CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G673			LDING	onstruction 00	(X3) DATE : COMPL 10/13/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3521 OXFORD  SOUTH BEND, IN46615				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0000	revisit to an exter recertification an completed on Seg Dates of Survey Facility number: Provider number AIM number: 10 Surveyor: Susan Surveyor III The following fe reflect state finding 460 IAC 9.	d state licensure survey ptember 6, 2011.  Coctober 12, 13, 2011.  009114  15G673  00244780  Reichert, Medical  deral deficiencies also ngs in accordance with completed 10/20/11 by Medical Surveyor auth Shackelford,	W	0000			
W0102	interview, the factorial Condition of Part Body. The govern	nd management	W	0102	Client #1 is no longer resing at the Oxford home. He had been transferred to an ES home that will better suit had behavioral needs.	as N	11/12/2011

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

TITLE

009114

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days 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.

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G673	B. WIN			10/13/2011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R		3521 O			
DUNGAF	RVIN INDIANA LLC				BEND, IN46615		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	an outside at the control of	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	1 of 4 sampled c	lients (client #1) from			The Program Director/QI	MRP	
	self injurious be	,			for the Oxford home had		
					reviewed this tag and had	ı	
		property destruction after a			been retrained on the		
		al aggression had been			expectation that incidents	of	
	· ·	ailed to ensure the home			physical aggression and		
		in good condition for 8 of			property destruction requi	re	
	8 clients living in	n the group home (clients			immediate action to preve	l l	
	#1, #2, #3, #4, #3	5, #6, #7 and #8).			recurrence of the incident		
					after the pattern of physic	al	
	Findings include	:			aggression and property		
					destruction or the potentia	al for	
	1. Please see W122. The facility failed to				physical aggression and		
		on of Participation:			property destruction has l	peen	
		as by failing to develop			identified. These measur	es	
					previously included revisi		
		olicy and procedures to			to the Behavior Interventi	on	
		and effective corrective			Plans, increasing staffing		
	-	t 1 of 4 sampled clients			ratios, and changes in		
	(client #1) from	self injurious behavior,			medications as recomme		
	physical aggress	ion and property			by this person's Psychiati		
	destruction after	a pattern of physical			assist in the controlling of		
	aggression had b	een identified.			identified behaviors. Alth	•	
					these measures were not		
	2. Please see W	104. The governing body			completely effective in	oolf	
		oversight and direction			curtailing all of client #1's injurious behavior, they d		
	*	sampled clients (client			reduce the overall numbe		
	_	jurious behavior, physical			incidents that were previo		
					occurring.	rusiy	
		roperty destruction after a			occurring.		
		al aggression had been			The damage to the home		
	· ·	ailed to ensure the home			caused by ongoing prope	l l	
		in good condition for 8 of			destruction by client #1 is	, I	
	8 clients living in	n the group home (clients			process of being repaired	l l	
	#1, #2, #3, #4, #3	5, #6, #7 and #8).			repairs are expected to be		
					complete by 12-1-11.		
	This deficiency	was cited on 9/6/11. The			r <b>,</b>		
FORM CMS-2	2567(02-99) Previous Version		JJ6S12	Facility I	ID: 009114 If continuation s	sheet Page 2 of 20	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED	
MOTLAN	or condition	15G673	A. BUILDING		10/13/2011
			B. WING STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		3521 O		
DUNGAR	VIN INDIANA LLC			BEND, IN46615	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	•	implement a systemic		The Program Coordinato	
	plan of correction	n to prevent recurrence.		continue to review all inci and assure that appropria	
	0.2.1(-)			action has been taken by	
	9-3-1(a)			Program Director, Behav	
				Specialist, and IDT to ass	sure
				that incidents of physical	
				aggression and property	
			destruction are being immediately addressed.		
				miniodiatory addressed.	
				System wide, all Progran	ı
				Director/QMRPs and Pro	·
				Coordinators have review	
				this standard for assuran	
				that this concern is being addressed at all Dungary	<b>I</b>
				ICF-MR's.	
				Persons Responsible:	
				Program Director/ QMR	Ρ,
W0104	The governing has	dy must exercise general		Program Coordinator	
W0104		d operating direction over			
	the facility.	, 5			
			W0104	Client #1 is no longer res	-
	•	rvation, record review		at the Oxford home. He	
		e governing body failed		been transferred to an Est home that will better suit	
	•	ght and direction to		behavioral needs.	
	•	npled clients (client #1)			
	-	us behavior, physical		The Program Director/Q	<b>I</b>
		roperty destruction after a		for the Oxford home had	<b>I</b>
		al aggression had been		reviewed this tag and had	<b>d</b>
	•	iled to ensure the home		been retrained on the expectation that incidents	s of
	was maintained in good condition for 8 of 8 clients living in the group home (clients			physical aggression, and	
	o chems hving if	i me group nome (chems		property destruction requ	<b>I</b>

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G673		LDING		10/13/2011
		1.55.0	B. WIN		ADDRESS OF THE CASE OF THE CASE	13.13.2011
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE  XFORD	
DUNGA	RVIN INDIANA LLC				I BEND, IN46615	
					T DEND, 114-0013	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAG	immediate action to preve	
	#1, #2, #3, #4, #.	5, #6, #7 and #8).			recurrence of the incident	
	F. 1				after the pattern of physic	
	Findings include	:			aggression and property	
					destruction or the potentia	al for
	1 The facility's	reportable incidents to			physical aggression and	
	-	evelopmental Disabilities			property destruction has	been
		) were reviewed on			identified. These measur	
	`	PM and included the			previously included revisi	ons
					to the Behavior Intervention	on
	following report	s involving client #1:			Plans, increasing staffing	
					ratios, and changes in	
	_	/7/11 indicated client #1			medications as recomme	
		ruck near him in the			by this person's Psychiat	
	-	"started begging for			to assist in the controlling	of
	things." The rep	ort indicated client #1 ran			the identified behaviors.  Although these measure	
	away from staff	when redirected and and			were not completely effect	
	tried to start the	mail truck. Client #1			in curtailing all of client #1	
	"wanted to engag	ge in self injurious			self injurious behavior, the	
	behavior" (not de	efined) when redirected			did reduce the overall nur	•
	from walking to	nearby houses and staff			of incidents that were	
	physically assist	ed him by holding him for			previously occurring.	
	less than 30 seco	onds. He was taken to a				
	mental health fac	cility for evaluation where			The damage to the home	
		him and ascertained "he			caused by ongoing prope	
		empt by facility staff to			destruction by client #1 is	
		lmitted to a mental health			process of being repaired	
		accessful as the physician			repairs are expected to be	9
		e could be admitted."			complete by 12-1-11.	
		n included 1 to 1 staffing			The Program Coordinator	·will
		#1 which was already in			continue to review all inci-	
		•			and assure that appropria	
	_	story of self injurious and			action has been taken by	
		ssive behavior, and staff			Program Director, Behavi	
		getting an emergency			Specialist, and IDT to ass	
	appointment wit	h a psychiatrist for			that incidents of physical	
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		15G673	B. WIN	G		10/13/2	011
	PROVIDER OR SUPPLIER			3521 OX	.ddress, city, state, zip code XFORD BEND, IN46615		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE
TAG	-a report dated 9, hit his head on the staff persons who physically assist free himself from "smashed" the ele then "smashed" the hand to bleed. CER and provided hospital, client # hit the wall with there. Client #1 [mental health far not have any bed action included the specialist on 9/12 with a psychiatric paragraph with a hocabinet on the was separated from the	/10/11 indicated client #1 ne wall and "fought the 2 to were trying to him," and was able to n the hold. Client #1 ectric can opener and a window causing his client #1 was taken to the l bandages. While at the 1 "got angry again" and his hand and made a hole "could not be admitted at acility] because they did I for him." Corrective raining by a behavior 3/11 and an appointment		TAG	aggression and property destruction are being immediately addressed.  System wide, all Program Director/QMRPs and Prog Coordinators have review this standard for assurant that this concern is being addressed at all Dungarvi ICF-MR's.  Persons Responsible: Program Director/ QMRF Program Coordinator	gram ed ce n	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G673	B. WIN			10/13/2	011
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULLEIE			3521 O			
DUNGAF	RVIN INDIANA LLC			SOUTH	BEND, IN46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		w up report dated 10/2/11					
		ad implemented client					
		ted staff had been					
		plan on 10/6/11, and an					
	, ,	red placement in a group					
	home on 10/24/1	11.					
	-a report dated 1	0/7/11 indicated client #1					
	•	d asked his neighbor for a					
		eighbor provided. Staff					
	_ ^	urn the pop and client #1					
		went into the house and					
		Client #1 made threats to					
		he wall and to bite his					
		was physically restrained					
		to hit the window, but					
	_	e one of the wounds in his					
	•	bled for a while." Client					
	_	st aid for his injury. Plan					
		led respectfully asking the					
	_	give client #1 anything					
	without checking	g first with staff.					
	Client #4 was in	terviewed on 10/12/11 at					
		ated, "Sometimes I don't					
		is happening (with client					
		n the line of fire" when					
		ne hallway, and "that's					
		ered sometimes."					
	where I get colli	cica sometimes.					
	The Program Co	oordinator (PC) and					
	_	or (PD) were interviewed					
	_	:30 PM. When asked					
		sibility to ensure policy					
	l i i i i i i i i i i i i i i i i i i i	., r,					

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

PRINTED: 11/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
ANDILAN	or connection	15G673		LDING	00	10/13/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			3521 O			
DUNGAF	RVIN INDIANA LLC				BEND, IN46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	-	o protect clients from					
		dicated it was ultimately					
		of the senior directors fthe governing body.					
	_	d despite staff attempts to					
		he was able to break					
	away and injure						
	away and injuic.	mmsen.					
	2. During observ	vation at the group home					
	_	n 6:09 PM until 6:37 PM,					
		les in the walls exposing					
		ing in size from 23"					
	(inches) by 23" t	o 6 inches in diameter,					
	and the closet do	or to the linen closets in					
	the main hallway	were leaning against the					
	living room wall	in the rear of the home.					
	The doors to the	bathroom door in the					
	back of the home	e was missing paint in					
	areas. The sofa in	n the front living room					
	did not have legs	, and there was a strong					
	odor in the home	·.					
	C4 - CC // 10						
		terviewed on 10/12/11 at					
		icated the sofa legs had					
	_	"as long as I've been					
		ted she had been working					
		months, and indicated					
	I -	egs had been broken. e odor in the home was					
		nt #1 urinating in his					
	room.	π π umanig m ms					
	100111.						
	During the obser	vation on 10/13/11 from					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
ANDILAN	or connection	15G673		LDING	00	10/13/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8		3521 O			
DUNGAF	RVIN INDIANA LLC				BEND, IN46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		, , , , , , , , , , , , , , , , , , ,		IAG	DEFICIENCY)		DATE
		10 AM, there was a worn					
	section of the rug in front of the kitchen island worn to the threads and 2 dark						
	stains on the front living room carpet ranging from 2 to 3 inches in diameter.						
		The house manager was interviewed on					
		AM. When asked about					
		vall, she stated, "they					
		of the walls," and					
	_	board covering the upper					
		the office/medication					
		ated a sofa had been					
	_	ce the sofa in the living					
	· ·	ited the carpets should be					
		licated the back bathroom					
	was supposed to	be repaired, but the work					
	had not been star	rted yet.					
	The PC was inte	rviewed on 10/13/11 at					
	11:50 AM and ir	ndicated there was only					
	one maintenance	e person in the department					
	and the facility h	and planned to wait until					
	client #1 went to	live at another group					
	home to replace	rather than repair the					
	walls.						
	The Program Co	ordinator (PC) and					
	I -	or (PD) were interviewed					
	_	:30 PM. When asked					
	about the respon						
	_	eds were addressed, the					
		vas ultimately the					
		the senior director who					
	responsibility of	the senior director who					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G673	A. BUII	LDING	NSTRUCTION 00	(X3) DATE ( COMPL 10/13/2	ETED
	PROVIDER OR SUPPLIER RVIN INDIANA LLC SUMMARY ST		B. WIN	STREET A	BEND, IN46615		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
W0122	facility failed to it plan of correction 9-3-1(a)  The facility must e protections require Based on observarecord review, the Condition of Protections. The and implement petake immediate a actions to protect (client #1) from sphysical aggressidestruction after	ras cited on 9/6/11. The implement a systemic in to prevent recurrence.  In the implement a systemic in to prevent recurrence.  In the implement a systemic in the prevent recurrence.  In the implement a systemic in the prevent recurrence.  In the implement a systemic in the prevent and the facility failed to meet in the prevent facility failed to develop the procedures to in the procedures to in the procedures to in the facility failed clients in the procedure	W	0122	Client #1 is no longer reside at the Oxford home. He had been transferred to an ES home that will better suit had been retrained on the expectation that incidents physical aggression, and property destruction requirimmediate action to prevene recurrence of the incident after the pattern of physical	as N is IRP of re	11/12/2011

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

Event ID:

UJ6S12 Facility ID:

009114

If continuation sheet

Page 9 of 20

NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC  (X4) ID  PREFIX TAG  ID  REGULATORY OR LSC IDENTIFYING INFORMATION)  1. Please see W149. The facility neglected to develop and implement policy and property destruction after a pattern of physical aggression and property destruction after a pattern of physical aggression and effective corrective action to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and property destruction after a pattern of physical aggression and property destruction of protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and property destruction of protect 1 of 4 sampled clients (client #1) from self injurious behavior had been identified.  2. Please see W157. The facility failed to implement immediate and effective corrective action to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and property destruction after a pattern of physical aggression and self injurious behavior had been identified.  This deficiency was cited on 9/6/11. The facility failed to implement a systemic plan of correction to prevent recurrence.  9-3-2(a)  The Program Coordinator will continue to review all incidents	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC  IX3 D  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  1. Please see W149. The facility neglected to develop and implement policy and procedures to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and property destruction after a pattern of physical aggression and property destruction to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and property destruction after a pattern of physical aggression and property destruction fer a pattern of physical aggression and property destruction of property destruction after a pattern of physical aggression and property destruction after a pattern of physical aggression and property destruction after a pattern of physical aggression and property destruction after a pattern of physical aggression and property destruction after a pattern of physical aggression and self injurious behavior, physical aggression and property destruction after a pattern of physical aggression and self injurious behavior had been identified.  This deficiency was cited on 9/6/11. The facility failed to implement a systemic plan of correction to prevent recurrence.  9-3-2(a)  STREET ADDRESS, CITY, STATE, ZIP CODE 3621 TAB SOUTH BEND, INA6615  SOUTH BEND, INA6615  CX5)  PREFIX TAG  P	AND PLAIN	OF CORRECTION				00	
DUNGARVIN INDIANA LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MINT BE PERCEDED BY PULL. REGULATORY OR LSC IDENTIFYING INFORMATION)  1. Please see W149. The facility neglected to develop and implement policy and procedures to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and self injurious behavior had been identified.  2. Please see W157. The facility failed to implement immediate and effective corrective action to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and self injurious behavior, physical aggression and property destruction after a pattern of physical aggression and self injurious behavior, physical aggression and property destruction of the Dehavior Intervention Plans, increasing staffing ratios, and changes in medications as recommended by this person's Psychiatrist to assist in the controlling of the identified behaviors. Although these measures were not completely effective in curtalling all of client #1's self injurious behavior, they did reduce the overall number of incidents that were previously occurring.  This deficiency was cited on 9/6/11. The facility failed to implement a systemic plan of correction to prevent recurrence.  9-3-2(a)  The Program Coordinator will			100070	B. WIN		DDDEGG CITY CTATE ZID CODE	10/10/2011
DUNGARVIN INDIANA LLC  (X4) ID     SUMMARY STATEMENT OF DEFICIENCES     PREFIX     TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  1. Please see W149. The facility neglected to develop and implement policy and procedures to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and property destruction after a pattern of physical aggression and self injurious behavior had been identified.  2. Please see W157. The facility failed to implement immediate and effective corrective action to protect 1 of 4 sampled clients (client #1) from self injurious behavior, physical aggression and property destruction of physical aggression and property destruction has been identified to assist in the controlling of the identified by this person's Psychiatrist to assist in the controlling of the identified behaviors. Although these measures were not completely effective in curtailing all of client #1's self injurious behavior, physical aggression and property destruction has been identified by this person's Psychiatrist to assist in the controlling of the identified behaviors. Although these measures were not completely effective in curtailing all of client #1's self injurious behavior, they did reduce the overall number of incidents that were previously occurring.  This deficiency was cited on 9/6/11. The facility failed to implement a systemic plan of correction to prevent recurrence.  9-3-2(a)  The Program Coordinator will	NAME OF P	PROVIDER OR SUPPLIER					
CX4)ID   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   REGULATORY OR LSC IDENTIFY AND TAG IDENTIFY AND TAG IDENTIFY AND TOR LIKE THE ARTORY OR LSC IDENTIFY AND TOR LORD THE ARTORY OR LSC IDENTIFY AND TORS OR LARGE CORD THE ARTORY OR LSC IDENTIFY AND TORS OR L	DUNGAF	RVIN INDIANA LLC					
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plan of correction to prevent recurrence.  9-3-2(a)  destruction by client #1 is in process of being repaired. All repairs are expected to be complete by 12-1-11.  The Program Coordinator will							-
9-3-2(a)  process of being repaired. All repairs are expected to be complete by 12-1-11.  The Program Coordinator will			-			•	
9-3-2(a) complete by 12-1-11.  The Program Coordinator will		1	1				
The Program Coordinator will		9-3-2(a)				•	
		. ,				complete by 12-1-11.	
						The Program Coordinator	will
						continue to review all incid	ents
and assure that appropriate							
action has been taken by the						-	
Program Director, Behavior						_	
Specialist, and IDT to assure						•	ıre
that incidents of physical							
aggression and property destruction are being							
immediately addressed.						_	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G673	A. BUII	LDING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/13/2011	
	ROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE KFORD BEND, IN46615		
(X4) ID PREFIX TAG	SUMMARY ST	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W0149	The facility must d written policies and mistreatment, neg Based upon obse and interview, the develop and improcedures to procedures to procedures (client #1) behavior, physical property destruct physical aggression behavior had been behavior had been been behavior and been been been been been been been be	evelop and implement d procedures that prohibit lect or abuse of the client.  rvation, record review e facility neglected to lement policy and otect 1 of 4 sampled of from self injurious al aggression and ion after a pattern of on and self injurious in identified.	W	0149	System wide, all Program Director/QMRPs and Program Coordinators have reviewed this standard for assurance that this concern is being addressed at all Dungarvin ICF-MR's.  Persons Responsible: Program Director/QMRP Program Coordinator  Client #1 is no longer reside at the Oxford home. He has been transferred to an ES home that will better suit has behavioral needs.  Dungarvin has a written personal procedures in place the prohibits mistreatment, neglect or abuse of the clie (Policy B-2). Dungarvin Administrative Team has recently made changes to policy to include language indicate policy on taking corrective action to protect clients when needed.  The Program Director/QM and Program Coordinator review all incident reports	ed e n ding as N is olicy nat ents this e to t	11/12/2011

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE S COMPLI	
		15G673	A. BUII B. WIN	LDING		10/13/20	011
			B. WIIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			3521 O			
DUNGAF	RVIN INDIANA LLC			SOUTH	BEND, IN46615		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		uck near him in the		1710	ensure that reports of abu	se	DATE
		'started begging for			are acted upon to protect		
	1	ort indicated client #1 ran			person being subjected to	the	
		when redirected and and			abuse.		
	tried to start the	mail truck. Client #1					
	"wanted to engag	ge in self injurious					
	`	efined) when redirected			System wide, all Program		
		nearby houses and staff			Director/QMRP's will revie		
	1 1 2	ed him by holding him for			this standard and assure	that	
		nds. He was taken to a			this concern is being addressed at all Dungarvi	n	
		cility for evaluation where him and ascertained "he			ICF-MR's.	''	
		empt by facility staff to					
		lmitted to a mental health			Persons Responsible:		
		ccessful as the physician			Program Director/ QMRF	,	
	1 *	could be admitted."			Program Coordinator		
		included 1 to 1 staffing					
		#1 which was already in					
	place due to a his	story of self injurious and					
	physically aggres	ssive behavior, and staff					
		getting an emergency					
		n a psychiatrist for					
	medication adjus	stment.					
	-a report dated 9/	/10/11 indicated client #1					
	_	ne wall and "fought the 2					
	staff persons who	o were trying to					
	physically assist	him," and was able to					
		n the hold. Client #1					
		ectric can opener and					
		a window causing his					
		lient #1 was taken to the					
		bandages. While at the					
	nospital, client #	1 "got angry again" and					

	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G673		LDING	NSTRUCTION  00	(X3) DATE : COMPL 10/13/2	ETED
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			3521 O	DDRESS, CITY, STATE, ZIP CODE KFORD BEND, IN46615	•	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
	hit the wall with there. Client #1 [mental health fa not have any bed action included a specialist on 9/1 with a psychiatrical report dated 1 argued with a head injury ched action included a all staff at the sit follow client #1' an investigation future for any in #1's target behave retrained on clie 10/6/11. A followindicated staff he #1's plan, indicated staff he #1's plan, indicated retrained on his agency had offer home on 10/24/11 areport dated 1 "ran outside" and pop which the ne asked him to retrained on the masked him to retrained to the masked	his hand and made a hole "could not be admitted at acility] because they did a for him." Corrective training by a behavior 3/11 and an appointment st on 9/12/11.  0/2/11 indicated client #1 truse mate and kicked a say to his room after being the house mate. Client #1 was for his head and a 24 hour k was started. Follow up an investigation involving the to make sure staff as behavior plan, and for to be implemented in the cidents involving client wiors. All staff were to be ant #1's behavior plan on w up report dated 10/2/11 and implemented client ted staff had been plan on 10/6/11, and an ared placement in a group				

				(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		. BUILD	ING	00			
		15G673	В.	. WING			_	10/13/2	VII
NAME OF F	PROVIDER OR SUPPLIER	<del></del>				DDRESS, CITY, STA	TE, ZIP CODE		
					3521 OX		:		
	RVIN INDIANA LLC					BEND, IN46615			
(X4) ID		TATEMENT OF DEFICIENCIES			ID		LAN OF CORRECTION	Ī	(X5)
PREFIX TAG	·	ICY MUST BE PERCEDED BY FULI R LSC IDENTIFYING INFORMATIO!			REFIX TAG	CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	ΓE	COMPLETION DATE
IAU		Client #1 made threats to	11)		1110	DEIT	•		DATE
		he wall and to bite his							
		was physically restrained							
		to hit the window, but							
	_	e one of the wounds in his							
	~	bled for a while." Client							
	_	st aid for his injury. Plan						l	
		led respectfully asking the	•					l	
	_	give client #1 anything							
	without checking	g tirst with staff.							
	The Day	andinatas (BC)							
	_	oordinator (PC) and							
	_	or (PD) were interviewed						l	
		:30 PM. When asked						l	
	-	sibility to ensure policy						l	
	_	to protect clients from						l	
		dicated it was ultimately							
		y of the senior directors							
	_	f the governing body.							
		d despite staff attempts to							
	-	, he was able to break							
	away and injure	himself.							
		licy and procedure							
	Concerning Prog							l	
		Assessment Plan updated							
	10/11 was review	wed on 10/13/11 at 1:10							
	PM and indicated	d in part, "It is the policy						l	
	of this organizati	ion to assess the						l	
	environment for	possible areas that are						l	
		lividual abuse, and to set						l	
		easures that will address						l	
		asonable efforts are made						l	
	to prevent situati	ions that could result in							
FORM CMS-2	2567(02-99) Previous Version		): UJ6	S12	Facility II	D: 009114	If continuation sh	eet Pac	ge 14 of 20

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

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER: 15G673	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 10/13/2011			
	PROVIDER OR SUPPLIER RVIN INDIANA LLC	STREET ADDRESS, CITY, STATE, ZIP CODE  3521 OXFORD  SOUTH BEND, IN46615					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR 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			
	abuse" The policy indicated policy to assure prevention of abuse by housemates or other individuals also being served within the same program site, but failed to include language to indicate the facility's policy on taking corrective action to protect clients from abuse, neglect or exploitation. "The facility's Policy and Procedure Concerning Consumer Abuse and Neglect dated 4/10 indicated "Neglect or abuse of any consumer is strictly prohibited in any [agency name] service delivery location."  This deficiency was cited on 9/6/11. The facility failed to implement a systemic plan of correction to prevent recurrence.  9-3-2(a)						
W0157	If the alleged violation is verified, appropriate corrective action must be taken.  Based on observation, interview and record review, the facility failed to implement immediate and effective	W0157	Client #1 is no longer resi at the Oxford home. He h been transferred to an ES home that will better suit h	as N			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		15G673	B. WIN			10/13/2011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
DIN C.	O) //N     N   D   A     A			3521 O		
DUNGAF	RVIN INDIANA LLC			SOUTH	BEND, IN46615	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		to protect 1 of 4 sampled			behavioral needs.	
	` '	) from self injurious			The Program Director/QM	RP
		al aggression and			has reviewed this standard	
		tion after a pattern of			Going forward, all incident	
	physical aggressi	ion had been identified.			will be reviewed by the	
					Program Coordinator to	
	Findings include	:			ensure that aggressive	
					corrective action is	
					implemented immediately	
		reportable incidents to			following any incident tren	d.
		evelopmental Disabilities				
	` /	) were reviewed on			Monthly the Dungarvin Sa	-
	10/12/11 at 3:55 PM and included the				Committee will review any	
	following reports	s involving client #1:			trends related to reportabl	
					incidents and also recomn	nend
	-a report dated 9/	7/11 indicated client #1			corrective action.	
		uck near him in the			Contain wide all Discussion	
		'started begging for			System wide, all Program Director/QMRP's has	
	1	ort indicated client #1 ran			reviewed this standard to	
		when redirected and and			assure that this concern is	
	<u> </u>	mail truck. Client #1			being addressed at all	
		ge in self injurious			Dungarvin ICF-MR's.	
		efined) when redirected			. J	
	`	,			Persons Responsible:	
	_	nearby houses and staff			Program Coordinator,	
	1 2 2	ed him by holding him for			Program Director /QMRP	
		nds. He was taken to a			-	
		cility for evaluation where				
		him and ascertained "he				
		empt by facility staff to				
		lmitted to a mental health				
		ccessful as the physician				
	"did not think he	could be admitted."				
	Corrective action	included 1 to 1 staffing				
	ration for client #	‡1 which was already in				
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID: L	<b>I</b> JJ6S12	Facility I	D: 009114 If continuation sl	neet Page 16 of 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	
		15G673	B. WIN			10/13/2	011
NAME OF I	PROVIDER OR SUPPLIEI	2	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				3521 O			
DUNGARVIN INDIANA LLC				SOUTH	BEND, IN46615		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	<b>†</b>	· · · · · · · · · · · · · · · · · · ·		TAG	DEFICIENCY)		DATE
	^	story of self injurious and staff					
		getting an emergency					
		h a psychiatrist for					
	medication adjus						
	inedication adjus	stiffent.					
	-a report dated 9	1/10/11 indicated client #1					
	hit his head on the	he wall and "fought the 2					
	staff persons wh	o were trying to					
	physically assist	him," and was able to					
	free himself fror	n the hold. Client #1					
	"smashed" the el	lectric can opener and					
	then "smashed"	a window causing his					
	hand to bleed. C	Client #1 was taken to the					
	ER and provided	d bandages. While at the					
	hospital, client #	<sup>4</sup> 1 "got angry again" and					
	hit the wall with	his hand and made a hole					
	there. Client #1	"could not be admitted at					
	_	acility] because they did					
	1	d for him." Corrective					
		training by a behavior					
	-	3/11 and an appointment					
	with a psychiatri	ist on 9/12/11.					
		0/0/44					
	_	0/2/11 indicated client #1					
	_	ouse mate and kicked a					
		ray to his room after being					
	-	he house mate. Client #1					
		s dresser. Client #1 was					
		for his head and a 24 hour					
		ek was started. Follow up					
		an investigation involving					
		te to make sure staff					
	follow client #1'	s behavior plan, and for					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G673		LDING	NSTRUCTION  00		E SURVEY PLETED '2011
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  3521 OXFORD  SOUTH BEND, IN46615				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	future for any in #1's target behave retrained on clied 10/6/11. A follow indicated staff has #1's plan, indicated retrained on his pagency had offer home on 10/24/11 agency had offer home on 10/24/11 are popt which the neasked him to return got noisy" and into his room. On this head on the hand. Client #1 after attempting "managed to bite right hand which #1 was given first to resolve including home including home including home. Client #4 was in 6:30 PM. He staked know a behavior #1) and end up it walking down the	0/7/11 indicated client #1 d asked his neighbor for a eighbor provided. Staff arn the pop and client #1 went into the house and dlient #1 made threats to ne wall and to bite his was physically restrained to hit the window, but e one of the wounds in his a bled for a while." Client st aid for his injury. Plan ed respectfully asking the give client #1 anything					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION (X3) DATE SURV  A. BUILDING (COMPLETED				
	15G673		A. BUILI B. WINC			10/13/2	011
NAME OF PROVIDER OR SUPPLIER  DUNGARVIN INDIANA LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  3521 OXFORD  SOUTH BEND, IN46615				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	The Program Cooperation on 10/12/11 at 2: indicated despite client #1, he was injure himself.  This deficiency was facility failed to in	ordinator (PC) and r (PD) were interviewed					
W0322	Based on record facility failed to dexamination for (client #2).  Findings include:  Client #2's record 10/13/11 at 12:30	review and interview, the obtain an annual physical 1 of 3 sampled clients  d was reviewed on 2 PM. Client #2's record als dated 3/22/10 and	Wo	0322	A system has been develor to track and monitor the date of each person's annual physicals and other routine appointments. At least bi-monthly, the Program Director/QMRP and facility nurse will meet to review a medical needs for each person, and this will include reviewing that upcoming needed appointments are	ates	11/12/2011

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

	of Correction identification number:  15G673	A. BUILDING  B. WING	COMPLETED 10/13/2011
	PROVIDER OR SUPPLIER RVIN INDIANA LLC	STREET ADDRESS, CITY, STAT 3521 OXFORD SOUTH BEND, IN46615	E, ZIP CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	DREELY (EACH CORRECTIVE)	NA OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE EIENCY)  CX5)  COMPLETION DATE
IAU	evidence of a physical between 3/10 and 9/11.  The Program Coordinator was interviewed on 10/12/11 at 1:05 PM and indicated the physicals for client #2 were not completed annually.  This deficiency was cited on 9/6/11. The facility failed to implement a systemic plan of correction to prevent recurrence.  9-3-6(a)	scheduled tim  The Program do quarterly s include a revi documentatio routine medic are being con  System wide, Director/QMR this standard this concern i	Coordinator will site visits that ew of the on, to ensure that cal appointments inducted timely.  all Program RP's will review to assure that is being all Dungarvin  ponsible: prdinator,