

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G456	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/11/2014
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NAME OF PROVIDER OR SUPPLIER DAMAR SERVICES INC--EL CAMIN	STREET ADDRESS, CITY, STATE, ZIP CODE 4912 EL CAMINO CT INDIANAPOLIS, IN 46221
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: April 7, 8, 9, 10 and 11, 2014</p> <p>Facility Number: 000970 Provider Number: 15G456 AIM Number: 100239760</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/17/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the governing body failed to exercise operating direction over the facility by failing to ensure the living room carpet was repaired or replaced, the walls of the group home were repainted and client #3's bedroom linoleum was repaired or replaced.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/7/14 from 2:26 PM to 5:50 PM and 4/8/14 from 6:08 AM to 7:51 AM. During</p>	W000104	<p>1. All items noted as needing to be repaired or replaced has been completed. · The living room carpet is schedule to be replaced on 5/2/14 · The kitchen walls are being painted and scheduled to be complete 5/1/2014 · The torn linoleum flooring in clients #3 bedroom has been removed and new carpet was installed on 4/1/2014</p> <p>2. All other rooms in the house were observed for broken or torn items in addition to need for painting. All bedrooms, living room and kitchen walls will be freshly painted to improve the overall environment of the home.</p>	05/11/2014

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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	<p>the observations the carpet in the living room had two areas near the kitchen, each 6 inches long, where the carpet was torn. There was a torn area in the carpet near the back door measuring 3 inches wide by 5 inches long. There was a tear in the carpet near the fireplace measuring 6 inches long and 3 inches wide. During the observations, client #3's bedroom floor linoleum was torn off the subfloor next to his bed. The area missing linoleum measured 3.5 feet wide by 7.5 feet long. During the observations, the walls in the group home throughout the common areas and in the clients' bedrooms (#1, #2, #3, #4, #5 and #6) were scuffed, marked, dented, discolored and had holes where items had once hung on the walls. The dining room walls also had dried food and liquids on the walls throughout the dining room. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>On 4/8/14 at 1:12 PM, a review of the Work Order Logs from 4/7/13 to 4/8/14 indicated there were no work orders submitted for painting the interior of the home, repairing client #3's bedroom floor and repairing or replacing the living room carpet.</p> <p>On 4/8/14 at 11:56 AM, staff #2 indicated the walls at the group home needed to be painted including the clients' bedrooms.</p> <p>On 4/10/14 at 10:29 AM the Residential Manager (RM) indicated the living room room carpet needed to be replaced due to the fraying in the carpet. The RM indicated a work order was submitted however she had not heard when the work was going to be completed. The RM indicated she completed a work order last week to have the home painted. The RM indicated the walls were</p>		<p>All holes have been repaired and hanging or attaching wall decoration will be done in an alternative way other than using nails (thus eliminating some holes in walls) 3. Work orders are completed by staff upon noticing a need for repair. A copy of the order should be maintained within the home. In addition to this, nightly, "Home Inspections" are complete by staff. Items in need of repair are also noted here and reference to the specific work order already submitted and/or a work order is completed and submitted. Work orders submitted are reviewed timely and addressed by Maintenance Departments upon priority needs. Monthly House Checklist is completed by the Dir. Of Group Home. During this check – items in need of repair will be checked against work orders already submitted. If needed, new work orders will be completed and outstanding work orders over 30 days will be noted on the checklist. Plan of action to correct any outstanding item will be determined by the maintenance department and communicated timely to the Dir. Of the Group Home. The Dir. Of Group Home will ensure the correction/repair has been completed. 4. In addition to the above steps, any outstanding work orders still not completed upon the next monthly check – will have the following action</p>		

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W000125	<p>scuffed and marked. The RM stated the white walls "shows everything" and looked "yuck." The RM indicated the home was last painted in early 2013. The RM stated, "It's due" to be painted. The RM indicated client #3's floor was being replaced on this date. The RM indicated client #3 tore the pieces of linoleum off about one month ago. The RM indicated client #3's floor needed to be replaced.</p> <p>On 4/7/14 at 4:53 PM, the Director of Group Homes (DGH) indicated the carpet in the living room needed to be replaced. The DGH indicated the tears in the carpet had been reported to maintenance. The DGH indicated client #3's bedroom flooring needed to be replaced. The DGH indicated client #3 tore the linoleum in his room about one month ago. On 4/8/14 at 12:23 PM, the DGH indicated the group home walls needed to be painted. The DGH indicated a work order had not been submitted for painting the group home's interior walls. The DGH indicated client #3's flooring needed to be fixed. The DGH indicated there had been numerous work orders submitted to repair client #3's floor.</p> <p>9-3-1(a) 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS 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</p>	W000125	<p>occurring · Agency Incident Report will be completed and submitted to the Dir. Of Maintenance · Dir. Of Maintenance will include a plan of action that ensures the outstanding work order will be complete within 7 days. Approval for the repair or replacement must be secured by the Vice President of Programs if the repair or replacement cannot occur within the seven days. Dir. Of group Home will ensure the outstanding work order has been completed and submit any follow up documentation. · All Incidents Reports are submitted to the agency Quality Assurance Department – trends noted will be communicated and addressed according to the agency requirements.</p> <p>1. All food has been removed from the office area and stored in</p>	05/11/2014			

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	<p>interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients had the right to due process in regard to locking of food in the medication area at the group home.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/7/14 from 2:26 PM to 5:50 PM and 4/8/14 from 6:08 AM to 7:51 AM. During the observations there was food stored in the locked medication area at the group home. The food consisted of pretzels, animal crackers, donuts, raisins, oatmeal, crackers, cookies, popcorn, chocolate chips, icing, fruit and grain bars, vanilla wafers, and several boxes of cereal. None of the items stored in the locked medication area was available, unlocked, to clients #1, #2, #3, #4, #5 and #6. None of the clients had a key to access the locked medication area. The clients accessed the food by requesting items from the staff who used a key to access the locked medication area. On 4/7/14 at 4:21 PM, clients #1, #2, #3, #4, #5 and #6 were given fruit and grain bars by staff #4 from the locked medication area.</p> <p>A review of client #1's record was conducted on 4/8/14 at 10:37 AM. There was no documentation in the record indicating the client required food to be locked.</p> <p>A review of client #2's record was conducted on 4/8/14 at 10:45 AM. There was no documentation in the record indicating the client required food to be locked.</p> <p>A review of client #3's record was conducted on 4/8/14 at 11:05 AM. There was no documentation in the record indicating the</p>		<p>kitchen cabinets</p> <p>2. All Residential Managers were updated on the policy regarding locking food and/or other belongings of the clients. Guardian, Human Rights approval along with a specific behavioral plan will be in place if this action is needed. All Residential Managers will ensure that food and/or client's belongings are not locked without proper approval.</p> <p>3. House food and/or client's belongings may not be stored in a locked area without proper approval. When needed, baseline data will be collected and discussed within IDT to determine if locking belongings are needed. Plan will be developed and include specific steps to help decrease these behaviors – specific testing and training will occur weekly and monthly summaries written to assess progress. Guardian approval will be sought from all residents living in the home to allow these actions to occur. In addition – all residents will receive informal training regarding healthy snacks and health portions. Fruits and vegetables are always available if one choses to have additional snacks.</p> <p>4. Staff will receive documented training by appropriate personnel</p>	

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	<p>client required food to be locked.</p> <p>A review of client #4's record was conducted on 4/8/14 at 11:23 AM. There was no documentation in the record indicating the client required food to be locked.</p> <p>A review of client #5's record was conducted on 4/8/14 at 10:41 AM. There was no documentation in the record indicating the client required food to be locked.</p> <p>A review of client #6's record was conducted on 4/8/14 at 10:30 AM. There was no documentation in the record indicating the client required food to be locked.</p> <p>On 4/8/14 at 6:26 AM, client #1 indicated he did not have access to the locked food.</p> <p>On 4/8/14 at 6:26 AM, client #5 indicated he did not have access to the locked food.</p> <p>On 4/8/14 at 7:40 AM, staff #2 stated the food was locked due to the "boys like to steal food." Staff #2 indicated the clients would hoard the preferred items (the items locked in the medication area) of food in their rooms. Staff #2 stated she "assumed" the locking of food was in the clients' plans.</p> <p>On 4/10/14 at 10:29 AM, the Residential Manager (RM) indicated the food should not have been locked in the medication area. The RM indicated the food was the clients' food and they should have access. The RM indicated she thought the food was being locked to keep costs down to control the access to the food. The RM indicated she was aware the food was being locked up and discussed with the staff the food should not be locked. The RM indicated there were no</p>		<p>regarding policy and procedures of locking items in the group home.</p> <p>Monthly House Checklist is completed by the Dir. Of Group Home. This checklist has been updated to ensure unauthorized locking of belongings is not occurring.</p>	

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W000148	<p>plans to lock the food. The RM indicated it was an unnecessary restriction.</p> <p>On 4/8/14 at 12:16 PM, the Director of Group Homes (DGH) indicated there was no reason for the food to be locked. The DGH stated the clients would "steal" the food if it was in the kitchen cabinets. The DGH indicated none of the clients had plans to lock the food in the home. The DGH indicated in order to lock the food, the facility needed to assess, plan, obtain consent and have a plan to reduce the restriction. The DGH indicated the food should not be locked.</p> <p>9-3-2(a) 483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on interview and record review for 1 of 3 non-sampled clients (#6), the facility failed to promptly notify the guardian of changes in the client's condition.</p> <p>Findings include:</p> <p>On 4/9/14 at 10:33 AM, client #6's guardian indicated she was not being informed of client #6's medical appointments and the outcome of the appointments (diagnosis, tests, results). Client #6's guardian indicated she requested the facility to have client #6 tested for scoliosis two months ago but had not been told if he had the appointment or if</p>	W000148	<p>1. Communication with Client #6's guardian has occurred and she was provided with all updated information. Client #6 went to dentist on 4/9/14 for root canal and crown #30 (temp crown put on), on 4/29/14 returned to have post and core placed and prepared tooth for crown, he returns on 5/6/14 for next stage of treatment. On 4/15/14 to Riley orthotics...took impressions for bilateral AFO's, returns on 5/6/14 for final fitting and trim and glasses were repaired on 4/9/2014. Client #6 has a medical appoint on 4/17/14</p>	05/11/2014

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	<p>an appointment was scheduled. The guardian indicated she requested the facility to clean client #6's ears of wax after his last visit two weeks ago. The guardian indicated she was unaware if this was implemented. The guardian indicated during the visit, client #6 was not wearing his leg braces. The guardian indicated client #6 broke one of his braces but she was not sure if the facility had made an appointment to get the brace replaced. The guardian indicated client #6 did not have his glasses during his last visit to her home. The guardian indicated she was not informed of the status of getting his glasses repaired. The guardian indicated client #6 complained of tooth pain during the visit. The guardian indicated she had not been given an update of the status of getting him into the dentist for a root canal. The guardian indicated client #6 needed a root canal however she was not informed one was completed.</p> <p>A review of client #6's record was conducted on 4/8/14 at 10:30 AM. There was no documentation in client #6's record indicating his guardian had been notified of his medical appointments and the outcome of the appointments.</p> <p>On 4/10/14 at 10:29 AM, the Residential Manager (RM) indicated the guardians should be contacted and informed of the things they wanted to be notified of.</p> <p>9-3-2(a)</p>		<p>and his scoliosis was observed and noted as a diagnosis. Damar's nurse and primary doctor are in conversation regarding what action (if any) is required.</p> <p>2. All resident's adaptive equipment has been checked to ensure in good condition. Staff and Residential Manager will receive documented training regarding the importance and required documentation of medical issues. Items discussed (but not limited to) will include responsibility of writing information in the nurses notes; passing on information to all staff via staff communication book and documenting outcomes of medical appointments.</p> <p>3. Communication with parents and/or guardians should occur ongoing and as needed. Furthermore, as an agency - we require at least two communication per month with parents, guardian and referral sources. All Residential Managers have been retrained on this expectation and proper ways to document the communication. In addition - all parents and/or guardian will be provided with the nurse's email address. This will increase the opportunity of not only communicating with the nurse on a one/one basis but also helping to ensure adequate and correct</p>	

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W000149	<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.</p> <p>Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting clients #1 and #3, the facility neglected to implement its policies and procedures to prevent abuse and neglect of a client, ensure the results of investigations were reported to the administrator within 5 working days and staff immediately reported</p>	W000149	<p>information is being communicated.</p> <p>Damar already has a protocol in place to ensure adaptive equipment needed but not covered under one's insurance is still secured timely. In this case, the root canal was not covered by Medicaid therefore, producing the delay in treatment until payment could be made. In the future, Damar will be able to cover all dental expenses not covered by Medicaid via a special fund. Once the Medicaid denied is received – immediate access to funds is available allowing the procedure to be completed in a more timely fashion.</p> <p>4. Nurse's notes are reviewed monthly by the nurse. Any concerns or further information required will be communicated to the Residential Manager to ensure appropriate action is taken.</p> <p>1. Damar Services, Inc. has a written Policy and Procedures in place for client abuse and neglect. All staff receives training of this during their initial orientation and as revisions occurs. All staff will receive documented training by the Residential Manager and/or Director</p>	05/11/2014	

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	<p>an allegation of abuse to the administrator.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/7/14 at 12:43 PM and indicated the following:</p> <p>1) On 3/5/14 at 5:00 PM, an Incident Report indicated, in part, "He (client #1) was upset and crying during the restraint due to excessive force by the other staff involved in restraint." Former staff #6 completed the report. The report indicated, "[Client #1] rushed [staff #4] and began to put his hands around his neck. [Former staff #7] grabbed [client #1] from behind in baskethold position. I assisted him in gently sitting him down. [Client #1] began to kick and scream, he attempted to bite [staff #7's] arm and [staff #7] smashed his face into floor. Then [client #1] was released. [Staff #7] began to argue with [client #1] again while [client #1] was still on the floor. He walked up to [client #1] and [client #1] began to try and hit him. [Staff #7] grabs [client #1's] head by the chin and holds his head backwards against the chair until [client #1] said he would stop. Then let him go." The report indicated client #1 had a scratch on his nose that was bleeding. The Restraint Debriefing Form, dated 3/6/14, indicated, in part, "[Client #1] was upset because staff said they were going to take his TV because he wouldn't do his training. He was frustrated & jumped up & went after staff." The report indicated, "Client alleges staff put their elbow in his face & grabbed him by the face/jaw forcing it into the floor. Client has injuries consistant (sic) with statement." The form indicated, "Staff suspended pending an investigation due to allegations made." Client #3's statement in</p>		<p>of Group Home regarding these steps. Agency Incident report form does include suggested time of report to be done within 15 minutes of suspected abuse or neglect. Emphasis will be placed on staff responsibility to immediately notify a supervisor in the case of suspected abuse or neglect.</p> <p>Damar's required Investigation Form has again been revised and now includes a space for the date to be documented when reviewed by Administer and/or others.</p> <p>2. All Residential Managers and staff (within other group homes) will receive updated training regarding Dam's Policy and Procedures for abuse and neglect</p> <p>3. All agency incident reports and investigation documentation are submitted to Quality Assurance. Ongoing data is track to ensure timely and accurate completion of required steps deemed by the incident are done. Trends or challenges noted from IR's or Investigation Reports are communicated to appropriate personal for plans to be developed to address these issues.</p> <p>4. Dir. of Group Home will be</p>	

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	<p>the investigation indicated, "He grabbed him by the throat. He needs to be fired. Who grabbed him? [Staff #7]. He tried to push his eye out too! How? With his elbow - like this (demonstrated elbow to face)." Client #1's statement in the investigation indicated, in part, "I tried to bite [staff #7] but I didn't he just acted like I did and he took his elbow & drove it into the side of my jaw ([client #1] clearly has red marks on his (L - left) jawline & cheek & a scratch by his ear). He also put his elbow into my throat and he grabbed my face & forced it into the ground - that's how I got the scratch on my nose (scratch on (R - right) side of nose... I hate [staff #7]. He needs fired. He is mean to us." The Conclusion of the investigation indicated a violation of policy or procedure occurred. The Action taken to correct section indicated, "Investigation regarding improper restraint was initiated 3/6/14. Staff [#7] was suspended pending outcome. [Staff #7] was directed to submit IR (incident report) stating his view. [Staff #7] failed to complete this. 3/7/14 - [staff #7] was directed to submit IR and he could pass it to the person at the front desk as they are there until 9pm. Envelope was left at desk & staff informed he would be in. [Staff #7] failed to complete. On 3/10/14, return call from him & left message inquiring if he would complete. No call was ever returned. Concluded unwilling to participate in investigation and accepted resignation."</p> <p>2) On 10/28/13, client #1 yelled at a peer who was singing a song. The peer told client #1 to "shut up." Client #1 threatened the peer with a "knuckle sandwich." Client #1 began to threaten staff who redirected him. Client #1 hit the staff in the head and face, knocking the staff onto the couch. The other staff asked client #1 to stop but he did not</p>		<p>notified by Quality Assurance if improper trends (such as untimely submission) are noted. The Dir. of Group Home will address any concerns with appropriate Residential Manager and staff regarding corrective action needing to be done. If concerns or improper trends are still noted - immediate disciplinary action will occur to emphasize the importance of needed action and responsibility to ensure it is done. All staff receives an annual evaluation in which "timely, accurate reporting" and implementing policy and procedures are reviewed and scored. Those receiving unsatisfactory rating receive a plan of correction.</p>	

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	<p>and continued to hit the staff. The staff attempted a baskethold but due to client #1's size, the staff was unable to implement the restraint. The staff then used a 2 man supine restraint to calm client #1. The investigation, dated 10/29/13, did not include documentation the results were reported to the administrator.</p> <p>3) On 10/12/13 during the morning shift, the investigation indicated client #3 did not sleep the night before. Client #3 was exhibiting elopement, verbal threats of harm to others, physical aggression and property destruction. Client #3 attempted to damage staff's vehicles. He attempted to damage the group home van. After consulting with the facility's security director, the staff called the police due to the unsafe situation for client #3 and others. The officers asked client #3 to go into the home. When client #3 entered the home, he grabbed a fire extinguisher off the wall and threw it at a staff member and another client. The officers entered the home and placed client #3 in handcuffs. Client #3 was transported to the hospital for an evaluation. The investigation, dated 10/14/13, did not include documentation the results of the investigation were reported to the administrator.</p> <p>A review of the facility's abuse and neglect policies and procedures was conducted on 4/9/14 at 10:37 AM. The Abuse and Neglect of Children Operational Policies and Procedures, dated 5/20/13, indicated, in part, "Child abuse can take at least six different forms: a. Physical abuse: a non-accidental physical injury to a child by a parent or caregiver that results in or threatens serious injury. A child may also be considered physically abused if the child is injured as a</p>			

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	<p>result of a parent or caregiver's failure to take appropriate action to prevent an injury. b. Neglect: the failure of a parent or caregiver to provide a child with adequate food, clothing, shelter, medical care, education or supervision." The Abuse and Neglect of Adults Operational Policies and Procedures, dated 5/20/13, indicated, in part, "Adult abuse can take at least six different forms: a. Physical abuse: a non-accidental physical injury to an adult by a caregiver that results in or threatens serious injury. An endangered adult may also be considered physically abused if the adult is injured as a result of a caregiver's failure to take appropriate action to prevent an injury. b. Neglect: the failure of a caregiver to provide an endangered adult with adequate food, clothing, shelter, medical care, education or supervision." The policy indicated, in part, "Investigations of abuse/neglect are coordinated through or arranged by the Vice President of Programs & Services and will be completed within five days of the reported incident."</p> <p>On 4/11/14 at 11:46 AM, the Residential Manager (RM) indicated the facility had a policy and procedure prohibiting abuse and neglect of the clients. The RM indicated the facility should ensure the policy and procedure were implemented. The RM indicated the facility should prevent abuse and neglect of the clients. The RM indicated the 3/5/14 incident involving client #1 was substantiated as abuse. The RM indicated she learned of the incident on 3/5/14 after reading the incident report on 3/6/14. The RM indicated the staff should have immediately reported the incident to her.</p> <p>On 4/11/14 at 12:16 PM, the Director of Group Homes (DGH) indicated the facility</p>			

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W000153	<p>had a policy and procedure prohibiting abuse and neglect of the clients which should be implemented. The DGH indicated the facility should prevent abuse and neglect of the clients. The DGH indicated the facility did not substantiate abuse by staff #7. The DGH indicated the facility substantiated the use of an improper restraint that violated policy. The DGH indicated the RM was contacted on 3/5/14 and the staff reported he had concerns about what he observed. The DGH indicated the RM directed staff #6 to fill out an incident report. The DGH indicated the RM reviewed the incident report on 3/6/14. The DGH indicated staff #7 was terminated for failing to cooperate with the investigation. The DGH indicated the timeframe for reporting an allegation of abuse was immediately.</p> <p>9-3-2(a) 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 15 incident/investigative reports reviewed affecting client #1, the facility failed to ensure staff immediately reported an allegation of abuse to the administrator, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/7/14 at 12:43 PM</p>	W000153	<p>1. Damar Services, Inc. has a written Policy and Procedures in place for client abuse and neglect. All staff receives training of this during their initial orientation and as revisions occurs. All staff will receive documented training by the Residential Manager and/or Director of Group Home regarding these steps. Agency Incident report form does include suggested time of</p>	05/11/2014

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	<p>and indicated the following: On 3/5/14 at 5:00 PM, an Incident Report indicated, in part, "He (client #1) was upset and crying during the restraint due to excessive force by the other staff involved in restraint." Former staff #6 completed the report. The report indicated, "[Client #1] rushed [staff #4] and began to put his hands around his neck. [Former staff #7] grabbed [client #1] from behind in baskethold position. I assisted him in gently sitting him down. [Client #1] began to kick and scream, he attempted to bite [staff #7's] arm and [staff #7] smashed his face into floor. Then [client #1] was released. [Staff #7] began to argue with [client #1] again while [client #1] was still on the floor. He walked up to [client #1] and [client #1] began to try and hit him. [Staff #7] grabs [client #1's] head by the chin and holds his head backwards against the chair until [client #1] said he would stop. Then let him go." The report indicated client #1 had a scratch on his nose that was bleeding. The Restraint Debriefing Form, dated 3/6/14, indicated, in part, "[Client #1] was upset because staff said they were going to take his TV because he wouldn't do his training. He was frustrated & jumped up & went after staff." The report indicated, "Client alleges staff put their elbow in his face & grabbed him by the face/jaw forcing it into the floor. Client has injuries consistant (sic) with statement." The form indicated, "Staff suspended pending an investigation due to allegations made." Client #3's statement in the investigation indicated, "He grabbed him by the throat. He needs to be fired. Who grabbed him? [Staff #7]. He tried to push his eye out too! How? With his elbow - like this (demonstrated elbow to face)." Client #1's statement in the investigation indicated, in part, "I tried to bite [staff #7] but I didn't he just acted like I did</p>		<p>report to be done within 15 minutes of suspected abuse or neglect. Emphasis will be placed on but not limited to</p> <ol style="list-style-type: none"> a. staff responsibility to immediately notify a supervisor in the case of suspected abuse or neglect. b. Types of abuse and neglect c. Documentation to complete <p>Damar's required Investigation Form has again been revised and now includes a space for the date to be documented when reviewed by Administer and/or others.</p> <ol style="list-style-type: none"> 2. All Residential Managers and staff (within other group homes) will receive updated training regarding Dam's Policy and Procedures for abuse and neglect 3. All agency incident reports and investigation documentation are submitted to Quality Assurance. Ongoing data is track to ensure timely and accurate completion of required steps deemed by the incident are done. Trends or challenges noted from IR's or 	

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	<p>and he took his elbow & drove it into the side of my jaw ([client #1] clearly has red marks on his (L - left) jawline & cheek & a scratch by his ear). He also put his elbow into my throat and he grabbed my face & forced it into the ground - that's how I got the scratch on my nose (scratch on (R - right) side of nose... I hate [staff #7]. He needs fired. He is mean to us." The Conclusion of the investigation indicated a violation of policy or procedure occurred. The Action taken to correct section indicated, "Investigation regarding improper restraint was initiated 3/6/14. Staff [#7] was suspended pending outcome. [Staff #7] was directed to submit IR (incident report) stating his view. [Staff #7] failed to complete this. 3/7/14 - [staff #7] was directed to submit IR and he could pass it to the person at the front desk as they are there until 9pm. Envelope was left at desk & staff informed he would be in. [Staff #7] failed to complete. On 3/10/14, return call from him & left message inquiring if he would complete. No call was ever returned. Concluded unwilling to participate in investigation and accepted resignation." There was no documentation indicating when the administrator was notified of the incident.</p> <p>On 4/11/14 at 11:46 AM, the Residential Manager (RM) indicated she learned of the incident on 3/5/14 after reading the incident report on 3/6/14. The RM indicated the staff should have immediately reported the incident to her.</p> <p>On 4/11/14 at 12:16 PM, the Director of Group Homes (DGH) indicated the RM was contacted on 3/5/14 and the staff reported he had concerns about what he observed. The DGH indicated the RM directed staff #6 to fill out an incident report. The DGH indicated</p>		<p>Investigation Reports are communicated to appropriate personal for plans to be developed to address these issues.</p> <p>4. Dir. of Group Home will be notified by Quality Assurance if improper trends (such as untimely submission) are noted. The Dir. of Group Home will address any concerns with appropriate Residential Manager and staff regarding corrective action needing to be done. If concerns or improper trends are still noted - immediate disciplinary action will occur to emphasize the importance of needed action and responsibility to ensure it is done. All staff receives an annual evaluation in which "timely, accurate reporting" and implementing policy and procedures are reviewed and scored. Those receiving unsatisfactory rating receive a plan of correction.</p>	

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W000156	<p>the RM reviewed the incident report on 3/6/14. The DGH indicated the timeframe for reporting an allegation of abuse was immediately.</p> <p>9-3-2(a) 483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview for 2 of 15 incident/investigative reports reviewed affecting clients #1 and #3, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/7/14 at 12:43 PM and indicated the following:</p> <p>1) On 10/28/13, client #1 yelled at a peer who was singing a song. The peer told client #1 to "shut up." Client #1 threatened the peer with a "knuckle sandwich." Client #1 began to threaten staff who redirected him. Client #1 hit the staff in the head and face, knocking the staff onto the couch. The other staff asked client #1 to stop but he did not and continued to hit the staff. The staff attempted a baskethold but due to client #1's size, the staff was unable to implement the restraint. The staff then used a 2 man supine restraint to calm client #1. The investigation, dated 10/29/13, did not include</p>	W000156	<p>1. Damar Services, Inc. has a written Policy and Procedures in place for Incidents Reporting to Governing Bodies (BDDS). Revision of Group <u>Home Investigation form.</u> has been revised in the following ways to ensure a complete investigation has been concluded and reported to administrator within five working days. There is now a clearly designated area for all to sign and date upon receiving and reviewing the information</p> <p>2. Director of Group Homes has provided training to all Residential Managers regarding how to use the revised investigation form.</p> <p>3. All agency incident reports</p>	05/11/2014

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W000186	<p>documentation the results were reported to the administrator.</p> <p>2) On 10/12/13 during the morning shift, the investigation indicated client #3 did not sleep the night before. Client #3 was exhibiting elopement, verbal threats of harm to others, physical aggression and property destruction. Client #3 attempted to damage staff's vehicles. He attempted to damage the group home van. After consulting with the facility's security director, the staff called the police due to the unsafe situation for client #3 and others. The officers asked client #3 to go into the home. When client #3 entered the home, he grabbed a fire extinguisher off the wall and threw it at a staff member and another client. The officers entered the home and placed client #3 in handcuffs. Client #3 was transported to the hospital for an evaluation. The investigation, dated 10/14/13, did not include documentation the results of the investigation were reported to the administrator.</p> <p>On 4/11/14 at 12:16 PM, the Director of Group Homes (DGH) indicated the results of investigations should be reported to the administrator within 5 working days as evidenced by the administrator's signature on the investigation.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p>		<p>and investigation documentation are submitted to Quality Assurance. Ongoing data is track to ensure timely and accurate completion of required steps are noted per protocol. Trends or challenges noted from IR's or Investigation Reports are communicated to appropriate personal for plans to be developed to address these issues.</p> <p>4. Dir. of Group Home will be notified by Quality Assurance if improper trends (such as untimely submission) are noted. The Dir. of Group Home will address any concerns with appropriate Residential Manager and staff regarding corrective action needing to be done. If concerns or improper trends are still noted - immediate disciplinary action will occur to emphasis the importance of needed action and responsibility to ensure it is done. All staff receives an annual evaluation in which "timely, accurate reporting" and implementing policy and procedures are reviewed and scored. Those receiving unsatisfactory rating receive a plan of correction.</p>		

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	<p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to provide sufficient staff to manage and supervise the clients.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/8/14 from 6:08 AM to 7:51 AM. From 6:08 AM to 6:59 AM, there was one staff working at the home with clients #1, #2, #3, #4, #5 and #6. At 6:08 AM, clients #3 and #6 were awake. At 6:08 AM, staff #5 woke up clients #1, #4 and #5. Staff #5 was working by herself at the group home with clients #1, #2, #3, #4, #5 and #6. Client #2 was in bed until after the second staff (#2) arrived at 6:59 AM. At 6:35 AM, client #3 was using the phone in the kitchen while staff #5 was in the medication area. Client #6 told staff #5 that client #3 was using the phone. Staff #5 indicated she would talk to client #3 after she finished passing medications. During that time, clients #1, #5 and #6 were eating breakfast unsupervised.</p> <p>A review of client #1's record was conducted on 4/8/14 at 10:37 AM. Client #1's Behavior Support Plan (BSP), dated 10/22/13, indicated he had the following maladaptive behaviors: non-compliance, inappropriate sexual behavior, physical aggression, inappropriate verbalizations, property destruction, and stealing.</p>	W000186	<p>1. The 1st shift schedule has been revised to ensure adequate coverage is ongoing. During the observation, a few of the clients were awakened earlier than normal thus creating the staff/client ratio to be incorrect. All residents are encouraged to awake on their own by an alarm clock and/or preferred choice. Because, there is no certain that the residents will not alter their awake time – an adjustment to the 1st shift schedule was done and the start time is now earlier. Recommended morning schedule is documented in the office and communication book and includes suggested times to awake each client and information regarding bus pickup times is also included.</p> <p>2. All homes 1st shift schedule have been checked and adjusted to ensure adequate staff/client ratio is occurring</p> <p>3. Residential Managers will routinely check the staff/client ratio to ensure adequate staffing is occurring.</p>	05/11/2014

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	<p>A review of client #2's record was conducted on 4/8/14 at 10:45 AM. Client #2's BSP, dated 8/15/13, indicated he had the following maladaptive behaviors: non-compliance, inappropriate sexual behavior, inappropriate verbalizations, property destruction, refusals to comply with requests, inappropriate space, and elopement.</p> <p>A review of client #3's record was conducted on 4/8/14 at 11:05 AM. Client #3's BSP, dated 12/9/13, indicated he had the following maladaptive behaviors: non-compliance, inappropriate sexual behavior, physical aggression, inappropriate verbalizations, property destruction, refusal to follow requests, self-injurious behavior, and elopement.</p> <p>A review of client #4's record was conducted on 4/8/14 at 11:23 AM. Client #4's BSP, dated 10/1/13, indicated he had the following maladaptive behaviors: physical aggression, inappropriate verbalizations, inappropriate sexual behavior, inappropriate space, and non-compliance.</p> <p>A review of client #5's record was conducted on 4/8/14 at 10:41 AM. Client #5's BSP, dated 6/17/13, indicated he had the following maladaptive behaviors: non-compliance, inappropriate sexual behavior, physical aggression, inappropriate verbalizations, property destruction, refusals to comply with requests, and inappropriate space.</p> <p>A review of client #6's record was conducted on 4/8/14 at 10:30 AM. Client #6's BSP, dated 11/7/13, indicated he had the following maladaptive behaviors: physical aggression, inappropriate verbalizations, property</p>			

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	<p>destruction, refusals to comply with requests, elopement, and self-injurious behavior.</p> <p>On 4/8/14 at 6:10 AM, staff #5 indicated she popped the clients' medications prior to the med pass and had them in cups due to being the only staff at the home. Staff #5 indicated she was not sure if one staff was sufficient to manage and supervise the clients. Staff #5 indicated the morning shift would be easier to manage if there were two staff working starting at 6:00 AM.</p> <p>On 4/10/14 at 10:29 AM, the Residential Manager (RM) indicated there was one staff at the home until 7:00 AM. The RM indicated staff #5 had been waking the clients up too early causing the issue with staffing levels at the home. The RM indicated staff #2's schedule was going to be changed so she came in at 6:30 AM instead of 7:00 AM. The RM indicated one staff was not sufficient when 5 clients were up especially if a client was having maladaptive behaviors.</p> <p>On 4/8/14 at 12:23 PM, the Director of Group Homes (DGH) indicated having one staff was not sufficient if all the clients were awake between 6:00 AM and 7:00 AM. The DGH indicated once three of the clients were awake, the facility needed to have an additional staff. The DGH indicated she was unaware of the time the clients got on the bus in the morning. The DGH indicated she thought the buses arrived later in the morning and having one staff was sufficient until 7:00 AM. The DGH indicated the facility needed to have additional staff in the morning once three of the clients were awake.</p> <p>9-3-3(a)</p>						

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W000227	<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.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#3), the facility failed to develop a plan addressing client #3's on-going maladaptive behavior of 1) pulling the fire alarm at the group home and school and 2) refusing to go to school.</p> <p>Findings include:</p> <p>1) On 4/7/14 at 12:43 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 1/23/14 at 2:00 PM, client #3 attempted to pull the fire alarm by the front door. The attempt was blocked by the Director of Group Homes (DGH). Client #3 struck the DGH in the face and body. Client #3 ran to the back door and pulled the alarm. The fire department and police responded. Client #3 was arrested for battery.</p> <p>On 4/8/14 at 11:05 AM, a review of client #3's record was conducted. Client #3's Individual Support Plan and Behavior Support Plan, dated 12/9/13, did not address pulling the fire alarm. Client #3 did not have a training objective or a targeted behavior addressing pulling the fire alarm.</p> <p>On 4/8/14 at 11:12 AM, staff #2 indicated one of client #3's probation stipulations was to not pull the fire alarm. Staff #2 indicated, from what she had heard, client #3 used to pull the</p>	W000227	<p>1. Client #3 does have a history of combative behaviors and pulling of fire alarm at home and at school. However, in review of this history, it should be noted that information provided was not accurate. During the month of Dec 2013, a team meeting was held at school to discuss client's ongoing refusal to participate and threats to pull the alarms. A classroom behavior plan was revised and included the step to have client removed from the school upon any physical and/or verbal threats to pull the alarm. A change in classroom to a more secured location was done and a specific behavioral plan was developed to indicate when and if a return to the open classroom could occur. Client # 3 has met several of the criterions and now spends close to half of the school week in the open classroom. This week he will attempt to spend three days in the classroom and if successful, will remain in the open classroom until the end of school.</p> <p>Client #3 ISP/BMP addressed behaviors such as noncompliance, physical aggression and property destruction. Although there was not</p>	05/11/2014

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	<p>fire alarm all the time.</p> <p>On 4/8/14 at 9:41 AM, client #3's former teacher indicated client #3 moved to his current location (a small room in between two classrooms) at the school with a new teacher and a 3 students to 1 teacher ratio due to pulling the fire alarm on two occasions.</p> <p>On 4/10/14 at 10:29 AM, the Residential Manager (RM) indicated client #3 had pulled the fire alarm at the group home at least 4 times (approximately) over the past 12 months. The RM indicated client #3 needed a plan to address pulling the fire alarm. The RM indicated she was not sure why he did not have a plan addressing pulling the fire alarm.</p> <p>On 4/8/14 at 12:47 PM, the Director of Group Homes (DGH) indicated client #3 pulled the fire alarm at school and was suspended. The DGH stated client #3 "pulled it (fire alarm) numerous, numerous times over the past year." The DGH indicated client #3 should have a plan addressing pulling the fire alarm. The DGH stated, "I never checked to see if he had a plan. That's a big one."</p> <p>2) On 4/8/14 at 11:12 AM, staff #2 stated client #3 refused to go to school for "about one month." Staff #2 indicated part of his probation was to attend school.</p> <p>On 4/8/14 at 11:05 AM, a review of client #3's record was conducted. Client #3's Individual Support Plan and Behavior Support Plan, dated 12/9/13, did not address refusals to attend school. Client #3 did not have a training objective or a targeted behavior addressing refusals to attend school. There was no documentation client #3 refused to</p>		<p>a specific objective for the behavior of alarm pulling – steps to prevent this was included and revised throughout the years as needed. Some of the revision included</p> <ul style="list-style-type: none"> · Adding additional staff to the home and designate a one/one staff for Client #3 · Revising the use of PRN medication · Revising the tracking of "manic" symptoms and utilizing PRN medication and increased staffing when symptoms indicate likely to become manic · Short term contracts to encourage appropriate behaviors · Working with probation officer · Psychotropic medication adjustment <p>Client #3 BMP will be revised to formally address decreasing incidents of pulling a fire alarm. The plan will include proactive and reactive steps for all to take.</p> <p>2. All maladaptive behaviors are noted and baseline upon occurrence. Incidents of pulling a fire alarm more two times in a 12 month period will be formally addressed. Monthly summary will</p>	

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W000285	<p>attend school for 3 weeks in March 2014 in client #3's record.</p> <p>On 4/10/14 at 10:29 AM, the RM indicated client #3 refused to go to school for three straight weeks in March 2014. The RM indicated client #3 needed a plan to address refusals to attend school. The RM indicated there was no documentation of client #3 refusing to attend school on his non-compliance behavior tracking form.</p> <p>On 4/8/14 at 12:50 PM, the DGH indicated client #3 needed a plan to address refusals to attend school.</p> <p>9-3-4(a)</p> <p>483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.</p> <p>Based on record review and interview for 1 of 3 non-sampled clients (#1), the facility failed to ensure his safety, welfare and civil and human rights were adequately protected during a restraint.</p> <p>Findings include:</p>	W000285	<p>be written to assess progress of decreasing the behaviors.</p> <p>3. All managers have received training regarding how to determine when to address this behavior. Monthly during fire drill, residents receive training regarding rules of a fire drill and consequences of making a false report.</p> <p>4. All managers have received training regarding when to formally address pulling of fire alarms as a mal adaptive behavior. Incidents of pulling a fire alarm more two times in a 12 month period will require a plan. Furthermore, protective plastic closure will be added to the pull stations when this behavior occurs more than two times in a months period.</p> <p>1. Damar Services, Inc. has a written Policy and Procedures in place for client abuse and neglect. All staff receives training of this during their initial orientation and as revisions occurs. All Residents receive a copy of the "Residents Right" upon admission. A copy of</p>	05/11/2014

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	<p>A review of the facility's incident/investigative reports was conducted on 4/7/14 at 12:43 PM and indicated the following:</p> <p>On 3/5/14 at 5:00 PM, an Incident Report indicated, in part, "He (client #1) was upset and crying during the restraint due to excessive force by the other staff involved in restraint." Former staff #6 completed the report. The report indicated, "[Client #1] rushed [staff #4] and began to put his hands around his neck. [Former staff #7] grabbed [client #1] from behind in baskethold position. I assisted him in gently sitting him down. [Client #1] began to kick and scream, he attempted to bite [staff #7's] arm and [staff #7] smashed his face into floor. Then [client #1] was released. [Staff #7] began to argue with [client #1] again while [client #1] was still on the floor. He walked up to [client #1] and [client #1] began to try and hit him. [Staff #7] grabs [client #1's] head by the chin and holds his head backwards against the chair until [client #1] said he would stop. Then let him go." The report indicated client #1 had a scratch on his nose that was bleeding. The Restraint Debriefing Form, dated 3/6/14, indicated, in part, "[Client #1] was upset because staff said they were going to take his TV because he wouldn't do his training. He was frustrated & jumped up & went after staff." The report indicated, "Client alleges staff put their elbow in his face & grabbed him by the face/jaw forcing it into the floor. Client has injuries consistant (sic) with statement." The form indicated, "Staff suspended pending an investigation due to allegations made." Client #3's statement in the investigation indicated, "He grabbed him by the throat. He needs to be fired. Who grabbed him? [Staff #7]. He tried to push his eye out too! How? With his elbow - like this</p>		<p>the resident/clients rights has been secured on a wall out in the living area for all to see and review. All residents were offered a copy to place in their rooms. During annual ISP/BMP – the resident’s rights document will be reviewed and resigned and dated to ensure ongoing information is being provided the residents regarding their right to live in a environment free of harm. In addition – all emancipated adults will be assessed to determine if an advocate or other person is needed to ensure they are able to demonstrate their right. All residents that have approved physical management restraints to be utilized it needed - will be provided formal and/or informal training regarding what is allowed to occur during a restraint and ways to communicate if they think a violation has occurred</p> <p>2. All Residential Managers will ensure the residents receive updated and ongoing training regarding client/residents rights</p> <p>3. The agency has implemented a client concern form that can be completed by clients, parents or others when a concern is noted. All residents and staff have received training on where these forms are</p>	

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	<p>(demonstrated elbow to face)." Client #1's statement in the investigation indicated, in part, "I tried to bite [staff #7] but I didn't he just acted like I did and he took his elbow & drove it into the side of my jaw ([client #1] clearly has red marks on his (L - left) jawline & cheek & a scratch by his ear). He also put his elbow into my throat and he grabbed my face & forced it into the ground - that's how I got the scratch on my nose (scratch on (R - right) side of nose... I hate [staff #7]. He needs fired. He is mean to us." The Conclusion of the investigation indicated a violation of policy or procedure occurred. The Action taken to correct section indicated, "Investigation regarding improper restraint was initiated 3/6/14. Staff [#7] was suspended pending outcome. [Staff #7] was directed to submit IR (incident report) stating his view. [Staff #7] failed to complete this. 3/7/14 - [staff #7] was directed to submit IR and he could pass it to the person at the front desk as they are there until 9pm. Envelope was left at desk & staff informed he would be in. [Staff #7] failed to complete. On 3/10/14, return call from him & left message inquiring if he would complete. No call was ever returned. Concluded unwilling to participate in investigation and accepted resignation."</p> <p>On 4/11/14 at 11:46 AM, the Residential Manager (RM) indicated client #1 was injured due to the restraint. The RM indicated the facility should prevent injuries during restraints.</p> <p>On 4/11/14 at 12:16 PM, the Director of Group Homes (DGH) indicated client #1 had a pressure mark on his chin and forehead due to the restraint. The DGH indicated the facility should prevent injuries during restraints.</p>		<p>located within the house and offices.</p> <p>4. "Home Inspections" are complete by staff daily. Section four does require the staff to check for the presence of the client/residents rights to be secured on a wall in the living area. Work order will be submitted to have the poster replace if need. Furthermore, Monthly House Check is completed by the Dir. Of Group Home. This item is also stated to be checked for to ensure it is present</p>	

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W000312	<p>9-3-5(a) 483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview for 2 of 2 clients in the sample with psychotropic medications (#2 and #3), the facility failed to ensure the clients' psychotropic medication reduction plans were attainable.</p> <p>Findings include:</p> <p>A review of client #2's record was conducted on 4/8/14 at 10:45 AM. Client #2's Psychotropic Medication Review, dated 2/22/14, indicated he took the following psychotropic medications: Risperdal, Citalopram, Intuniv and Prazosin for post traumatic stress disorder and panic disorder. Client #2 was prescribed Menest for sexual urges. The Psychotropic Objectives indicated, "1. Property destruction (can be seen as hitting, kicking objects, breaking objects, hitting windows, walls, slamming, doors, etc.) - [Client #2] will maintain 0 incidents of property destruction per month for 6 consecutive months. 2. Inappropriate Sexual Behavior (seen as: touching others on privates, buttocks, etc. talking about sexual subjects) - [Client #2] will decrease incidents of inappropriate sexual behavior from 6 to 3 incidents per month for 3 consecutive months." The Plan for Decreasing Risperdal indicated, "If #1 (property destruction)</p>	W000312	<p>1. During the recent psychotropic review meeting – it was noted by the Dir. Of Group Homes that many of the psychotropic plans were inadequate. With Nurse and doctors input guidelines were developed and on 4/6/2014 – a summary of changes that were needed to occur was emailed to all managers to review. On 4/16/2014 – training was provided to all managers regarding how to write accurate psychotropic reduction plans. The following items discussed but not limited to</p> <ul style="list-style-type: none"> · Psychotropic objectives have to be measurable and realistic. · When a psychotropic objective is met – a medication reduction should occur or be discussed. · If a medication is being used for a behavior or a diagnosis – we should be tracking that and specific behaviors are to go with specific 	05/11/2014

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	<p>maintain at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Risperdal in increments recommended by the doctor." The Plan for Decreasing Citalopram indicated, "If #1 maintain at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Citalopram in increments recommended by the doctor." The Plan for Decreasing Intuniv indicated, "If #1 maintain at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Intuniv in increments recommended by the doctor." The Plan for Decreasing Prazosin indicated, "If #1 maintain at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Prazosin in increments recommended by the doctor." The Plan for Decreasing Menest indicated, "If #2 (inappropriate sexual behavior) maintain at or below the current psychotropic review objectives for 6 consecutive months, will consider decrease in Menest in increments recommended by the doctor."</p> <p>On 4/8/14 at 1:14 PM, the Director of Group Homes (DGH) indicated client #2's medication reduction plans did not match. The DGH indicated the plan had two sets of criteria for reduction listed in the psychotropic objectives section and the plan for reduction. The DGH indicated the plan needed to be attainable.</p> <p>A review of client #3's record was conducted on 4/8/14 at 11:05 AM. Client #3's Psychotropic Medication Review, dated 3/20/14, indicated he took the following psychotropic medications: Paroxetine, Topamax, Zyprexa, Geodon and Lithium for</p>		<p>medications</p> <ul style="list-style-type: none"> · not every maladaptive behavior being addressed in ones BSP has to be listed on a psychotropic review · Every medication has to have an individual increasing /decreasing plan. · If tracking diagnosis such as depression – we need to counting the number of episodes/days this depression was present. In order to do this we have to decide what symptoms or behaviors are present when one is in this state. If using a symptom tracking sheet – determine which key symptoms need to be exhibited and for how long (i.e.: three consecutive days). This is what needs to be reported. · ADHD – what is the ADHD behaviors that are causing problems. There are basically three different major symptoms that are related to ADHD. Inattention; Hyperactivity or Impulsivity. Different meds are better for different symptoms. Use a tracking sheet that helps determine if it is “Attention deficient”; “hyperactivity” or both. · ADHD – why was it prescribed? Was it to help focus at school? If so, track how many days they had difficulty maintaining or focusing (based on a school report) or use an IEP goal that might be 	

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	Bi-polar disorder and Lorazepam for manic episodes. The Plan for Decreasing Paroxetine indicated, "If psychotropic objective #1 or #2 is maintained at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Paroxetine in increments recommended by the doctor." Psychotropic Objective #1 indicated, "Will decrease incidents of physical aggression (includes but is not limited to hitting, pushing, throwing items at another person or animal or any attempt that has the potential to cause tissue damage to another person or animal) from 1 to 0 incidents per month for 3 con (consecutive) months." Psychotropic Objective #2 indicated, "Will decrease incidents of property destruction (includes but is not limited to kicking walls and doors, punching walls, doors and windows, slamming doors and destroying property that does not belong to [client #3]) from 2 to 0 incidents per month for 3 con months." The Plan for Decreasing Topamax indicated, "If psychotropic objective #1 or #2 is maintained at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Topamax in increments recommended by the doctor." The Plan for Decreasing Zyprexa indicated, "If psychotropic objective #1 or #2 is maintained at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Zyprexa in increments recommended by the doctor." The Plan for Decreasing Geodon indicated, "If psychotropic objective #1 or #2 is maintained at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Geodon in increments recommended by the doctor." The Plan for Decreasing Lithium indicated, "If psychotropic objective #1 or #2		related to ADHD. 2. All psychotropic review plans will be reviewed and revised to ensure correct information is being provided 3. All psychotropic plans will be reviewed at all upcoming appointment. Any additional changes that are needed as recommended by the doctor will be revised during the review and form updated. Examples of psychotropic forms for specific behaviors and/or diagnosis has been developed and stored on the global drive for all to review and use. 4. Psychotropic plans will be reviewed during each annual ISP/BMP meeting. If needed – revision of psychotropic objectives will be done to ensure objectives are measurable and realistic for one’s present state (rather than just continuing the same objective year after year). Annual Department of Health surveys are complete and psychotropic plans are reviewed again at this time.	

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W000331	<p>is maintained at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Lithium in increments recommended by the doctor." The Plan for Decreasing Lorazepam indicated, "If psychotropic objective #1 or #2 is maintained at or below the current psychotropic review objectives for 3 consecutive months, will consider decrease in Lorazepam in increments recommended by the doctor."</p> <p>On 4/8/14 at 1:14 PM, the DGH indicated the plans of reduction needed to have criteria set that were attainable for the client.</p> <p>9-3-5(a) 483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 1 of 3 clients in the sample (#2) and one additional client (#6), the facility's nursing services failed to ensure the clients received dental services as recommended.</p> <p>Findings include:</p> <p>1) A review of client #2's record was conducted on 4/8/14 at 10:45 AM. Client #2's most recent dental appointment, dated 8/1/13, indicated, in part, "No decay/6 MRC (return in 6 months)." There was no documentation client #2 had a dental appointment since 8/1/13.</p> <p>On 4/8/14 at 12:16 PM, the Director of Group Homes (DGH) indicated client #2 should have had a follow up appointment within the</p>	W000331	<p>1. Clients #2 and client #6 dental appointments have been completed. Client #6 – will return in early May to complete the procedure.</p> <p>2. Residential Manager will review all residents medical records have been reviewed to ensure all annual medical and dental appointments are in place as recommended. Any new appointments made were communicated to the nurse to be included on the <u>Year's Medical Appointment Chart</u></p>	05/11/2014

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	<p>recommended timeframe of 6 months.</p> <p>On 4/10/14 at 10:29 AM, the Residential Manager (RM) stated the "ball got dropped" when there was a transition between managers. The RM indicated she was aware client #2 needed to have a dental appointment and attempted to schedule it. The RM indicated client #2 was on the list to call if an appointment was cancelled by someone else so he could get an earlier appointment. The RM indicated client #2 had an appointment scheduled on 4/10/14.</p> <p>On 4/9/14 at 11:45 AM, the nurse indicated client #2 should have had an appointment within the recommended timeframe. The nurse indicated if the appointment was canceled or rescheduled, there should be documentation in his record indicating the reason an appointment was not held.</p> <p>2) An observation was conducted at the group home on 4/7/14 from 2:26 PM to 5:50 PM. At 3:52 PM, two minutes after returning home from school, client #6 complained to the DGH of tooth pain. The DGH indicated she would write a note in the Nursing Notes. The DGH prompted client #6 to gargle with warm salt water. At 5:38 PM, client #6, during dinner, complained his tooth hurt. Staff #4 prompted client #6 to chew using the other side of his mouth and to dip his crackers in his milk.</p> <p>On 4/8/14 at 8:26 AM an interview with client #6's school aid indicated client #6 had issues with on-going tooth pain.</p> <p>On 4/8/14 at 8:34 AM, client #6's teacher indicated client #6 had on-going issues with tooth pain.</p>		<p>-</p> <p>3. All physician orders notes will be copied and submitted to nurse after an appointment. If needed – formal training and/or increased staff observation during a treatment will be added to ones' plan. Follow up appointments needed will be documented on the nurse's yearly <u>Medical Appointment Chart</u>. Medical appointment made will have the date and time of the appointment entered on the chart. A yellow highlighted area will be placed on the chart indicating an appointment needs to be made. All Residential Managers have received training on how to access the <u>Medical Appointment Chart</u> created by the nurse and kept on the global drive. At the beginning of each month, the chart will be checked to ensure all appointments needed are scheduled. At the end of each month, Residential Manager will check the chart again to ensure all appointments were completed as scheduled.</p> <p>4. Nurse's notes are reviewed monthly by the nurse. Any concerns or further information required will be communicated to the Residential Manager to ensure appropriate action is taken; this may include the need to schedule an appointment. Monthly, the nurse will review the</p>	

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	<p>On 4/8/14 at 8:44 AM during an observation at client #6's school, client #6 indicated during "Sharing Time" that his tooth was still hurting last night. Client #6 indicated he was not sure when he was going to the dentist.</p> <p>On 4/8/14 at 1:31 PM, the DGH received a call from client #6's school indicating he needed to be picked up due to tooth pain.</p> <p>A review of client #6's record was conducted on 4/8/14 at 10:30 AM. Client #6 had a dentist appointment of 1/14/14. The Medical Order/Medical Visit Sheet indicated, in part, "Needs to brush better. A lot of heavy plaque everywhere. Has 2 new cavities in addition to the 2 he has from last time. 4 cavities total. Needs fillings." On 1/20/14, client #6 returned to the dentist. The Medical Order form indicated, in part, "Fillings upper right, left sides and front tooth. NPO (nothing by mouth) until numbness gone, nothing hard 24 hours. Will need root canal, post & build up, crown on lower right. Needs assistance brushing & flossing 3 times daily!" The Medical Order form, dated 3/11/14, indicated, in part, "Patient came in for toothache on tooth #30. Patient was seen in 1/14 where we treatment planned a root canal & crown or extraction. Cannot perform any procedure today without guardian's consent (sic). Root canal & crown #30." There was no documentation in client #6's record indicating he had a root canal and crown. A review of the Nurse's Notes for April 2014 indicated there were no notes addressing client #6's complaints of tooth pain.</p> <p>On 4/8/14 at 10:28 AM, staff #2 (responsible for scheduling and taking clients to the dentist) indicated client #6 had been to the</p>		<p>Medical Appointment Chart. At the beginning of each month, the chart will be checked to ensure all appointments needed are scheduled. Nursing will verify with each Residential Manager or designee that the scheduled appointments are on the house calendar. At the end of each month, nursing will check the chart again to ensure all appointments were completed as scheduled. We have revised the protocol for missed appointments. We will continue to work with our businesses to secure a make-up appointment for missed events. This typically includes being notified of the next available time slot form others that have missed an appointment. However, if a date cannot be secured within 30 days of the missed appointment, a new appointment will be made.</p>	

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	<p>dentist. Staff #2 indicated she was not sure if there was follow up or not. Staff #2 indicated client #6 had not complained to her of having tooth pain.</p> <p>On 4/10/14 at 10:29 AM, the RM indicated client #6 had been complaining of a toothache on and off. The RM indicated a root canal was recommended in January but it took awhile to get the appointment scheduled. The RM indicated part of the issue was getting a check to pay for the dental work since Medicaid would not pay. The RM stated, "I would have liked to get it done quicker. I would want to get it done quicker." The RM indicated client #6 had the root canal on 4/9/14.</p> <p>On 4/8/14 at 12:55 PM, the DGH indicated it was ultimately her responsibility for obtaining guardian consent for medical procedures. The DGH indicated the Residential Manager could also obtain consent from a guardian. The DGH indicated it should not take 3 weeks to obtain consent for a dental procedure. The DGH stated, "I dropped the ball." The DGH indicated the nurse also received copies of medical appointments and should have followed up to ensure client #6 received the recommended dental services.</p> <p>On 4/9/14 at 11:45 AM, the nurse indicated client #6 had the root canal performed on 4/9/14. The nurse indicated the procedure was timely. The nurse indicated Medicaid would pay for the extraction of the tooth but not the cap and crown. The nurse indicated she applied for a waiver and needed to obtain consent from client #6's guardian. The nurse indicated she was on vacation the last week of March 2014 and the dentist was on vacation the first week of April 2014. The</p>			

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W000367	<p>nurse indicated the root canal was first ordered in January 2014. The nurse indicated client #6 went several weeks without complaining of pain.</p> <p>9-3-6(a) 483.460(k) DRUG ADMINISTRATION The facility must have an organized system for drug administration that identifies each drug up to the point of administration.</p> <p>Based on observation and interview for 5 of 6 clients living in the group home (#1, #2, #4, #5 and #6), the facility failed to ensure staff did not prepare medications for administration prior to the clients being present to take their medications.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 4/8/14 from 6:08 AM to 7:51 AM. At 6:10 AM, when staff #5 was told the surveyor wanted to observe the medication administration to the clients, staff #5 indicated she had already popped the clients' medications and had them in cups due to being the only staff at the home. Staff #5 indicated she had passed client #3's medication prior to the arrival of the surveyor. Staff #5 indicated she was not trained to prepare the medication prior to the clients being ready for their medications. Staff #5 stated, "Only way to get it all done." Staff #5 stated she "always" prepared the clients' medications prior to the clients being ready for their medications. Upon observation, there were 5 medication cups (clear, see-through, small containers) sitting on top of the locked medication cabinet in the</p>	W000367	<ol style="list-style-type: none"> All staff working within the Group homes receives Core A and B medication training prior to being allowed to administer medication to the clients. Ongoing and/or updated training is provided by the nurse on ongoing basis. The steps that the staff took that morning are a direct violation of the med passing procedures and have resulted in a "Med Error". Disciplinary action and training has occurred to ensure further compliance. Residential Managers will routinely observe med passing by staff members to ensure proper steps are being followed. Residential Managers will routinely observe med passing by staff members to ensure proper steps are being followed. Common rules of medication passing have been posting in all med rooms to provide daily reminders of the procedures. 	05/11/2014

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	<p>locked medication room. Each cup had the initials, in marker, of clients #1, #2, #4, #5 and #6 on the outside of the cup. At 7:05 AM, staff #5 stated, "That's my routine." Staff #5 stated, "I know I made a mistake" by preparing the medications ahead of time. Staff #5 indicated she was trying to make the morning go easier for staff #2. Staff #5 indicated she knew each clients' medications from the initials written on the outside of the medication cup. Staff #5 stated, "Preparation prevents poor performance." Staff #5 indicated, due to being the only staff, if she did the medication administration the way she was trained, she would run out of time due to the arrival of the clients' buses to go to school.</p> <p>On 4/9/14 at 11:45 AM, the nurse stated, after being told of what was observed during the morning medication pass, "that's not normally how it's done." The nurse indicated the staff should prepare the medications for each client when the client was ready for their medications. The nurse indicated the staff were not trained to pass medications by preparing the medications ahead of time. The nurse indicated staff #5 committed a medication error.</p> <p>On 4/10/14 at 10:29 AM, the RM indicated staff #5 should have prepared each clients' medications individually. The RM stated, "Pour one, give one." The RM indicated the clients' medications should not be pre-popped. The RM stated, "Bigger med error waiting to happen."</p> <p>On 4/8/14 at 12:29 PM, the Director of Group Homes (DGH) indicated the staff should prepare each clients' medication when the client was ready for their medications. The</p>		<p>4. All "Med Errors" are documented and reviewed by the nurse. A plan of correction is developed and often includes retraining of certain procedures and/or the retaking of Core A or B. Repeat offenders are may be determine non eligible to pass medication to residents and thus transferred to a department where this is not required.</p>	

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W000436	<p>DGH indicated the staff should not pre-pour the clients' medications. The DGH indicated the staff did not follow the policy and procedure for administering medications. The DGH indicated staff #5 committed a medication error due to preparing the medications prior to the clients being ready for their medications.</p> <p>9-3-6(a) 483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 5 clients (#6) living at the group home with adaptive equipment, the facility failed to furnish and maintain in good repair client #6's glasses and leg brace.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 4/7/14 from 2:26 PM to 5:50 PM and 4/8/14 from 6:08 AM to 7:51 AM. During the observations, client #6 was not observed to be wearing glasses or leg braces.</p> <p>On 4/8/14 at 8:26 AM, an aid from client #6's classroom indicated client #6 recently broke his one of his leg braces and glasses. The aid indicated the glasses and leg brace had not been repaired or replaced.</p> <p>On 4/8/14 at 10:30 AM a review of client #6's</p>	W000436	<p>1. Clients' #6 ISPs have been revised to include formal training and an interactive guideline for eye glass wearing. This interactive guideline will include steps that staff should take to encourage daily wearing of eye glasses. Staff will receive training by Residential Manager regarding these revisions</p> <p>2. All residents that utilize adaptive equipment will be assessing for need of additional training in the proper use of the equipment and/or encouragement to consistently use the equipment. If needed, any plan that requires a</p>	05/11/2014

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	<p>record was conducted. The Medical Order/Medical Visit Sheet, dated 1/23/14, indicated, in part, "Eyes are myopic. Amblyopic (lazy eye) left eye. With Rx (prescription): 20/60." There was no documentation in client #6's record indicating who ordered the leg braces and the date. On 4/10/14 at 2:00 PM, the Director of Group Homes indicated in an email, "According to the manager - we do not have a physician order for the braces. He was admitted with them."</p> <p>On 4/8/14 at 10:43 AM, a review of the staff communication log, dated 4/7/14, from the Residential Manager to staff #2 indicated, in part, "...Call (name of leg brace company) @ (at) [phone number] & (and) make appt (appointment) to get [client #6] braces fixed he has shattered one of them - they're in the off (office)."</p> <p>On 4/8/14 at 10:28 AM, staff #2 (responsible for making and taking clients to medical appointments) indicated client #6 broke his glasses when he was mad. Staff #2 indicated she was unaware if arrangements had been made to get his glasses repaired or replaced. Staff #2 indicated client #6's leg brace was broken. Staff #2 indicated she called the doctor's office on 4/7/14 to make an appointment but did not receive a return call. Staff #2 indicated his brace had been broken for less than two weeks.</p> <p>On 4/8/14 at 12:55 PM, the Director of Group Homes (DGH) indicated the facility should ensure client #6's glasses and leg brace were replaced. The DGH indicated she was unaware client #6 wore glasses and leg braces. The DGH indicated she had not been contacted or informed client #6 broke</p>		<p>revision will be completed by the Dir. of Program/QDDP and, staff will receive training on the new or revised goals.</p> <p>3. New prescription for use adaptive equipment such as eye glasses or braces will identify the level of usage recommended (i.e.: must be worn during awake hours, must be used for reading etc.). Programs will be put in place if ensure recommendation are met. Furthermore, individuals' program incentive (allowance) will be revised to encourage the daily wearing of equipment.</p> <p>4. Monthly reviews will monitored by the Dir. of Program/QDDP to determine if programs in place are producing progress or need for training. Weekly program incentive forms are turned into the Residential Manager and calculated for allowance. The Residential Manager will review the forms to asses if one is using their adaptive equipment as prescribed.</p>	

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W000488	<p>his glasses and leg brace.</p> <p>On 4/10/14 at 10:29 AM, the Residential Manager (RM) indicated he just found out his glasses were broken. The RM indicated client #6's glasses previously needed to be adjusted prior to him breaking them. The RM indicated it had been less than 2 weeks since he broke his glasses. The RM indicated staff #2 made an appointment to have client #6's brace replaced. The RM stated the facility "typically" had repairs completed right away. The RM indicated the facility should ensure the client's adaptive equipment remains in good condition.</p> <p>On 4/9/14 at 11:45 AM, the nurse stated client #6's glasses were a "constant issue." The nurse indicated she was not informed client #6 broke his glasses. The nurse indicated she was not aware client #6 broke his leg brace. The nurse indicated client #6's glasses and leg brace needed to be repaired or replaced.</p> <p>On 4/9/14 at 10:33 AM, client #6's guardian indicated client #6 was at her home about 2 weeks ago. The guardian indicated client #6 did not have his leg braces during the visit due to breaking one of them. The guardian indicated client #6 did not have his glasses with him due to breaking them. The guardian indicated client #6 had an issue with breaking his glasses and leg braces. The guardian indicated she was not sure how long it took to get him to the doctor to get them replaced.</p> <p>9-3-7(a) 483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her</p>			

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	<p>developmental level.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with grocery shopping and preparing breakfast.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 4/7/14 from 2:26 PM to 5:50 PM. Upon arrival to the group home, staff #3 was observed to be carrying groceries into the group home from the group home van. At the time, clients #1, #2, #3, #4, #5 and #6 were not home from school.</p> <p>On 4/7/14 at 2:54 PM, staff #2, who was putting groceries away without client assistance (none of the clients arrived home from school yet), indicated the clients typically go grocery shopping with her. Staff #2 then indicated the clients did not go shopping every time. Staff #2 indicated she had just returned from vacation and the home was low on groceries so she went shopping without the clients. On 4/8/14 at 7:40 AM, staff #2 indicated she worked from 7:00 AM to 3:00 AM, Monday to Friday. Staff #2 indicated she was responsible for doing the grocery shopping for the home. Staff #2 indicated the clients started returning home from school around 3:00 PM.</p> <p>On 4/8/14 at 12:41 PM, the Director of Group Homes (DGH) indicated the clients should be involved with grocery shopping.</p> <p>On 4/10/14 at 10:29 AM, the Residential Manager (RM) indicated staff #2 did the</p>	W000488	<p>1. Grocery shopping is routinely done two through three times throughout the week and typically completed while clients are participating in school. Other shopping such as for household items, clothing and special events are typically completed during the 2nd shift and clients participate. Shopping skills such as price comparison, item location and ingredient reading are done during these trips thus; ongoing informal shopping skills are being implemented. Grocery shopping times have been revised and will be completed at least one time a week during 2nd shift. Residents that did not participate in shopping will be offered opportunity to put the food away and/or date items as required. Extra Program incentive (allowance points) points will be offered to those participating in all or part of a shopping activity.</p> <p>Clients' participating in meal preparation is scheduled to occur at breakfast and dinner times throughout the week. Clients are assigned certain jobs during these times and Program Incentive points are given for participation. The schedule of meal duties assignments are located in the kitchen area and should be followed at all times. The staff failed to follow the schedule during the observation on 4/8/2014.</p>	05/11/2014			

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	<p>shopping during the day when the clients were at school. The RM stated, "A lot of times they don't want to go." The RM indicated the clients should have the opportunity to go grocery shopping.</p> <p>2) An observation was conducted at the group home on 4/8/14 from 6:08 AM to 7:51 AM. Upon arrival to the group home, there were five plates (client #3 had eaten prior to the surveyor's arrival) with eggs and biscuits on them on the kitchen counter. Clients #3 and #6 were awake. Client #6 had just exited his bedroom upon arrival. Clients #1, #2, #4, #5 and #6 were not observed to cook eggs or biscuits for breakfast.</p> <p>On 4/8/14 at 6:36 AM, staff #5 indicated client #3 assisted her with making breakfast (biscuits and eggs).</p> <p>On 4/8/14 at 6:49 AM, client #3 initially indicated he assisted with breakfast preparation. Client #3 then stated, "they cooked it." Client #3 stated, "I cooked dinner last night." Client #3 indicated he did not assist with making breakfast.</p> <p>On 4/10/14 at 10:29 AM, the RM indicated the clients were capable and should be involved with breakfast preparation.</p> <p>On 4/8/14 at 12:39 PM, the DGH indicated the clients should be involved with making breakfast.</p> <p>9-3-8(a)</p>		<p>2. Training has been provided to all staff regarding ways to encourage and allow residents' to participate in breakfast preparation.</p> <p>Some suggested ways were</p> <ul style="list-style-type: none"> · Allowing each resident to pour the ready-made pancake mix when they arrive to the table. · Allowing each resident to make his own toast · Allowing each resident to pour their own cereal, milk, juice, etc. · Allowing each resident to serve themselves the allowed portion when breakfast casserole are prepared · It times allows – allowing one to make his own type of egg (scrambled or fried) · All residents are expected to clean their eating area and load their dishes in the dishwasher. <p>3. Residential Manager will make routine observation during the morning meal time to ensure residents' are participating in meal preparation. Weekly program incentive points are awarded to residents for participating in assigned meal duties</p>	

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(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: 16) A medication error or medical treatment error and 18) Use of a PRN (as needed) medication related to an individual's behavior.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 15 incident/investigative reports reviewed affecting client #3, the facility failed to report the incidents to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/7/14 at 12:43 PM and indicated the following:</p>	W009999	<p>4. Residential Manager will make routine observation during the morning meal time to ensure residents' are participating in meal preparation</p> <p>1. Damar Services, Inc. has a written Policy and Procedures in place for reportable incidents to be reported to Governing Bodies (BDDS) with 24 hours.</p> <p>· Medication error such as administering PRN medication or missing a dosage of medication are too l be reported as required within 24 hours.</p> <p>2. Dir. Of Program has provided training to all Residential Managers reviewing the protocol for reporting incidents to BDDS within 24 hours of occurrence.</p> <p>3. The agency policy regarding incidents reporting to Governing Bodies has been reviewed to ensure it complies with State and Federal regulations. All Residential Manager have received training from the Director of the program regarding the protocol for reporting incidents to BDDS.</p>	05/11/2014

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	<p>1) On 10/12/13 at 9:00 PM, the BDDS report indicated client #3 had been in a severe manic episode since 10/11/13. Client #3 went to the hospital earlier in the day for an evaluation due to safety issues but was released a few hours later. The report indicated upon returning to the group home he continued to display manic symptoms that were increasing in intensity including elopement (with staff following him). He was given Lorazepam 1 milligram due to displaying 9 out of 11 manic symptoms on his protocol. The report was submitted to BDDS on 10/14/13.</p> <p>2) On 7/13/13 at 8:00 AM, client #3 was administered his evening medications at 8:00 AM. There were no adverse effects noted. The BDDS report was submitted on 7/15/13.</p> <p>On 4/7/14 at 1:01 PM, the Director of Group Homes indicated BDDS reports should be reported to BDDS within 24 hours.</p> <p>9-3-1(b)</p>		<p>4. All reportable incidents will occur as directed by agency policy regarding Incidents Reporting. All copies of IR's and investigations are submitted to agency Quality Assurance for monitoring of compliance. Review of policy and procedures pertaining to this will be reviewed at least annually and revised as needed. Additional training will occur with any revisions</p>	