dated 4/3/14 indicated staff was preparing client #4's 11:00 P.M. medications in the office. When staff went to client #4's bedroom to administer the medications client #4 was gone. Staff noticed him walking down the road and followed him to a gas station where client #4 entered. Once back at the group home it was found that client #4 had stolen two energy drinks and two sodas. Further review of the report failed to indicate the group home is located on a country road approximately 2 miles from the gas station which is located on a major rural divided highway. Further review of the reports failed to indicate the facility took		policies and procedures that prohibit mistreatment, neglect, or abuse of our Individuals Served. The Area Director has retrained the House Manager and QDDP on the need to monitor, and immediately and effectively address any pattern of behavior that may risk the health and safety of any Individual Served. For the Individual who has been exhibiting a pattern of elopement, the IDT has developed and implemented a plan for one-on-one staffing including constant supervision except for private time. All staff have been trained on this protocol and at this time, the protocol appears to be effective. Immediately and for one month, or until compliance has been demonstrated, the House Manager, QDDP, Nurse, or Behaviorist will complete daily observations to ensure this protocol is being followed. Once compliance has been demonstrated and ongoing, the QDDP or House Manager will complete weekly observations to ensure this protocol is being followed. Furthermore, the IDT will regularly review the effectiveness of this protocol and his BSP and make changes as necessary to best support the Individual in preventing additional incidents of elopement. System wide, all House Managers, Program Directors, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's.	

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	15G793	A. BUILDING 00 B. WING	06/13/2014

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	effective/sufficient corrective action to prevent recurrence. A review of client #4's record was conducted on 6/6/14 at 2:15 P.M.. Review of client #4's Behavior Support Plan (BSP) dated 4/14 indicated staff should follow him and keep him within eye sight at all times. The record failed to indicate staff documented 15 minute checks on client #4 at all times. An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/9/14 at 4:20 P.M.. The QIDP indicated staff were retrained on client #4's BSP. The QIDP indicated client #4's BSP was not reviewed after the mentioned incidents. The QIDP indicated staff are to do 15 minute checks on client #4 at all times. The QIDP further indicated there was no documentation available for review to indicate any measures were put in place to prevent recurrence. 9-3-2(a)		**Will be completed by: 7/1/14** **Persons Responsible: Area Director, House Manager, and QDDP**	

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W000189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview, the facility failed for 1 of 2 sampled clients (client #2), to ensure staff were sufficiently trained to assure competence in following his diet order. Findings include: An observation was conducted at the group home on 6/4/14 from 11:15 A.M. until 1:15 P.M.. At 12:08 P.M., client #2 poured himself some kool aid in his cup and began drinking it with his meal. Direct Support Professionals (DSPs) #1 and #2 did not add Thick-It to his drink. An observation was conducted at the group home on 6/6/14 from 7:15 A.M. until 9:05 A.M.. At 8:37 A.M., Direct Support Professional (DSP) #5 retrieved a bottle with a pump of "Thick-It" and pumped 2 pumps into client #2's cup.	W000189	**W 189 483.430(e)(1) STAFF TRAINING PROGRAM** The House Manager and QDDP will review this Standard. All staff will be retrained on all Individuals' Health Risk/Diet Plans. The Area Director has retrained the House Manager, Nurse, and QDDP on the need to monitor, and immediately and effectively address any failure of staff to correctly implement and follow an Individual's ISP, Risk Plans, and/or Diet Plan. Immediately and for one month, or until compliance has been demonstrated, the House Manager, QDDP, Nurse, or Behaviorist will complete daily observations to ensure all Individuals' Plans are being consistently adhered to by staff. Once compliance has been demonstrated and ongoing, the QDDP or House Manager will complete weekly observations to ensure compliance.	07/13/2014

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	Client #2 then poured juice into his cup and began drinking. At 8:55 A.M., client #2 asked for another cup of juice. DSP #5 picked up client #2's cup and stated "All the Thick-It is at the bottom of the cup." DSPs #5 and #6 did not stir the client's drink, and did not prompt client #2 to stir his juice and did not check the consistency of the liquid. An interview with DSPs #5 and #6 was conducted on 6/6/14 at 9:00 A.M.. When asked what consistency client #2's liquids were ordered to be, DSPs #5 and #6 stated "Nectar thick." When asked how they check for the ordered consistency, DSPs #5 and #6 stated "We stir it." A review of client #2's record was conducted on 6/6/14 at 1:45 P.M.. Review of client #2's "Nutritional Assessment" dated 5/26/14 indicated: "Nectar thick liquids...Use Thick-It...Health Risks: Dysphasia." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 6/9/14 at 4:20 P.M.. The QIDP indicated staff should have followed client #2's prescribed diet and made sure they added Thick It and stirred client #2's juice. The QIDP further indicated client #2 was at risk for		System wide, all House Managers, Program Directors, Nurses, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/13/14** **Persons Responsible: Area Director, House Manager, Nurse, and QDDP**	

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	choking and his liquids are to be of a nectar thick consistency. The QIDP further indicated all staff receive client specific training before working at the group home with clients #1, #2, #3 and #4. 9-3-3(a)			
W000362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed for 4 of 4 clients living at the group home, (clients #1, #2, #3 and #4) to ensure the pharmacist reviewed clients' medications on a quarterly basis. Findings include: The pharmacist's medication review record was reviewed at the group home on 6/6/14 at 2:53 P.M.. Review of the pharmacist's medication review record indicated no medication reviews for the second, third and fourth quarters of 2013 for clients #1, #2, #3 and #4.	W000362	**W362 483.460(j)(1) DRUG REGIMEN REVIEW** **This citation was for failure to ensure the pharmacist reviewed clients' medications on a quarterly basis; records could not be located for the 2nd, 3rd, and 4th quarters of 2013. This is due to the Agency having acquired the facility on 1/1/14, and the clients' pharmacist review documents had been removed by the previous Agency. Since 1/1/14, regular quarterly pharmacist reviews of Individuals' medication regimens have been completed, and will continue to be completed at least each quarter. The Nurse will ensure these audits are completed as required, on**	07/01/2014

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	A review of client #1's record was conducted on 6/6/14 at 1:15 P.M.. The record indicated client #1 was prescribed medications. A review of client #2's record was conducted on 6/6/14 at 1:50 P.M.. The record indicated client #2 was prescribed medications. A review of client #3's record was conducted on 6/6/14 at 2:20 P.M.. The record indicated client #3 was prescribed medications. A review of client #4's record was conducted on 6/6/14 at 2:45 P.M.. The record indicated client #4 was prescribed medications An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted at the facility's administrative office on 6/9/14 at 4:20 P.M.. When asked how often medications are to be reviewed by the pharmacist, the QIDP stated "They should be reviewed quarterly." No further documentation was available for review to indicate medications were reviewed by the pharmacist. 9-3-6(a)		**time, and records available for review.** System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. **Completed: 7/1/14** **Persons Responsible: Nurse and QDDP**	

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W000436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review, and interview, for 1 of 2 sampled clients who were prescribed eyeglasses and hearing aids (client #1), the facility failed to provide, encourage and teach the use of their prescribed eyeglasses and hearing aids. Findings include: An observation was conducted at the group home on 6/4/14 from 11:15 A.M. until 1:15 P.M.. During the entire observation period, client #1 did not and was not prompted to wear his prescribed eyeglasses. Direct Support Professionals (DSPs) #1, #2, #3 and #4 did not prompt client #1 to wear his eyeglasses. An observation was conducted at the group home on 6/6/14 between 7:15 A.M. and 9:05 A.M.. Client #1 was	W000436	**W 436 483.470(g)(2) SPACE AND EQUIPMENT** The QDDP and House Manager have retrained all staff to ensure all clients are encouraged to use their adaptive equipment. Any client refusals to use their adaptive equipment will be documented by staff and data recorded by QDDP. In the event a client is regularly refusing, QDDP will develop a plan/goal to teach the client to use and make informed choices about the use of their adaptive equipment. Immediately and for one month, or until compliance has been demonstrated, the House Manager, QDDP, Nurse, or Behaviorist will complete daily documentation reviews and observations to ensure all Individuals are encouraged to use their adaptive equipment, and working on any goals with the individuals concerning the use of their adaptive equipment. Any staff person who fails to adhere to these	07/01/2014

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	observed the entire observation period not wearing eyeglasses. Direct Support Professionals (DSP) #1, #5 and #6 did not prompt client #1 to wear his eyeglasses. A review of client #1's record was conducted on 6/6/14 at 1:15 P.M.. A review of client #1's Individual Support Plan (ISP) dated 8/21/2013 indicated client #1 was prescribed eyeglasses and hearing aids. Client #1's "General Eye Exam" dated 3/15/13 indicated he was prescribed eyeglasses. Client #1's "Hearing Evaluation" dated 4/14/14 indicated he wore hearing aids. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed at the facility's administrative office on 6/9/14 at 4:20 P.M.. The QIDP indicated staff should be teaching clients to wear their eyeglasses at all times. The QIDP further indicated staff should have prompted client #1 to wear his eyeglasses. The QIDP indicated client #1's hearing aids needed to be replaced. The QIDP did not indicate when client #1's hearing aids would be available for his use. 9-3-7(a)		procedures will receive prompt disciplinary action up to, and including termination from employment. Once compliance has been demonstrated and ongoing, the QDDP or House Manager will complete weekly documentation reviews and observations to ensure active treatment continues to be in compliance, including the implementation and documentation of training objectives and encouraging the individuals to use their adaptive equipment as prescribed. System wide, all House Managers and Program Director/QDDP's will review this standard and assure that this concern is being addressed at all Dungarvin ICF's. **Will be completed by: 7/1/14** **Persons Responsible: QDDP, Nurse, and House Manager**	

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W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the day shift (7:00 A.M. to 3:00 P.M.), the evening shift (3:00 P.M. to 11:00 P.M.) and the overnight/asleep shift (11:00 P.M. to 7:00 A.M.) during the second quarter (April 1st through June 30th) of 2013, the third quarter (July 1st through September 30th) of 2013 and the last quarter (October 1st through December 31st) of 2013 which affected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4.) Findings include: The facility's records were reviewed on 6/6/14 at 3:15 P.M.. The review failed to indicate the facility held any evacuation drills for clients #1, #2, #3 and #4 for the second, third and fourth quarters of 2013. The Qualified Intellectual Disabilities Professional (PD/QIDP) was interviewed on 6/9/14 at 4:20 P.M.. The QIDP	W000440	**W 440 483.470(i)(1)** **EVACUATION DRILLS** At the time of Survey, the Surveyor was not provided the evacuation drills for the 2nd, 3rd, and 4th quarters of 2013 because these drills could not be located. After completion of the Survey, staff located the documents in a separate binder located at the home. These documents have been uploaded as supporting documentation for this Plan of Correction. The House Manager, Lead DSP, and QDDP have been retrained on maintaining the emergency binder with all evacuation drills of at least one year. The House Manager or QDDP will continue to ensure these evacuation drills are completed at least quarterly for all individuals, and complete monthly audits of the emergency binder at the home, to ensure compliance, and that at least the last 12 months of drills are located in the binder. System wide, all House Managers and Program Director/QDDP's will	07/01/2014

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	indicated evacuation drills are to be conducted during each quarter for each shift. The QIDP indicated she did not know why the documents were not available with the first quarter of 2014 drills. 9-3-7(a)		review this standard and assure that this concern is being addressed at all Dungarvin ICF's. **Will be completed by: 7/1/14** **Persons Responsible: QDDP, Nurse, and House Manager**	
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview, for 1 of 2 sampled clients (client #2), the facility failed to assure the staff provided food in accordance with the client's diet orders. Findings include: An observation was conducted at the group home on 6/4/14 from 11:15 A.M. until 1:15 P.M.. At 12:08 P.M., client #2 poured himself some kool aid in his cup and began drinking it with his meal. Direct Support Professionals (DSPs) #1 and #2 did not add Thick-It to his drink. An observation was conducted at the group home on 6/6/14 from 7:15 A.M. until 9:05 A.M.. At 8:37 A.M., Direct	W000460	**W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES** In conjunction with the Plan of Correction for W189, the House Manager and QDDP will review this Standard; that each Individual must receive a nourishing, well-balanced diet including modified and specially prescribed diets. All staff will be retrained on all Individuals' Health Risk/Diet Plans. The Area Director has retrained the House Manager, Nurse, and QDDP on the need to monitor, and immediately and effectively address any failure of staff to correctly implement and follow an Individual's ISP, Risk Plans, and/or Diet Plan. Staff not following the prescribed plans will receive disciplinary action up to and including termination from	07/01/2014

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	Support Professional (DSP) #5 retrieved a bottle with a pump of "Thick-It" and pumped 2 pumps into client #2's cup. Client #2 then poured juice into his cup and began drinking. At 8:55 A.M., client #2 asked for another cup of juice. DSP #5 picked up client #2's cup and stated "All the Thick-It is at the bottom of the cup." DSPs #5 and #6 did not stir the client's drink, and did not prompt client #2 to stir his juice and did not check the consistency of the liquid. An interview with DSPs #5 and #6 was conducted on 6/6/14 at 9:00 A.M.. When asked what consistency client #2's liquids were ordered to be, DSPs #5 and #6 stated "Nectar thick." When asked how they check for the ordered consistency, DSPs #5 and #6 stated "We stir it." A review of client #2's record was conducted on 6/6/14 at 1:45 P.M.. Review of client #2's "Nutritional Assessment" dated 5/26/14 indicated: "Nectar thick liquids...Use Thick-It...Health Risks: Dysphasia." An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/9/14 at 4:20 P.M.. The QIDP indicated staff should have followed client #2's prescribed diet and made sure they stirred client #2's		employment. Immediately and for one month, or until compliance has been demonstrated, the House Manager, QDDP, Nurse, or Behaviorist will complete daily observations to ensure all Individuals' Plans are being consistently adhered to by staff. Once compliance has been demonstrated and ongoing, the QDDP or House Manager will complete weekly observations to ensure compliance. System wide, all House Managers, Program Directors, Nurses, and QDDPs will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/1/14** **Persons Responsible: Area Director, House Manager, Nurse, and QDDP**	

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	juice. The QIDP further indicated client #2 was at risk for choking and his liquids are to be of a nectar thick consistency. 9-3-8(a)			
W000484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview, the facility failed for 1 of 2 sampled clients (client #2) to provide table knives at the dining table. Findings include: An observation was conducted at the group on 6/4/14 from 11:15 A.M. until 1:15 P.M.. At 11:40 A.M., Direct Support Professional (DSP) #2 retrieved a table knife from the kitchen drawer and cut up client #2's bologna sandwich, and placed the plate on the table in front of client #2 as he sat with no activity. No table knives were on the table for client #2's use.	W000484	**W 484 483.480(d)(3) DINING AREAS AND SERVICE** The House Manager, QDDP, and Behaviorist will review this standard. All staff will be retrained on the expectation that each Individual must be supplied with appropriate eating utensils and dishes designed to meet the developmental needs of each client, and that the active treatment during meal time be provided in a manner allowing the individual to participate fully at their developmental level. Table knives, forks, and spoons will be provided to all Individuals at meal times unless the utensil is specifically restricted from that Individual as stated in their HRC approved BSP and/or ISP. At least daily for one month, and	07/13/2014

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	An interview with the Qualified Intellectual Disabilities Professional (QIDP) was conducted on 6/9/14 at 4:20 P.M.. The QIDP indicated table knives should be put on the table for the clients to use. 9-3-8(a)		then at least weekly ongoing, the House Manager and/or QDDP will complete random site visits to ensure each Individual is supplied with appropriate eating utensils and dishes designed to meet the developmental needs of each client, and that the active treatment during meal time be provided in a manner allowing the individual to participate fully at their developmental level. System wide, all House Managers, Program Directors, QDDPs, and Behaviorists will review this standard and assure that this concern is being addressed at all Dungarvin ICF-MR's. **Will be completed by: 7/13/14** **Persons Responsible: House Manager, QDDP, and Behaviorist**	