

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/01/2013
NAME OF PROVIDER OR SUPPLIER  DAMAR SERVICES INC--MAIN ST			STREET ADDRESS, CITY, STATE, ZIP CODE 411 E MAIN ST PLAINFIELD, IN 46168		
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: January 28, 29, 30, 31, and February 1, 2013.</p> <p>Provider Number: 15G088 Facility Number: 000629 AIM Number: 100239570</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/6/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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W0104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview, the governing body failed to exercise general direction in a manner that resulted in the facility being well maintained for 6 of 6 clients (clients #1, #2, #3, #4, #5 and #6) who lived in the group home.</p> <p>Findings include:</p> <p>On 1-29-13 from 3:20 p.m. until 6:00 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. Client #3's room had a white stain 8 inches by 6 inches on the carpet. Client #6's bedroom had black and brown marks on the walls and four 2 inch by 2 inch holes. Client #6 had no decorations on his walls. Client #1's bedroom had no decorations. Client #1's bedroom walls had brown marks and a patched area which was 2 feet by 1 foot. Clients #5 and #6's bedroom had four 2 inch by 2 inch holes and black and brown marks on the walls. The upstairs bathroom had black and brown marks on the walls. The closet door had a cracked panel 6 inches by 2 feet. The bathroom closet door had black marks and chipped paint. The exhaust fan in the upstairs bathroom was</p>	W0104	<p><b>W104 483.410 Governing Body</b> <b>The governing body must exercise general policy, budget, and operating direction over the facility.</b> 1. Work orders have been completed and submitted to the Maintenance supervisor for all identified maintenance deficiencies. The Main St Residential Manager will get with the clients for their input on decorations for the home and ensure that the common areas of the house and clients rooms are appropriately decorated. 2. The Residential Manager and staff will ensure that work orders are documented and completed in a timely manner. The Residential Manager will follow up with the Maintenance Supervisor on any issues that are not resolved and require immediate action. The Residential Manager will ensure that any on-going maintenance concerns and general upkeep are immediately brought to the attention of the QDDPD or the Program Director for immediate resolution and repair. 3. The QDDPD will provide documented training to the Residential Manager and the staff to ensure they are properly trained on the procedures regarding identification and the timely reporting of maintenance issues.</p>	03/03/2013			

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	<p>covered in a gray substance. Client #4's bedroom walls had black and brown marks on them and three 6 inch by 6 inch areas of unfinished drywall. Client #2's bedroom had a 6 inch by 4 inch hole in the wall by his closet. Client #2's bedroom door had three 2 feet by 1/4 of an inch cracks through the door. The kitchen counter top had a 6 inch by 6 inch brown and black stain on it and two (2 inch by 2 inch and 1 inch by 2 inch) areas of the front of the counter top which were broken off. The kitchen wall had a 10 inch by 5 inch area with a brown substance on it. The 2 vents in the kitchen floor were rusted. The oven door did not close properly.</p> <p>On 1-30-13 at 1:30 p.m. a review of the facility's maintenance log dated 1-25-13/12-13-12 was conducted. The maintenance log did not have the above items listed on it to be repaired.</p> <p>On 1-30-13 at 2:00 p.m. an interview with the Residential Manager indicated maintenance concerns should be addressed and completed in a timely manner.</p> <p>9-3-1(a)</p>		<p>The Residential Manager will ensure that any on-going maintenance concerns are immediately brought to the attention of the QDDPD or the Program Director for immediate resolution and repair. The QDDPD will complete routine environmental observations to ensure the home is up to regulatory standards. 4. The Group Home Manager and QDDPD shall conduct monthly inspections of the facility and identify potential environmental deficiencies to ensure all maintenance issues are being addressed in a timely fashion and work orders are completed, when needed, during these inspections. These inspections shall be documented and kept in a binder within the group home. Random surveys are completed by an unbiased member of the Performance and Quality Improvement and their finding are reported to the QDDPD and Program Director for immediate attention and/or repair. 5. Systemic changes will be completed by: March 3, 2013</p>		

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W0125	<p><b>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</b> The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the rights for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home by locking their food in the basement.</p> <p>Findings include:</p> <p>On 1-29-13 from 3:20 p.m. until 6:00 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. At 4:15 p.m. direct care staff (DCS) #4 unlocked the basement door and brought up granola bars and crackers for clients #1, #2, #3, #4, #5, and #6 to eat for snack. Direct care staff #4 also brought up hash browns and omelets for supper. At 5:55 p.m. client #2 asked for skim milk; the House Manager unlocked the basement and went down and got client #2 skim milk.</p> <p>On 1-30-13 at 8:30 a.m. a record review for client #1 was conducted. The Comprehensive Functional Assessment (CFA) dated 8-12 did not indicate he needed his food and snacks locked up.</p>	W0125	<p><b>W125 483.420(a)(3) Protection of Client Rights</b> The facility must ensure that the rights of all clients. Therefore, the facility must allow and encourage individual client to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. 1. The Clients [1,2,3,4,5 and 6] do not currently have any restrictions that would keep them from having access to food in the home. The Group Home Manager, and Direct Care Staff will be provided with documented re-training by the QDDPD on Client Rights, including their right to access food in their home. The lock on the basement door that was restricting access to food in the basement based on a discharged clients plan has been removed and replaced with a non-locking door knob. 2. All clients currently residing at the Main St group home have the ability and right to has access to food in the home and will be permitted to do so. The Group Home Manager, and staff will be provided with</p>	03/03/2013			

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	<p>The Behavior Support Plan (BSP) dated 8-21-12 did not indicate a need for locked food.</p> <p>On 1-30-13 at 9:30 a.m. a record review for client #2 was conducted. The CFA dated 9-12 did not indicate he needed his food and snacks locked up. The BSP dated 12-26-12 did not indicate a need for locked food.</p> <p>On 1-30-13 at 11:30 a.m. a record review for client #3 was conducted. The CFA dated 1-13 did not indicate he needed his food and snacks locked up. The BSP dated 1-30-12 did not indicate client #3 had a need for locked food.</p> <p>On 1-30-13 at 12:45 p.m. a record review for client #4 was conducted. The CFA dated 9-12 did not indicate he needed his food and snacks locked up.</p> <p>On 1-30-13 at 10:25 a.m. a record review for client #5 was conducted. The CFA dated 9-12 did not indicate he needed his food and snacks locked up.</p> <p>On 1-30-13 at 12:30 p.m. a record review for client #6 was conducted. The CFA dated 8-12 did not indicate he needed his food and snacks locked up.</p> <p>On 1-29-13 at 4:20 p.m. an interview with</p>		<p>documented retraining on client rights, including the right to access their food. The QDDPD will check the home to ensure there are no other unauthorized restrictions in place. 3. The Group Home Manager, clients and staff will be provided with documented retraining on client rights, including the right to access their food. The QDDPD will continue to provide consistent supervision, including at least weekly visits, to ensure that Client Rights are being protected, ensured, and advocated for. All group home staff is retrained at least yearly on Client Rights. 4. The Group Home Manager and QDDPD will ensure that all client rights are being upheld and not violated. All group home staff is retrained at least yearly on Client Rights including the use of restrictions in a group home environment. If a plan requires restrictive interventions, the Group Home Manager will ensure that parent/legal guardian approval is obtained and then present it to the Human Rights Committee for approval prior to implementation. This plan must also include a plan for reintroduction. 5. Systemic changes will be completed by: March 3, 2013</p>				

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	<p>DCS #3 indicated clients #1, #2, #3, #4, #5, and #6 used the basement as a meeting place for tornado drills and food was kept locked in the basement. DCS #2 indicated the basement was kept locked for security purposes.</p> <p>On 1-29-13 at 4:15 p.m. an interview with DCS #4 indicated the basement door was kept locked because some of the clients would eat too much if it wasn't.</p> <p>On 1-30-13 at 7:35 a.m. an interview with client #3 indicated he does not steal food and the basement was locked because a client who no longer lived in the home used to steal the food. Client #3 stated they were "second class citizens" so the food was locked up.</p> <p>On 1-30-13 at 2:00 p.m. an interview with the Residential Manager indicated clients #1, #2, #3, #4, #5, and #6 did not have an assessed need for food to be locked up and the food should be available for clients to use.</p> <p>9-3-2(a)</p>				

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W0149	<p><b>483.420(d)(1) STAFF TREATMENT OF CLIENTS</b> 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, the facility failed for 4 of 6 clients (clients #1, #3, #4, and #6) who lived in the home, to implement the Abuse/Neglect policy for 4 of 16 Bureau of Developmental Disabilities Services (BDDS) reports to ensure clients were free from Abuse/Mistreatment and were supervised per their Individualized Support Plans (ISP).</p> <p>Findings include:</p> <p>On 1-28-13 at 2:15 p.m. a review of the facility's BDDS reports was conducted. The BDDS reports dated 2-12 through 1-28-13 indicated the following:</p> <p>-A BDDS report dated 2-1-12 for client #3 indicated he hit another client on the shoulder who no longer lives in the group home. No injury noted.</p> <p>-A BDDS report dated 2-9-12 for client #1 indicated the Residential Manager entered the unlocked group home at 12:20 p.m. and found client #1 home by himself (sleeping in his bed). An investigation was completed on 2-9-12 and the staff involved admitted she "accidentally" left</p>	W0149	<p><b>W149 483.420 (d)(1) Staff Treatment of Clients</b> The facility must develop and implement written policy and procedures that prohibit mistreatment, neglect, or abuse of a client. 1. Damar Services, Inc. has a written Policy and Procedure in place for client abuse and neglect. The Group Home manager and QDDPD will ensure that all safeguards are in place for any client that has physical aggression or elopement in their BSP and that appropriate supervision is in place. Staff will ensure that all visual supervision is completed and any suspected incidents are reported clearly and accurately to the group home manager and QDDPD immediately. 2. Incident reports from the home have been reviewed by the QDDPD to identify the potential need for reporting additional follow-up. A review of staff supervision schedules and training has been reviewed to ensure safeguards and policy implementation is in place. At this time, all other incidents have been documented and reported appropriately and supervision scheduling is appropriate to the clients being served. All documentation will be completed, including an agency</p>	03/03/2013			

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	<p>client #1 at the house without supervision. The staff involved was terminated for leaving client #1 at home unsupervised.</p> <p>-A BDDS report dated 2-18-12 at 4:25 p.m. for client #3 indicated they lost sight of client #3 and had to call the police to implement the missing persons protocol. The police located client #3 at 4:49 p.m. and returned him to his home. Client #3 indicated he ran because he just wanted to "go for a walk and blow off some steam and he did not want to be restrained."</p> <p>-A BDDS report dated 4-21-12 for client #6 indicated he was hit by a duster by client #5. Client #6 had a laceration between his ring finger and pinkie. Client #6 was taken to [name of hospital] where the doctor applied sterile strips to the wound. Client #6 was instructed to keep the strips on for 5 days and keep the wound clean and dry.</p> <p>-A BDDS report dated 9-5-12 for client #3 indicated client #6 kicked him in his private area then client #3 hit client #6 in the face. Client #6 had a lump under his right eye and a red face.</p> <p>-A BDDS report dated 9-24-12 indicated client #4 was hit several times in the head by a peer (at the facility owned school) and was bleeding. Client #4 had a cut</p>		<p>Incident Report (immediately), BDDS Incident Report (within 24 hours) and a thorough investigation (within 5 days) for all incidents requiring a BDDS reportable. 3. The agency policy regarding Abuse and Neglect has been reviewed to ensure it complies with current State and Federal regulations and provides appropriate safeguards for the individuals currently being served. The Residential Manager and group home staff will receive documented training by the QDDPD on the Agency Policy for Abuse and Neglect and the Policy and Procedure for reporting incidents. 4. All incidents of physical aggression and elopement will be reported to the Residential Manager, QDDPD, Group Home Administrator, and if necessary, the group home nurse immediately following the incidents occurrence. The initial investigation will begin immediately in the form of an Agency Incident Report. Additional information will be gathered within 24 hours of the incidents occurrence and reported to the Bureau of Developmental Disabilities Services by the Residential Manager. BDDS incident report notifications regarding closure or the need for additional follow-up are received electronically from the State by the Group Home Administrator and disseminated to the QDDPD and Home</p>				

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	<p>below his right eyebrow and a bruise above his eyelid. Client #4 had a small abrasion on is right upper cheek. Client #4 was taken to the eye doctor on 9-25-12 and the doctor indicated he had irritated blood vessels and bruising to his right eye.</p> <p>On 1-30-13 at 8:30 a.m. a record review for client #1 was conducted. The Individualized Support Plan (ISP) dated 8-21-12 indicated client #1 needed 24/7 supervision.</p> <p>On 1-30-13 at 11:30 a.m. a record review for client #3 was conducted. The ISP dated 1-30-12 indicated client #3 needed 24/7 supervision.</p> <p>On 1-28-13 at 2:10 p.m. a review of the facility's Abuse/Neglect policy dated 7-12-12 indicated clients were to be ensured safety and be protected. The Abuse/Neglect policy indicated abuse was defined as a non-accidental physical injury. Neglect was defined as the failure to give adequate supervision.</p> <p>On 1-30-13 at 2:00 p.m. an interview with the Residential Manager indicated the Abuse/Neglect policy should be implemented at all times and staff should attempt to keep the clients busy and active to decrease the opportunity for client to</p>		<p>Manager for appropriate action. Staff training and policies will be reviewed at least annually and revised as needed by the Damar Policy and Procedure committee.</p> <p>5. Date Systemic changes will be completed: March 3, 2013</p>		

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	client aggression. The RM indicated clients #1 and #3 were on 24/7 supervision and staff should have remained with the clients at all times.  9-3-2(a)				

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W0249	<p><b>483.440(d)(1) PROGRAM IMPLEMENTATION</b></p> <p>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.</p> <p>Based on observation, record review, and interview, the facility failed for 3 of 3 clients (clients #1, #2, and #5) observed during medication administration, to ensure their medication goals were implemented per their Individualized Support Plans (ISP).</p> <p>Findings include:</p> <p>On 1-30-13 at 7:03 a.m. an observation for client #5's medication administration was conducted. Direct care staff (DCS) #2 administered client #5 his Fluticasone for allergies, Polyethylene Glycol for bowels, Amphetamine for ADHD (attention deficit hyperactivity disorder), Multi-vitamin for nutrition, Loratadine for allergies, Risperdone for aggression, Benztropine for Parkinson, and Oxcarbazepine for bi-polar. DCS #2 did not ask client #5 to state the dosage amount of his morning medication.</p> <p>At 7:12 a.m. DCS #2 administered client #1's Olanzapine for psychosis, Divalproex for mood, Fish oil for nutrition, and</p>	W0249	<p><b>W249 483.440(d) (1) Program Implementation</b> 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.1. The QDDPD will meet with all Main St staff and provide documented retraining of each client's Individual Support Plan goals and medication training that should be provided during medication administration times for each client. Staff will ensure that continuous informal and formal active treatment is provided to each client as appropriate opportunities occur. 2. The QDDPD will meet with all Main St staff and provide documented retraining of each client's Individual Support Plan goals and medication training that should be provided during medication administration</p>	03/03/2013			

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	<p>Risperidone for aggression. DCS #2 did not ask client #1 to identify his a.m. medications.</p> <p>At 7:16 a.m. DCS #2 administered client his Vyvanse for ADHD, Invega for mood, Lamotrigine for mood, Lithium Carbonate for mood, and Fish oil for nutrition.</p> <p>On 1-10-13 at 10:25 a.m. a record review for client #5 was conducted. The ISP dated 7-11-12 indicated client #5 had a goal to state the dosage amount for his morning medications.</p> <p>On 1-30-13 at 9:30 a.m. a record review for client #2 was conducted. The ISP dated 12-26-12 indicated client #2 had a goal to state the names of his routine medications.</p> <p>On 1-30-13 at 8:30 a.m. a record review for client #1 was conducted. The ISP dated 8-21-12 indicated client #1 had a goal to identify his a.m. medication.</p> <p>On 1-30-13 at 2:00 p.m. an interview with the Residential Manager indicated clients #1, #2, and #5's medication goals should be implemented per their ISPs.</p> <p>9-3-4(a)</p>		<p>times for each client. During medication administration, the med passer will implement individualized training of medication goals for each client per their Individual Support Plan. 3. The QDDPD will provide documented training to the Group Home Manager and staff on the implementation of formal and informal goals for all clients per their individualized plans. Goal tracking sheets are developed and monitored by the Group Home Manager and the QDDPD with a statistical analysis completed on a monthly basis for each client for all ISP and BSP goals. A review of new hire orientation and medication administration training will occur to ensure formal and informal medication administration training is taught to regulatory standards. 4. Medication administration will be routinely monitored by the Group Home Manager and QDDPD on a random basis. The Group Home Manager will ensure that the clients within the group home are actively participating in medication goals during medication administration. The Group Home Manager will ensure that the clients are utilizing their Formal/Informal training goals and that staff are taking advantage of teachable moments during medication administration for medication goals and all other aspects of their formal training</p>		

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			goals. 5. Systemic changes will be completed by: March 3, 2013	

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W0261	<p><b>483.440(f)(3)</b> <b>PROGRAM MONITORING &amp; CHANGE</b> The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>Based on record review and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home, to ensure the specially constituted committee consisted of parents, qualified persons who have experience to change inappropriate behaviors and persons with no ownership or controlling interests in the facility.</p> <p>Findings include:</p> <p>On 2-1-13 at 1:45 p.m. a record review of the facility's Human Rights Committee (HRC) Officers roster was conducted (for clients #1, #2, #3, #4, #5 and #6). The review indicated HRC meetings conducted on 6-13-12, 7-11-12, 8-7-12, 9-12-12, 10-10-12, 11-14-12, 12-12-12 and 1-9-12 included facility staff members and a client representative but a parent, a qualified person with experience to change inappropriate behaviors and a person with no ownership or controlling interests in the facility were not present</p>	W0261	<p><b>W261 483.440 (f) (3) Program monitoring and change</b> The facility must designate and use a specially constituted committee consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change appropriate client behavior, and persons with no ownership or controlling interest in the facility.</p> <p>1. Damar Services, Inc. is currently seeking candidates including parents or persons who can assist in developing ways to change inappropriate behaviors or a person with no controlling interest in the facility to serve as a representative on their Human Rights Committee. 2. The Damar Human Rights Committee will ensure that a parent or person who can change inappropriate behaviors or a person with no controlling interest in the facility is seated on their committee at all times. Multiple candidates will be added to the committee to fulfill this</p>	03/03/2013			

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	<p>for the HRC meetings.</p> <p>On 2-1-13 at 1:50 p.m. an interview with the Qualified Mental Retardation Professional Designee indicated the HRC had facility staff and a client representative, but the HRC did not include a parent, a person who could change behaviors or a person with no controlling interest.</p> <p>9-3-4(a)</p>		<p>requirement and help ensure compliance in the event a member leaves the committee. 3. The Human Rights Committee will ensure that a parent or person who can change inappropriate behaviors or a person with no controlling interest in the facility is seated on their committee. If a current parent or person who can change inappropriate behaviors or a person with no controlling interest in the facility must leave the committee the HRC will ensure that a replacement is sought out as soon as notice is given and the replacement is secured in a timely fashion. 4. The Human Rights Committee will ensure that a parent or person who can change inappropriate behaviors or a person with no controlling interest in the facility is seated on their committee. If a current parent or person who can change inappropriate behaviors or a person with no controlling interest in the facility must leave the committee the HRC will ensure that a replacement is sought out as soon as notice is given. The HRC reports to and is monitored by the Performance and Quality Improvement (PQI) Committee chaired by the Director of Quality Assurance. The HRC will continue to make the PQI committee aware of any unmet needs. 5. Systemic changes will be completed by: March 3, 2013</p>		

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W0323	<p><b>483.460(a)(3)(i) PHYSICIAN SERVICES</b> The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #3) to ensure his vision was evaluated annually.</p> <p>Findings include:</p> <p>On 1-30-13 from 11:30 a.m. a record review for client #3 was conducted. The annual physical dated 1-12-12 did not indicate client #3's vision had been evaluated. The last vision screening available for review was dated 4-20-11.</p> <p>On 1-30-13 at 2:00 p.m. an interview with the Residential Manager indicated client #3's vision was entered in the computer incorrectly and the last one available for review was 4-20-11.</p> <p>9-3-6(a)</p>	W0323	<p><b>W323 483.460(a)(3)(i) Physician Services</b> The facility must provide or obtain annual physical examinations for each client that at a minimum includes an evaluation for vision and hearing. 1. An eye exam was scheduled and completed for client #3 on 1/13/13 at Abrams Eyecare Center. 2. The Main St group home manager will ensure that annual appts for all clients residing at the Main St Group Home are within regulatory compliance. The QDDPD will provide documented training to the Residential manager and staff on compliance of medical appts. The group home nurse will also track and ensure all appointments are within compliance and appointments are set as needed. 3. The Main St group home will ensure that annual appts for all clients residing at the Main St Group Home are within regulatory compliance. The QDDPD will provide documented training to the Residential manager and staff on compliance of medical appts. The group home nurse will also track and ensure all appts are within compliance and appts are set as needed. The Residential Manager and group home nurse</p>	03/03/2013			

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			will ensure that each client has an eye exam scheduled annually. 4. The Residential Manager and group home nurse will ensure that each client has an eye exam scheduled and completed annually. The group home nurse tracks medical appointments for the Group Home clients on a spreadsheet and will ensure that the clients are seen annual for an eye exam per their last visit. The Residential Manager will ensure that all that all annual eye exams are completed by completing monthly chart audits to ensure medical appointments are current and scheduled/completed as required. 5. Date Systemic changes will be completed: March 3, 2013	

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W0440	<p><b>483.470(i)(1)</b> <b>EVACUATION DRILLS</b> The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who lived in the home, to ensure evacuation drills were conducted quarterly for each shift.</p> <p>Findings include:</p> <p>On 2-1-13 at 2:45 p.m. a review of the facility's evacuation drills for clients #1, #2, #3, #4, #5 and #6 was conducted. For the 2nd quarter (April, May, and June 2012) there was no midnight (11:00 p.m. until 7:00 a.m.) drill or days (7:00 a.m. until 3:00 p.m.) drill available for review. For the 4th quarter (October, November, and December 2012) there was no midnight drill available for review.</p> <p>On 2-1-13 at 2:55 p.m. an interview with the Qualified Mental Retardation Professional Designee (QMRPD) indicated there were no other evacuation drills available for review and she could not find a midnight drill for the 2nd or 4th quarter or a day drill for the 2nd quarter.</p> <p>9-3-7(a)</p>	W0440	<p><b>W440 483.470(i)(1)</b> <b>EVACUATION DRILLS</b> The facility must hold evacuation drills at least quarterly for each shift of personnel. 1. All fire and tornado drills prior to and since the identified deficiency for the Main St.Group Home have been completed in accordance with regulatory standards. The evacuation drills are documented on a tracking sheet for each shift/month and are located in the Fire/Tornado Drill binder located in the group home office. An additional 3rd shift drill (2) and 1 st shift drill will be added to ensure both staff and clients receive adequate practice evacuating the home during day and night hours. 2. All residents will be assessed annually and during each evacuation drill for their ability to evacuate the home. All fire and tornado drills prior to and since the identified deficiency for the Group Home have been completed in accordance with regulatory standards. The evacuation drills are documented on a tracking sheet for each shift/month and are located in the Fire/Tornado Drill binder located in the group home office. An additional 3rd shift drill (2) and 1 st shift drill will be added to ensure both staff and clients</p>	03/03/2013	

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			<p>receive adequate practice evacuating the home during day and night hours. 3. The Group Home Manager and staff will receive documented training by the QDDPD in the regulatory requirements for evacuation drills. The Group Home Manager will assign designated times and dates for drills to occur and monitor the completion and documentation of each drill. The QDDPD will review documentation regularly to ensure that drills are completed and documented within regulatory standards. 4. An unbiased reporter assigned by the Damar Safety Committee tracks all fire and tornado drills monthly for completion. Results of the Fire drill checks are reported to the Damar Safety Committee monthly with deficiencies forwarded to the QDDPD and Director of Community Living and Support Services for immediate corrective action. 5. Systemic Changes will be completed: March 3, 2013</p>		