

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G403	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/04/2013
NAME OF PROVIDER OR SUPPLIER DAMAR SERVICES INC--BRADFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 8835 E CR 200 S AVON, 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, February 1 and 4, 2013.</p> <p>Provider Number: 15G403 Facility Number: 000917 AIM Number: 100249320</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 2/7/13 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>483.410(a)(1) GOVERNING BODY</p> <p>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 1-28-13 from 4:05 p.m. until 6:05 p.m. an observation at the home of clients #1, #2, #3, #4, #5, and #6 was conducted. The hallway vent by the front door was rusted. Six 1 foot by 1 foot areas of unfinished drywall were in the hallway going upstairs. The door going into the kitchen had a metal hinge with a gray substance covering it. The french doors in the kitchen had glass with a white substance and a 2 foot by 1 inch piece of wood with a putty substance on it. The handle on the oven fell off when it was touched. The vent above the stove was covered in a sticky white, yellow, and gray substance. A brown substance was on the kitchen ceiling and television room off of the kitchen. The vent in the television room between the kitchen and dining room was rusted. The vent in the</p>	W0104	<p>W104 483.410 Governing Body</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility. 1. Work orders have been completed and submitted to the Maintenance supervisor for all identified maintenance deficiencies. The Bradford Residential Manager will complete daily checks of the home to ensure it is clean and dust free and maintenance issues are identified and addressed in a timely manner. 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>	03/06/2013			

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	<p>wall in the television room was rusted with a gray substance on it. The downstairs bathroom had dust on the 3 bulb light fixture and both of the ceiling vents were rusted and dusty. Client #3's bedroom walls had black and brown marks on the walls, the vent in the floor had a brown substance on it and the vent in the ceiling was covered in dust. Clients #1 and #2's bedroom walls had black, green, and brown marks on them, and the black shelf had bent hinges and was hanging from the wall. The upstairs bathroom had a rusted vent with dust on it.</p> <p>On 1-29-13 at 8:00 a.m. a review of the facility's maintenance log dated 11-6-12/1-16-13 was conducted. The maintenance log did not have the above items listed on it to be repaired.</p> <p>On 1-29-13 at 11:20 a.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 Committee 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 6, 2013</p>				

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed for 3 of 6 clients (clients #2, #3, and #5) who lived in the home, to implement their Abuse/Neglect policy for 4 of 24 Bureau of Developmental Disabilities Services (BDDS) reports to ensure clients were free from Abuse/Mistreatment/Neglect.</p> <p>Findings include:</p> <p>On 1-28-13 at 1:00 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 12-5-12 for client #3 indicated her hair was grabbed and she was hit in the face by client #5. Client #3 had a scratch on her face.</p> <p>-A BDDS report dated 5-8-12 for client #5 indicated she was hit in the head by a client who no longer lived in the home. The police were called and recommended one of the girls leave the home for the night due to the physical aggression. Client #5 had a lump on the top of her head.</p>	W0149	<p>W149 483.420 (d)(1) Staff Treatment of Clients</p> <p>The facility must develop and implement written policy and procedures that prohibit mistreatment, neglect, or abuse of a client.</p> <p>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.</p> <p>2. Incident reports from the home have been reviewed by the</p>	03/06/2013			

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	<p>-A BDDS report dated 5-7-12 for client #5 indicated she was hit in her arm by a client who no longer lived in the home. Client #5 had a bruise developing on her upper right arm.</p> <p>-A BDDS report dated 7-4-12 indicated client #5 and client #2 got into a fight.</p> <p>-A BDDS report dated 9-26-12 for client #3 indicated she ran off due to being upset and was missing for 20 minutes. Client #3 was found in 20 minutes and no injuries were noted.</p> <p>On 1-29-13 at 9:45 a.m. a record review for client #3 was conducted. The Individualized Support Plan (ISP) dated 7-25-12 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 1-29-13 at 11:20 a.m. an interview with the Residential Manager indicated the Abuse/Neglect policy should be implemented at all times and staff should</p>		<p>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 Incident Report (immediately), BDDS Incident Report (within 24 hours) and a thorough investigation (within 5 days) for all incidents requiring a BDDS reportable.</p> <p>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.</p> <p>4. All incidents of physical aggression and elopement will be reported to the Residential</p>		

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	<p>process the situation and keep clients safe. The RM indicated client #3 was on 24/7 supervision and staff should have remained with her at all times.</p> <p>9-3-2(a)</p>		<p>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 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 6, 2013</p>		

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W0227	<p>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, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure client #1 had a goal in her Individualized Support Plan (ISP) to assist her with drooling.</p> <p>Findings include:</p> <p>On 1-28-13 from 4:05 p.m. until 6:05 p.m. an observation at the home of client #1 was conducted. Client #1 drooled on her clothes, the furniture, the floor, and the dining room table during this observation. Direct care staff #1 did not prompt client #1 to wipe her chin or clean the saliva which fell on items in her home.</p> <p>On 1-29-13 at 8:05 a.m. a record review for client #1 was conducted. The ISP dated 5-8-12 did not have a goal/objective to assist client #1 with her drooling.</p> <p>On 1-29-12 at 11:20 a.m. an interview with the Residential Manager indicated client #1 did not have a goal in place to assist her with her drooling.</p>	W0227	<p>W227 483.440(c)(4) Individual Program Plan The individual program plan states the specific objectives necessary to meet the clients needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. 1. An ISP addendum was written on 2/21/13 to address client #1 drooling. The Residential Manager will provide documented staff training on the new goal and ways to address Client #1 drooling. 2. All clients ISP/BSP will be reviewed by the QDDP and Group Home Manager to ensure that there are not any social, psychological, or educational needs that are not being addressed for the individuals within the Group Home. Any plan that requires revision due to an identified or recommended need, will be reviewed and modified, and will receive approval by the IDT, Human Rights Committee, and respective parent/guardian, prior to implementation. All plans will be revised, at least annually and as needed per the needs of each individual client and recommendation from client's IDT. 3. The QDDPD will</p>	03/06/2013			

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	9-3-4(a)		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 to assess the on-going and changing needs for each client for all ISP and BSP goals. 4. Formal and informal training 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 Individual Support Plan goals. 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 for all clients' formal training goals. Goal tracking sheets are developed and monitored by the Group Home Manager and the QDDPD with a statistical analysis completed on a monthly basis to assess the on-going and changing needs for each client for all ISP and BSP goals. 5. Systemic changes will be completed by March 6, 2013		

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</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 2 of 3 sampled clients (clients #1 and #2) to ensure active treatment was provided per their Individualized Support Plans (ISP).</p> <p>Findings include:</p> <p>On 1-28-13 from 4:05 p.m. until 6:05 p.m. an observation at the home of clients #1 and #2 was conducted. Client #1 was prompted to sit on the couch by direct care staff (DCS) #1. When client #1 would get up or attempt to get up, DCS #1 would prompt her to sit down and wait for supper to be ready. Client #1 ate her supper and walked around her home holding a game. Client #2 stayed in her room and listened to music as she danced. Client #2 did come down and set the table when requested by DCS #1. Client #2 ate her supper after her housemates had finished supper.</p> <p>On 1-29-13 at 8:05 a.m. a record review for client #1 was conducted. The ISP</p>	W0249	<p>W249 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. 1. The QDDPD will meet with all Bradford staff and provide documented retraining of each client's Individual Support Plan goals. 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 Bradford 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. During medication administration, the med passer will implement</p>	03/06/2013	

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	<p>dated 5-8-12 indicated client #1 had goals/objectives to: sit on the toilet, stand at the door for medications, engage in a task, indicate when a car is coming, complete words in a sentence, knock on a door before entering, identify the stove is hot, pull up her adult brief, wash her face, brush her teeth, point to an item to purchase, and take her spoon to her mouth without spilling the food.</p> <p>On 1-29-13 at 9:00 a.m. a record review for client #2 was conducted. The ISP dated 8-20-12 indicated client #2 had goals/objective to: trace her house number, state the reasons for her PRN (as needed) medications, floss her teeth, operate the washer, measure a liquid ingredient, identify coins, hang clean clothes in her closet, write her first name, and discuss male/female relationships.</p> <p>On 1-29-13 at 11:20 a.m. an interview with the Residential Manager (RM) indicated clients #1 and #2 should be prompted to participate in activities. The RM indicated DCS #1 was the only staff at the home so she was assisting client #3 with the supper meal and did not ensure clients #1 and #2 had active treatment available to them.</p> <p>9-3-4(a)</p>		<p>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. Formal and informal training 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 Individual Support Plan goals. 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 and all other aspects of their formal training goals. 5. Systemic changes will be completed by: March 6, 2013</p>				

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W0261	<p>483.440(f)(3) PROGRAM MONITORING & CHANGE 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 1-29-13 at 10:15 a.m. a record review of the facility's Human Rights Committee (HRC) Officers roster for clients #1, #2, #3, #4, #5, and #6 was conducted. 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>W261 483.440 (f) (3) Program monitoring and change</p> <p>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.</p>	03/06/2013			

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	<p>for the HRC meetings.</p> <p>On 1-29-12 at 11:20 a.m. an interview with the Residential Manager 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>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 requirement and help ensure compliance in the event a member leaves the committee.</p> <p>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.</p> <p>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</p>		

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			<p>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.</p> <p>5. Systemic changes will be completed by: March 6, 2013</p>		

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W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) and for one additional client (client #6) to ensure dignity and respect was promoted by staff speaking in a conversational tone and not posting toileting schedules for all to see.</p> <p>Findings include:</p> <p>On 1-28-13 from 4:05 p.m. until 6:05 p.m. an observation at the home of client #2 was conducted. When direct care staff (DCS) #1 wanted client #2 she would yell from the kitchen or the bottom of the stairs. Client #2 was in her bedroom with the music playing loudly when DCS #1 yelled for her to come down to the kitchen and set the table. Client #2 did not respond. DCS #1 yelled again and indicated to client #2 if she did not come and set the table she would have one of her housemates do it and she would give client #2's points to the housemate. DCS #1 did not walk up the stairs, knock on the door, and ask client #2 if she was ready to come set the table. DCS #1 yelled from the kitchen for client #2 to come down for supper. Client #2 was in her room listening to music and dancing.</p>	W0268	<p>W268 483.450 (a) (1) (i) Conduct toward clients These policies and procedures must promote the growth, development and independence of the client.</p> <p>1. Client #1 "potty training chart" has been moved to an area where it is not visible to others to maintain the confidentiality and dignity of Client #1. Staff has all been re-trained by the residential manager on 2/4/13 on how to appropriately speak to the clients and provide them with dignity and respect and not to shout through the house. 2. The QDDPD will provide documented training to the Residential Manager and staff regarding client privacy, confidentiality and treating clients with respect and dignity. The QDDPD has conducted a survey the Bradford home to look for visual cues or items that need to be kept more private. The QDDPD and Residential Manager have surveyed the clients' at the Bradford home and asked them how we can treat them with more dignity, respect and provide them the</p>	03/06/2013			

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	<p>Client #2 did not respond to DCS #1's yelling. DCS #1 did not go to client #2's bedroom door and knock to see if she was ready to come down for supper.</p> <p>On 1-29-13 from 5:50 a.m. until 7:45 a.m. an observation at the home of clients #1 and #6 was conducted. At 6:05 a.m. client #6 was prompted by DCS #7 to blow dry her hair and not "get lippy" or there would be "consequences." At 6:20 a.m. DCS #7 indicated to client #6 her hair needed to be brushed better. Client #6 indicated she needed to hurry because she didn't want to miss the bus. DCS #7 told her to "shut it" and go brush her hair. At 6:35 a.m. a chart on the wall in the television room downstairs indicated client #1 had a "potty training chart." The chart indicated to toilet client #1 every 2 hours and check the box regardless of the outcome.</p> <p>On 1-29-13 at 11:20 a.m. an interview with the Residential Manager (RM) indicated DCS should not yell when they want a client but should walk up the stairs and talk with the client. The RM indicated DCS #7 should be respectful when speaking to clients. The RM indicated the toileting schedule for client #1 should not be posted in an area visible for all to see.</p>		<p>privacy they would like. 3. All newly hired staff are required to attend Client Rights Training as part of their new hire orientation. All current staff go through Client Rights training annually to ensure that they are kept aware of the Clients Rights and their responsibilities to ensure they are being upheld. . The QDDPD will periodically survey the Bradford home to look for visual cues or items that need to be kept more private. The QDDPD and Residential Manager will periodically survey the clients' at the home and ask them how we can treat them with more dignity, respect and provide them the privacy they would like. 4. All clients are provided with the opportunity to fill out a Client Grievance form if they feel their rights have been violated. These are reviewed by the Damar Human Rights Committee and the Damar Critical Review Committee for follow up. The Performance and Quality Improvement Committee monitors the completion of an annual Client Satisfaction Surveys with each client and these surveys are given to and reviewed by the Performance and Quality Improvement chairperson for follow up to any concerns.</p>				

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	9-3-5(a)		5. Systemic changes will be completed by: March 6, 2013		

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W0323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES 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 her vision was evaluated annually.</p> <p>Findings include:</p> <p>On 1-29-13 from 9:45 a.m. a record review for client #3 was conducted. The annual physical dated 6-26-12 did not indicate client #3's vision had been evaluated. The last vision exam available for review was dated 2-8-11. The vision appointment form did not indicate when client #3 was to return for her next visit.</p> <p>On 1-29-13 at 11:20 a.m. an interview with the Residential Manager indicated client #3's vision was completed every 2 years due to medicaid rules. The RM indicated client #3's last visual exam was completed on 2-8-11.</p> <p>9-3-6(a)</p>	W0323	<p>W323 483.460(a)(3)(i) Physician Services The facility must provide or obtain annual physical examinations for each client that at a minimum includes an evaluation for vision and hearing. 1. Client #3 was discharged from Bradford on 2/8/13. All clients' appointments have been reviewed by the group home nurse and QDDPD to ensure they are all within regulatory compliance. All other clients at the Bradford group home are within compliance. 2. The Bradford group home manager will ensure that annual appointments for all clients residing at the Bradford 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 Bradford group home will ensure that annual appts for all clients residing at the Bradford Group Home are within regulatory compliance. The QDDPD will provide documented training to the Residential manager and staff on compliance</p>	03/06/2013	

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			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 will ensure that each client has an eye exam scheduled and completed 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 annually for an eye exam per their last visit. The Residential Manager will ensure that all that all annual eye exams are compliant by completing monthly chart audits to ensure medical appointments are current and scheduled/completed as required. 5. Date Systemic changes will be completed: March 6, 2013		

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W0484	<p>483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure she needed an adaptive cup at meal times and for 3 of 3 sampled clients (clients #1, #2, and #3) to ensure they had a full set of silverware at supper time.</p> <p>Findings include:</p> <p>1. On 1-28-13 from 4:05 p.m. until 6:05 p.m. an observation for client #1 was conducted. Client #1 used a sippy cup when she was offered a drink by direct care staff #1 for snacks and meals.</p> <p>On 1-29-13 at 8:05 a.m. a record review for client #1 was conducted. The Individualized Support Plan dated 5-8-12 did not indicate client #1 needed an adaptive cup. The dietary review dated 3-23-12 indicated client #1 used a scoop plate but did not indicate client #1 needed an adaptive sippy cup.</p> <p>On 1-29-13 at 11:20 a.m. an interview with the Residential Manager indicated client #1 did not have an order for the sippy cup but they started to use one</p>	W0484	<p>W484 483.480(d) (3) Dining areas and Service The facility must equip areas with tables, chairs, eating utensils, and dishes designated to meet the developmental needs of each client.1. The Group Home will ensure that Clients 1,2 and 3 have the appropriate utensils available to eat food properly at each of their meals. Group Home staff will receive documented training on the regulation and agency expectations regarding appropriate tableware during meal times. An order from Dr. Campbell, dated 5/24/11 and Nutritional Assessment dated 3/23/12 shows an order for client #1 to use a straw/sippy cup for drinking. Staff will continue to follow the doctor's order until he discontinues the use of the cups.2. Group Home staff will receive documented training on the regulation and agency expectations regarding appropriate tableware during meal times. The Group Home will ensure that all appropriate utensils (fork, spoon, knife, etc.) are present at every meal when the table is set. Direct Care staff will check the table prior to the clients sitting down for meals and ensure all utensils are present. If</p>	03/06/2013			

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	<p>because client #1 would throw her cup and spill her drink.</p> <p>2. On 1-28-13 from 4:05 p.m. until 6:05 p.m. an observation at the home of clients #1, #2, and #3 was conducted. Clients #1, #2, and #3 had bread and butter, country fried steak, potatoes, broccoli, and milk. Client #3 buttered and cut the bread. Clients #1, #2, and #3 were not offered a full set of silverware at supper time.</p> <p>On 1-29-13 at 8:05 a.m. a record review for client #1 was conducted. The Comprehensive Functional Assessment (CFA) dated 4-30-12 indicated client #1 was safe to have knives and needed physical assistance to use them.</p> <p>On 1-29-13 at 9:00 a.m. a record review for client #2 was conducted. The CFA dated 2-8-12 indicated client #2 could use a knife.</p> <p>On 1-29-13 at 9:45 a.m. a record review for client #3 was conducted. The Individualized Support Plan dated 7-25-12 did not indicate client #3 could not use a knife at meal times.</p> <p>On 1-29-13 at 11:20 a.m. an interview with the Residential Manager indicated clients #1, #2, and #3 could all use knives and should be offered them at meals so</p>		<p>all appropriate utensils are not present on the table, staff will assist the clients in identifying and retrieving the needed utensils. Staff will follow written orders for adaptive equipment during meals and snack times.3. Group Home staff will check the table prior to the clients sitting down for meals to ensure all necessary utensils are present. If all appropriate utensils (fork, spoon, knife, etc.) are not present on the table, staff will assist the clients in identifying and retrieving the needed utensils. The Group Home Manager and QDDPD will periodically observe meal times to ensure that staff are following and meeting regulations and agency expectations regarding the availability and use of appropriate eating utensils. Group home clients have a Nutritional Assessment completed yearly by a Dietician and staff will ensure that they are following the recommendations made on the Assessments.4. The Residential Manager will ensure that the group home has the appropriate utensils (fork, spoon, knife, etc.) needed for each meal time. If the appropriate utensils are not available in the home or are in need of being replaced, the Residential manager will ensure that they are purchased and available for the next meal setting. The Group Home Manager will periodically observe meal times to ensure that staff</p>				

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	they can learn how to use them correctly. 9-3-8(a)		are following and meeting regulations and agency expectations regarding the availability and use of appropriate eating utensils. Group home clients have a Nutritional Assessment completed yearly by a Dietician and staff will ensure that they are following the recommendations made on the Assessments.5. Systemic changes will be completed by: March 6. 2013		

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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review, and interview, the facility failed for 1 of 3 sampled clients (client #1) to ensure she participated in meal preparation consistent with her developmental level.</p> <p>Findings include:</p> <p>On 1-28-13 from 4:05 p.m. until 6:05 p.m. an observation at the home of client #1 was conducted. Client #1 was prompted to sit on the couch when she attempted to get up and assist direct care staff (DCS) #1 with the supper meal. DCS #1 prompted client #1 ten times to sit down so DCS #1 and client #3 could get supper completed. DCS #1 prepared client #1's plate and drink for her. DCS #1 placed a second helping of potatoes on client #1's plate for her. DCS #1 took client #1's dishes to the sink for her when she was done eating.</p> <p>On 1-29-13 at 8:05 a.m. a record review for client #1 was conducted. The Comprehensive Functional Assessment dated 4-30-12 indicated client #1 was able to assist with meal preparation, assist in fixing her own plate, or assist with taking/washing her dishes.</p>	W0488	<p>W488 483.480 (d) (4) Dining Areas and Service The facility must ensure that each client eats in a manner consistent with his or her developmental level. 1. The QDDPD will meet with each staff and provide documented retraining of each client's Individual Support Plan and completion of individualized training. Training will include the implementation of both formal and informal active treatment opportunities for affected clients during the preparation of meals and meal service. Staff will ensure that all clients are utilizing their developmental abilities during meal preparation and service. 2. The QDDPD will meet with each staff and provide documented retraining of each client's Individual Support Plan and completion of individualized training. Training will include the implementation of both formal and informal active treatment opportunities for all clients during the preparation of meals and meal service. Staff will ensure that all clients are utilizing their developmental abilities during meal preparation and service. 3. The QDDPD will provide documented training to the Group Home Manager and</p>	03/06/2013			

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	<p>On 1-29-13 at 11:20 a.m. an interview with the Residential Manager indicated DCS should be teaching her to assist with meal preparation with hand over hand assistance.</p> <p>9-3-8(a)</p>		<p>staff on the Agency expectations and Regulatory requirements for clients to be actively involved during meal preparation and service and implementation of formal and informal goals for all clients per their individualized plans including goals related to meal preparation and service. 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. 4. Meal preparation and service will be routinely monitored by the Group Home Manager on a random basis. The Group Home Manager will ensure that the clients within the group home are actively participating in meal preparations in the home. 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 meal preparation and all other aspects of their service. 5. Systemic changes will be completed by: March 6, 2013</p>		

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met.</p> <p>460 IAC 9-3-1(5)(b) Governing body Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #3) and for 2 of 24 Bureau of Developmental Disabilities Services (BDDS) reports to ensure falls and medication errors were reported to BDDS.</p> <p>Findings include:</p> <p>On 1-28-13 at 1:00 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 internal incident reports were not reported to BDDS:</p>	W9999	<p>W9999 FINAL OBSERVATIONS</p> <p>State Findings: 460 IAC 9-3-1 (5) (b)Sec 1 (b) Governing Body The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division1. The Bradford group home manger and QDDPD will ensure that all required BDDS reports are completed as required by the governing body (BDDS), including medications errors and falls. 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. All documentation will be completed, including an agency 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 and incident reported have been reviewed to ensure they comply with current State and Federal regulations and</p>	03/06/2013			

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	<p>-On 9-4-12 an internal incident report for client #1 indicated she fell off the toilet and hit her forehead. Client #1 had a knot on her forehead.</p> <p>-On 7-28-12 an internal incident report for client #3 indicated she was given her p.m. dose of Vimpat (300 milligrams), for seizures instead of her a.m. dose of Vimpat (200 milligrams). No side effects were noted.</p> <p>On 2-1-13 at 10:00 a.m. a review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS...Incidents to be reported to BQIS include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual" including but not limited to: "A fall resulting in injury, regardless of the severity of the injury....A medication error or medical treatment error as follows:...wrong medication dosage</p>		<p>provide 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 med errors and falls 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 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. 5. Date Systemic changes will be completed: March 6, 2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G403	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2013
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NAME OF PROVIDER OR SUPPLIER DAMAR SERVICES INC--BRADFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 8835 E CR 200 S AVON, IN 46168
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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
	<p>given...."</p> <p>On 1-29-13 at 11:20.m. an interview with the Residential Manager (RM) indicated BDDS reports should be filed within 24 hours of the incident. The RM indicated client #1's fall and client #3's medication error were not reported to BDDS.</p> <p>9-3-1(b)(5)</p>			