STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G750	A. BUILDING 00 B. WING	04/18/2016

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DUNGARVIN INDIANA LLC	60680 LILAC RD SOUTH BEND, IN 46614

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W 0000 Bldg. 00	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: April 12, 13, 14, 15, and 18, 2016 Facility number: 011765 Provider number: 15G750 AIM number: 200908290 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/21/16.	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, the facility's governing body failed to exercise general operating direction over the facility by failing to ensure walls and ceilings in the facility were repaired and painted for 2 of 2 sampled clients (clients #1 and #2), and 2 of 2 additional clients (clients #3 and #4). Findings include:	W 0104	**W104 483.410(a)(1)** **GOVERNING BODY** The Program Director/ QIDP and Lead DSP will review thisStandard. The Maintenance Coordinator willarrange for the following: 1. The walls in the dining room and both livingrooms that have, "…numerous black and white marks and multiple holes and scrapes" will	05/18/2016

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

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	The group home where clients #1, #2, #3, and #4 resided was inspected during the 4/12/16 observation period from 6:47 A.M. until 8:40 A.M. Walls in the dining room and both living rooms had numerous black and white marks and multiple holes and scrapes. Areas of the ceiling were noted to have brown spray markings on them. The floor in client #1's bedroom had a 4 inch by 4 inch hole in the floor covering. These areas of the facility were regularly accessed by clients #1, #2, #3, and #4. House manager #1 was interviewed on 4/14/16 at 9:11 A.M. House manager #1 stated, "We have put repair orders in and I guess maintenance is getting around to painting and fixing the areas that need fixing." 9-3-1(a)		be patched and painted. 2. Theareas of ceiling that have brown spray markings will be cleaned and/orpainted. 3. The floor in client # 1's bedroom that has a4" by 4" inch hole in the floor covering will be repaired or replaced. The Maintenance Coordinator and Program Director willperform a thorough walk through and evaluation of the home and arrange to haveany other issues identified repaired or replaced. The Lead DSP will arrange for staff tocomplete a thorough walk through of the home and ensure it is thoroughlycleaned, including all walls. The LeadDSP and Program Director will be retrained on the procedure by whichMaintenance Requests are made and follow up procedures to ensure they arecompleted timely, and that the maintenance Coordinator is aware of the issues. For two weeks and then until compliance has beendemonstrated, the Program Director and Lead DSP will do site-visits at least threetimes per week to ensure the home is thoroughly clean and free of any environmentalconcerns that need repair. If an item isnoted that needs repair or replacement, they will ensure a maintenance Requestwas submitted per procedure and that the Maintenance Coordinator is aware. Thereafter, the Lead DSP and/or ProgramDirector will complete these checks at least weekly.	

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			Will be completedby: 5/18/16 **Persons Responsible: Program Director/QIDP, MaintenanceCoordinator, and Lead DSP**	
W 0137 Bldg. 00	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview, the facility failed to assure 1 of 4 sampled clients (client #1) wore a clean shirt. Findings include: Client #1 was observed during the group home observation period on 4/12/16 from 6:47 A.M. until 8:40 A.M. Upon entering the group home, client #1 was wearing a blue striped shirt with numerous black and yellow stains on the chest area. Client #1 wore the shirt as he left for day program. Direct care staff #1, #2, and #3 did not assist or prompt the client to put on a clean shirt. House manager #1 was interviewed on 4/14/16 at 9:11 A.M. House manager #1 stated, "He (client #1) has clean shirts available. They (direct care staff) should have assisted [client #1] to put on a clean	W 0137	**W137 483.420(a)(12)** **PROTECTION OFCLIENTS RIGHTS** The Program Director/ QIDP and Lead DSP will review thisStandard. All staff will be retrained onensuring all individuals are appropriately dressed and groomed at all times andthat they are prompted to use their accessories, such as a belt, as necessary. The Program Director and Lead DSP will perform a thorough checkof Client #1's clothing and accessories, and all other individuals in the home,to ensure they have adequate and appropriate clothing in good repair, and allnecessary accessories, such as belts, hat, gloves, winter coats, shoes,etc. If any individual does not havesufficient and appropriate clothing or accessories, they will immediatelyarrange for	05/18/2016

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	shirt." 9-3-2(a)		their purchase. For two weeks and then until compliance has beendemonstrated, the Program Director, Area Director, Behaviorist, Nurse, or Lead DSP will perform a daily site visit toensure all individuals are appropriately and adequately dressed, with allnecessary accessories such as a belt. They will also ensure staff are prompting the individuals to use theirnecessary accessories and or change, if their clothing is notappropriate/adequate, or clean. Thereafter, the Lead DSP and/or Program Director willcomplete these checks at least weekly. **Will be completedby: 5/18/16** **Persons Responsible: Program Director/QIDP, Area Director,Behaviorist,, and Lead DSP**	
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 comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview, and record review, the facility failed to assure 1 of 2 sampled clients (client #2) had a speech therapy screening as recommended by the facility's IDT	W 0227	**W227 483.440(c)(4)** **INDIVIDUALPROGRAM PLAN** The Program Director/ QIDP and Lead DSP will review thisStandard.	05/18/2016

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	(Inter-Disciplinary Team). Findings include: Client #2 was observed at the group home on 4/12/16 from 6:47 A.M. until 8:40 A.M. and from 4:33 P.M. until 6:34 P.M. During the observation periods, client #2 spoke with direct care staff #1, #2, #3, #4, #5, and #6 several times. The client's speech was occasionally difficult to be understood by staff/others. Direct care staff #1, #3, and #5 were interviewed on 4/14/16 at 8:02 A.M. Direct care staff #1, #3, and #5 indicated they often times have difficulty understanding what client #2 is saying. Client #2's record was reviewed on 4/14/16 at 8:44 A.M. Review of the client's 10/22/15 Individual Support Plan indicated client #2 "needs a speech therapy screening" as recommended by the facility's IDT. House manager #1 was interviewed on 4/14/16 at 9:11 A.M. House manager #1 stated, "I was not aware of this (speech therapy screening recommendation)." 9-3-4(a)		The PD/QIDP will be retrainedon ensuring all IDT recommendations for all individuals are completedpromptly. The Program Director/QIDP will schedule a speech therapyscreening for Client #2, per the recommendation of the individual's IDT. The PD/QIDP will then review all ISPs of allindividuals and ensure all IDT recommendations are addressed and completed. Ongoing, the PD/QIDP will complete an audit of each individuals' file atleast quarterly, to ensure all IDT recommendations have beenaddressed/completed per this Standard and Agency Policy. **Will be completedby: 5/18/16** **Persons Responsible: Program Director/QIDP, Area Director,Behaviorist,, and Lead DSP**	

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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, the facility failed to implement medication objectives during times of opportunity for 2 of 2 sampled clients (clients #1 and #2). Findings include: Clients #1 and #2 were observed at the group home on 4/12/16 from 6:47 A.M. until 8:40 A.M. At 7:01 A.M., Direct care staff #2 administered medications to client #1. During the administration, direct care staff #2 did not prompt or assist client #1 to identify three of his medications and state why he takes them. At 7:31 A.M., Direct care staff #2 administered medications to client #2. During the administration, direct care staff #2 did not prompt or assist client #2 in identifying all of his routine medications.	W 0249	**W249 483.440(d)(1)** **PROGRAMIMPLEMENTATION** The Program Director/ QIDP and Lead DSP will review thisStandard. All staff will be retrained onActive Treatment and on ensuring all objectives/goals, as noted in theindividual's ISP, are implemented at every available opportunity throughout theday. For two weeks and then until compliance has beendemonstrated, the Program Director, Area Director, Behaviorist, Nurse, or Lead DSP will perform a site visit atleast three times per week to ensure active treatment is being provided at alltimes, per this Standard and Agency Policy and that all individuals'objectives/goals are being implemented by staff at every available opportunity,including during medication administration.	05/18/2016

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	Client #1's records were reviewed on 4/14/16 at 7:43 A.M. Client #1's Individual Support Plan dated 3/1/16 indicated the following medication administration objective: "ID (identify) three of his medications and state why he takes each." Client #2's records were reviewed on 4/14/16 at 8:44 A.M. Client #2's Individual Support Plan dated 10/22/15 indicated the following medication administration objective: "Identify all routine medications." House manager #1 was interviewed on 4/14/16 at 9:11 A.M. House manager #1 stated, "Medication objectives should have been implemented." 9-3-4(a)		Thereafter, the Lead DSP and/or Program Director willcomplete these site visit observation at least weekly, to ensure continuedcompliance. **Will be completedby: 5/18/16** **Persons Responsible: Program Director/QIDP, Area Director,Behaviorist, Nurse, and Lead DSP**	
W 0336 Bldg. 00	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed to assure nursing assessments were conducted at least quarterly (every 90 days) for 2 of 2	W 0336	**W 336 483.460(c)(3)(iii)** **NURSING SERVICES** The ProgramDirector/QIDP and	05/18/2016

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	sampled clients (clients #1 and #2). Findings include: Client #1's records were reviewed on 4/14/16 at 7:43 A.M. A review of the client's quarterly nursing assessments from 4/1/15 to 4/14/16 indicated quarterly nursing assessments were completed on 2/29/16, 11/1/15, 8/14/15, and 5/4/15. The review failed to indicate the client's nursing assessments were routinely completed at least quarterly (every 90 days). Client #2's records were reviewed on 4/14/16 at 8:44 A.M. A review of the client's quarterly nursing assessments from 4/1/15 to 4/14/16 indicated quarterly nursing assessments were completed on 2/29/16, 11/1/15, 10/20/15, 8/14/15, and 5/5/15. The review failed to indicate the client's nursing assessments were routinely completed at least quarterly (every 90 days). Area Director #1 was interviewed on 4/14/16 at 9:55 A.M. Area Director #1 stated, "Our (the facility's) nurse was on sick leave and there might be some assessments (quarterly nursing assessments) that have not been completed at this time."		Nurse have reviewed this standard. The Area Director has retrained the PD/QIDP andNurse on this Standard. The nurse will now complete quarterly (atleast every 90 days) assessments on each client's health status and forwardall nursing summaries promptly to the PD/QIDP for review. Ongoing, the QIDP andNurse will complete an audit of each individuals' file at least quarterly, toensure all nursing assessments have been completed and filed timely. **Will be completedby: 5/18/16** **Persons Responsible: PD/QIDP and Nurse**	

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	9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, the facility failed to assure 1 of 10 administered medications were administered according to physician's orders for 1 of 2 sampled clients (client #2). Findings include: Client #2 was observed during the group home observation period on 4/12/16 from 6:47 A.M. until 8:40 A.M. At 7:31 A.M., direct care staff #2 administered medications to client #2. Direct care staff #2 did not assist or prompt client #2 to administer Fixodent denture adhesive to client #2 for denture retention. Client #2 was further observed during the 4/12/16 observation period from 6:47 A.M. until 8:40 A.M. During the entire observation period, as client #2 spoke his dentures floated up and down in his mouth and did not retain properly on his upper and lower gums.	W 0369	**W 369 483.460(k)(2) DRUG ADMINISTRATION** The ProgramDirector/QIDP, Lead DSP, and Nurse have reviewed this standard. The PD/QIDP will retrain the staffresponsible for not ensuring all medications were administered according tophysician's orders, for not prompting Client #2 to apply Fixodent to hisdentures. All staff will beretrained on Agency Policy regarding Medication Administration, and on ensuringall medications are administered according to physician's orders, including theapplication of Fixodent to Client #2'sdentures. For two weeks and until compliance is demonstrated, the PD/QIDP,Lead DSP, Nurse, Area Director, or other trained-trainer will conduct dailyobservations at the home. Aftercompliance is demonstrated, theseobservations will occur at least weekly, to ensure staff are following AgencyPolicy and this Standard	05/18/2016

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	Client #2's record was reviewed on 4/14/16 at 8:44 A.M. Review of client #2's 11/29/15 physician's orders indicated the following orders: "Fixodent, apply to dentures in A.M. (morning) and prn (as needed)." House manager #1 was interviewed on 4/14/16 at 9:11 A.M. House manager #1 stated, "She (direct care staff #2) should have prompted or at least asked him (client #2) to put the Fixodent on his (client #2's) dentures." 9-3-6(a)		concerning Medication Administration. **Will be completedby: 5/18/16** **Persons Responsible: PD/QIDP, Nurse, and Lead DSP**	
W 0436 Bldg. 00	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, the facility failed to assure 1 of 2 sampled clients (client #2) was prompted to wear his eyeglasses and hearing aid. Findings include:	W 0436	**W436 483.470(g)(2) SPACE ANDEQUIPMENT** The Program Director/ QIDP and Lead DSP will review thisStandard. All staff will be retrained on this Standard and Agency Policy and	05/18/2016

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	Client #2 was observed at the group home on 4/12/16 from 6:47 A.M. until 8:40 A.M. and from 4:33 P.M. until 6:34 P.M. During the observation periods, client #2 did not wear eyeglasses or a hearing aid. Direct care staff #1, #2, #3, #4, #5, and #6 did not prompt or assist client #2 to wear his eyeglasses or hearing aid. Client #2's record was reviewed on 4/14/16 at 8:44 A.M. Review of a 11/1/15 vision exam indicated the client was to wear eyeglasses. Review of a 2/1/16 hearing exam indicated the client was to wear a hearing aid in his left ear. House manager #1 was interviewed on 4/14/16 at 9:11 A.M. House manager #1 stated, "[Client #2] has eyeglasses and a hearing aid he is supposed to wear. He doesn't always comply though." 9-3-7(a)		Procedure concerning anindividual's adaptive equipment. Daily, for two weeks, and then until compliance has beendemonstrated, the PD/QIDP, Area Director, Lead DSP, Behaviorist, Nurse, or othertrained-trainer, will complete a sitevisit during a random time of day to observe if all individuals are wearingtheir prescribed eyeglasses and any other adaptive equipment. At least 4 times per week, these visit willoccur in the morning, when the individuals are getting up, to see if staff areprompting the individuals to use their eyeglasses/adaptive equipment. If the individual is not wearing theireyeglasses or adaptive equipment, documentation will be checked to see if thereis proper documentation to see if the individual refused to utilize their adaptive equipment and whatprompting was utilized. If it isdetermined an individual is regularly refusing to wear their eyeglasses, theissue will be presented to their IDT, by the Program Director, in order tocreate a formal goal and address the refusals. Thereafter, Program Director willcomplete these visits at least weekly to ensure continued compliance. **Will be completedby: 5/18/16** **Persons Responsible: Program Director/QIDP, Area Director, and LeadDSP**	

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W 0460 Bldg. 00	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, the facility failed to assure 2 of 2 sampled clients (clients #1 and #2) were offered meals per their assessed dietary needs. Findings include: Client #1 was observed during the 4/12/16 group home observation period from 6:47 A.M. until 8:40 A.M. At 7:07 A.M., direct care staff #1 stated to client #1, "You need to get yourself something to eat." Client #1 prepared himself a bowl of cold cereal and a glass of 1% milk. At 7:44 A.M., direct care staff #1 asked client #2 if he was going to eat. Client #2 fixed himself a bowl of cold cereal and a glass of tea. Both clients sat at the dining room table and ate the foods that they had prepared. Direct care staff #1 did not offer clients #1 and #2 any additional foods for their morning meal. Direct care staff #1 was interviewed on 4/12/16 at 7:58 A.M. When asked if the facility had a meal menu which was followed to meet the dietary needs of clients #1 and #2, direct care staff #1 stated, "I don't know what menu we are	W 0460	**W 460 483.480(a)(1) FOOD AND NUTRITION SERVICES** The Program Director/QIDP (PD) and Area Director (AD) willreview this Standard. PD/QIDP, Lead DSP, and all staff will be re-trained on thisStandard and Agency Policy and Procedure concerning menus and dietary needs ofthe individuals. All staff will bere-trained on each individuals' dining plan. For at least two weeks and until compliance has beendemonstrated, the PD/QIDP, Lead DSP, AD, Nurse, Behavioral Clinician, or othertrained-trainer will be at the home daily to observe a meal time, during theshift of a different staff person on each occasion, to ensure compliance andcompetence. Ongoing, the PD, AD, or Nurse, will complete weekly randommeal time observations to ensure compliance of this Standard and Agency Policyand Procedure. **Will be completed by: 5/18/16** **Persons Responsible: Program Director/QIDP, Lead DSP, and**	05/18/2016

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(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
	to be using now." The facility records were reviewed on 4/13/16 at 7:48 A.M. Review of the facility's menu for 4/12/16 indicated the following foods were to be offered for the morning meal on 4/12/16: "Juice of choice, Asst (assorted) cold cereal, wheat toast, margarine, jelly, citrus sections, 1% milk, beverage of choice." Client #1's records were reviewed on 4/14/16 at 7:43 A.M. Review of the client's Annual Nutrition Assessment, dated 7/22/15, indicated the client was on a regular diet with no concentrated sweets, no added salt, and no additional portions. Client #2's records were reviewed on 4/14/16 at 8:44 A.M. Review of the client's Annual Nutrition Assessment, dated 7/22/15, indicated the client was on a regular diet with high fiber and no concentrated sweets. House manager #1 was interviewed on 4/14/16 at 9:11 A.M. House manager #1 stated, "Staff (direct care staff) should follow the menus we have and at least offer what is on the menus." 9-3-8(a)		**Nurse**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G750	A. BUILDING 00 B. WING	04/18/2016

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