

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/20/2012
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NAME OF PROVIDER OR SUPPLIER DAMAR SERVICES INC--MAIN ST	STREET ADDRESS, CITY, STATE, ZIP CODE 411 E MAIN ST PLAINFIELD, IN 46168
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W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>This visit was in conjunction with a post recertification revisit (PCR) to the investigation of complaint #IN00094232 completed on 8/30/11.</p> <p>This visit was in conjunction with a post recertification revisit (PCR) to the investigation of complaint #IN00096229 completed on 10/03/11.</p> <p>Survey Dates: January 17, 18, 19 and 20, 2012</p> <p>Facility Number: 000629 Aim Number: 100239570 Provider Number: 15G088</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 1/27/2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		
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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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W0149	<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review, for 3 of 6 reportable incidents reviewed (clients #1, #4), the facility failed to implement policy and procedures to immediately report allegations of abuse/neglect to the facility director and the Bureau of Developmental Disabilities Services (BDDS). The facility failed for 1 of 6 investigations reviewed to ensure facility policy and procedures were followed to ensure a thorough investigation was completed.</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 1/18/12 at 10:07a.m. The incident report review indicated the following:</p> <p>1) An incident report dated 10/29/11 indicated client #1 had eloped from the facility. The incident report indicated staff had used a baskethold and physical escort restraint on client #1. The incident report indicated client #1 had kicked out a window in the van. The incident report indicated staff #2 had been involved with the elopement incident and with the implementation of client restraint. The incident investigation report indicated staff #2 (whom had been involved in the</p>	W0149	<p>W149 483.420 (d)(1) Staff Treatment of Clients The facility must develop and implement written policy and procedures that prohibit mistreatment, neglect, or abuse of a client. 1. Damar Services, Inc. has a written Policy and procedure in place for Incident Reporting to Governing Bodies (BDDS). The Residential Manager will ensure that any incidents of allegations of abuse/neglect or any other reportable incident is reported to BDDS within 24 hours of the incident occurring. Staff will notify the Residential Manager of the incident and ensure that all injuries or other reportable incidents are reported clearly and accurately. The Residential Director will also ensure that all incidents are investigated by an appropriate person not involved in the incident. The Residential Director completed a thorough investigation of the incident involving Client #1 on 1/24/12. The BDDS report was completed for client #1 on 12/3/11 and additional follow ups have been completed per BDDS requests. BDDS has closed the report. The BDDS report was completed for client #4 on 12/4/11 and additional follow ups have been completed per BDDS requests. BDDS has closed the report. 2.</p>	02/19/2012			

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	<p>incident) had done/completed the facility investigation of the elopement and staff interventions.</p> <p>2) An incident report dated 12/2/11 indicated client #1 had been identified as possibly involved in an inappropriate touching incident with a family member. The incident report indicated the facility direct care staff were aware of the allegation on 12/1/11. The allegation of abuse was reported to the facility director on 12/2/11. The facility reported the allegation on 12/3/11 to BDDS.</p> <p>3) An incident report dated 12/2/11 indicated client #4 had eloped, had gotten out of staff's sight and police had been called. The incident report indicated BDDS had been notified on 12/4/11 of the elopement incident.</p> <p>The facility's policy and procedures were reviewed on 1/18/12 at 11:20a.m. The facility policy "Incident Reporting to Governing Bodies- Bureau of Developmental Disability Services (BDDS), Department of Child Services, Child Protective Services, Adult Protective Services" dated 3/21/11, indicated: reportable incidents included all allegations and reports of sexual misconduct and willful elopement if the person becomes missing. The policy indicated for allegations of sexual misconduct the facility should "report</p>		<p>Incident reports from the home have been reviewed by the Residential Director to identify the potential need for reporting additional follow-up and/or further investigation. At this time, all other incidents have been documented and reported appropriately. All documentation will be completed, including an agency Incident Report (immediately), BDDS Incident Report (within 24 hours) and a thorough investigation (within 5 days) for all incidents requiring a BDDS reportable. The Group Home Investigation form was revised in 1/2012 to include the following statement "if you were a person directly involved in this incident STOP and seek out the next appropriate person to complete the investigation and investigation form" The Residential Director completed a thorough investigation of the incident involving Client #1 on 1/24/12. Documented retraining will be completed with the Residential Manager on the polic and procedure for Incident Reporting to Governing Bodies and ensuring a thorough investigation is completed by the appropriate party and not anyone who was directly involved in the incident being investigated. 3. The agency policy regarding Incident Reporting to governing bodies has been reviewed to ensure it</p>				

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	<p>upon knowledge of allegation- do not wait until the allegation is investigated." The policy indicated all reportable incidents are to be reported to BDDS, via the BDDS Incident Report Form, within 24 hours by the Residential Director. The facility policy "Incident Reporting" dated 3/21/11 indicated "any suspicion or report of abuse or neglect should be reported to the Director of Treatment and the Senior Vice President immediately." The facility 1/12 "Group Home Investigation Form" indicated "If you were a person directly involved in this incident STOP and seek out the next appropriate person to complete the investigation and investigation form."</p> <p>Staff #1 was interviewed on 11/19/12 at 11:02a.m. Staff #1 indicated the above identified incidents of allegations of abuse/neglect had not been immediately reported to the facility director and to BDDS. Staff #1 indicated the facility investigation, of the reported 10/29/11 incident, should not been conducted by a staff person who had been involved in the incident.</p> <p>9-3-2(a)</p>		<p>complies with current State and Federal regulations. The Residential Manager and group home staff will receive documented training by the Residential Director on the Agency Policy for Incident Reporting to Governing Bodies including the requirement to report within 24 hours and have a neutral party complete the investigation. 4. All reportable incidents will be reported to the Residential Manager, Residential Director and Group Home Administrator immediately following the incidents occurrence. The initial investigation will begin immediately in the form of an Agency Incident Report. Additional information will be gathered within 24 hours of the incidents occurrence and reported to the Bureau of Developmental Disabilities by the Residential Manager and a thorough investigation completed within 5 days of the incident by a party not involved in the incident. BDDS incident report notifications regarding closure or the need for additional follow-up are received electronically from the State by the Group Home Administrator and disseminated to the QDDP and Home Manager for appropriate action. 5. Systemic changes will be completed by: February 19, 2012</p>		

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W0153	<p>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, the facility failed for 2 of 6 facility reportable incidents (clients #1, #4), to immediately report allegations of abuse/neglect to the facility director and to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 1/18/12 at 10:07a.m. The incident report review indicated the following:</p> <p>1) An incident report dated 12/2/11 indicated client #1 had been identified as possibly involved in an inappropriate touching incident with a family member. The incident report indicated the facility direct care staff were aware of the allegation on 12/1/11. The allegation of abuse was reported to the facility director on 12/2/11. The facility reported the allegation on 12/3/11 to BDDS.</p> <p>2) An incident report dated 12/2/11 indicated client #4 had eloped, had gotten out of staff's sight and police had been called. The incident report indicated BDDS had been notified on 12/4/11 of</p>	W0153	<p>W 153 483.420(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 the other officials in accordance with State law through established procedures. 1. Damar Services, Inc. has a written Policy and procedure in place for Incident Reporting to Governing Bodies (BDDS). The Residential Manager will ensure that any incidents of allegations of abuse/neglect or any other reportable incident is reported to BDDS within 24 hours of the incident occurring. Staff will notify the Residential Manager of the incident and ensure that all injuries or other reportable incidents are reported clearly and accurately. The BDDS report was completed for client #1 on 12/3/11 and additional follow ups have been completed per BDDS requests. BDDS has closed the report. The BDDS report was completed for client #4 on 12/4/11 and additional follow ups have been completed per BDDS requests. BDDS has closed the report. 2. Incident reports from</p>	02/19/2012			

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	<p>the elopement incident.</p> <p>Staff #1 was interviewed on 1/19/12 at 11:02a.m. Staff #1 indicated the above identified incidents of allegations of abuse/neglect had not been immediately reported to the facility director and BDDS.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>		<p>the home have been reviewed by the Residential Director to identify the potential need for additional follow up and/or further investigation. At this time, all other incidents have been documented completely. All documentation will be completed, including an agency Incident Report (immediately), BDDS Incident Report (within 24 hours) and a thorough investigation (within 5 days) for all incidents requiring a BDDS reportable. 3. The Residential Manager will receive documented training by the Group Home Administrator on the requirements of incident reporting and incident investigation documentation including the requirement to complete a BDDS report within 24 hours of the incident. The group home investigation/reporting policy has been reviewed to ensure it is current and reflective of the regulatory standards.4. All incidents requiring an investigation will be reported to the Residential Manager, Residential Director and Group Home Administrator immediately following the incidents occurrence. The initial investigation will begin immediately in the form of an Agency Incident Report. Additional information will be gathered within 24 hours of the incidents occurrence and reported to the Bureau of Developmental Disabilities. The</p>		

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			Residential Manager and Residential Director will also complete a documented investigation including a summary for submission to the Group Home Administrator within 5 working days of the incident.5. Date Systemic changes will be completed: February 19, 2012	
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W0154	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 1 of 6 facility investigations of reportable incidents (alleged neglect, client #1) reviewed to ensure all allegations were thoroughly investigated.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 1/18/12 at 10:07a.m. The incident report review indicated the following:</p> <p>An incident report dated 10/29/11 indicated client #1 had eloped from the facility. The incident report indicated staff had used a basket hold and physical escort restraint on client #1. The incident report indicated client #1 had kicked out a window in the van. The incident report indicated staff #2 had been involved with the elopement incident and with the implementation of client restraint. The incident investigation report indicated staff #2 (whom had been involved in the incident) had done/completed the facility investigation of the elopement and staff interventions.</p> <p>Interview of staff #1 on 1/19/12 at 11:02a.m. indicated the facility failed to</p>	W0154	<p>W154-483.420(d) (3) Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated. 1. Damar Services, Inc. has completed and documented a thorough investigation of the incident involving client #1 on 1/24/12. The Group Home Investigation form was revised in 1/12 to include the following statement "If you were a person directly involved in this incident STOP and seek out the next appropriate person to complete the investigation and investigation form"</p> <p>2. Incident reports from the home have been reviewed by the QMRP to identify the potential need for additional follow up and/or further investigation. At this time, all other incidents have been documented completely. All documentation will be completed, including an agency Incident Report (immediately), BDDS Incident Report (within 24 hours) and a through investigation (within 5 days) for all incidents requiring a BDDS reportable. The Group Home Investigation form has been revised to call attention to the person investigating the incident that if you are involved you are to stop and refer the investigation to the next appropriate person for</p>	02/19/2012			

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	<p>complete a thorough investigation of the 10/29/11 incident. Staff #1 indicated the facility staff (staff #2) involved in the incident should not have been the facility staff used to conduct the investigation of the 10/29/11 allegation of neglect.</p> <p>9-3-2(a)</p>		<p>completions. The form was revised in 1/2012.</p> <p>3. The Residential Manager and QMRP will receive documented training by the Group Home Administrator on the requirements of incident reporting and incident investigation documentation including the requirement to complete a thoroughly documented investigation within 5 working days of the incident by someone not involved in the incident. The Group Home Incident Investigation form has been revised to ensure complete and thorough investigations are performed and completed by the correct person. The group home investigation/reporting policy has been reviewed to ensure it is current and reflective of the regulatory standards.</p> <p>4. All incidents requiring an investigation will be reported to the Residential Manager, Residential Director and Group Home Administrator immediately following the incidents occurrence. The initial investigation will begin immediately in the form of an Agency Incident Report. Additional information will be gathered within 24 hours of the incidents occurrence and reported to the Bureau of Developmental Disabilities. The Residential Manager and Residential Director or an assigned designee who was not</p>		

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			involved in the incident will be responsible for completing the documented investigation including a summary for submission to the Group Home Administrator within 5 working days of the incident. 5. Date Systemic changes will be completed: February 19, 2012		

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W0159	<p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 4 sampled clients (#1, #2), the Qualified Mental Retardation Professional (QMRP) failed to monitor clients' programs in regard to ensuring: client visitation recommendations were addressed (client #1) and client #2 was assisted with acquiring a personal identity card to aid client #2 with cashing personal checks.</p> <p>Findings include:</p> <p>1. Record review for client #1 was done on 1/19/12 at 8:32a.m. Client #1 had a 12/2/11 interdisciplinary team meeting (IDT) to address an incident of an allegation made by client #1's family against client #1. The IDT indicated the facility would look at a possible plan to put in place once the investigation was completed for client #1 in regards to family visits. The IDT indicated the plan would include safeguards to protect client #1 from another allegation being made against him and would be in place before client #1 visited family again. Client #1's 1/30/11 individual support plan (ISP) did not address client #1's family visits.</p> <p>Staff #1 was interviewed on 1/19/11 at</p>	W0159	<p>W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated, and monitored by a qualified mental retardation professional.</p> <p>1. A Safety plan was written for Client #1 on 1/23/12 and has been reviewed with client #1 and his parents and approved by the Human Rights committee. A bank account was opened for Client #2 on 2/2/12 and all checks that were on hand have been deposited into this account 2. The Residential Manager will review all clients at the Main Street Group Home charts and ISP/BSP to ensure that any clients in need of a safety plan have one in place. The Residential Director will review all client financial records and ensure that any client receiving benefits from the state have a bank account opened and that those checks are being deposited into the account as received monthly.</p> <p>3. The Residential Director will provide documented training to the Residential Manager on ensuring that each client within the home receiving benefits from the State have a bank account opened as soon as benefit checks begin to be received.</p>	02/19/2012			

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	<p>11:02a.m. Staff #1 indicated the IDT had not met to put in place a plan to address client #1's family visits.</p> <p>2. Record review of client finances entrusted to the facility was done on 1/19/12 at 10:16a.m. Client #2 had uncashed government checks in his financial file kept locked in the facility office. Client #2 had checks dated 9/28/11, 10/3/11, 11/11/11, 12/11 and 12/30/11 for \$30 each.</p> <p>Staff #2 was interviewed on 1/19/12 at 10:16a.m. Staff #2 indicated client #2 had uncashed personal checks going back to 9/11 due to client #2 not having a personal identity card. Staff #2 indicated client #2 had not had an identity card since 9/11 and needed assistance with getting a card.</p> <p>9-3-3(a)</p>		<p>The Residential Manager and Residential Director will review all clients' charts/ISP's monthly to ensure that they are meeting the current needs of the clients and to assess if there is a need for any additions or modifications to be made to the plans.</p> <p>4. The Residential Manager and Residential Director will review all clients' charts/ISP's monthly to ensure that they are meeting the current needs of the clients and to assess if there is a need for any additions or modifications to be made to the plans.</p> <p>The Residential Director will review all clients financials upon admission and ongoing to ensure that any client receiving benefits from the state have a bank account opened and that those checks are being deposited into the account as received monthly. 5. Date Systemic changes will be completed: February 19, 2012</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0371	<p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (#1) to provide client #1 with a medication administration training program.</p> <p>Findings include:</p> <p>The record of client #1 was reviewed on 1/19/12 at 8:32a.m. Client #1's 1/30/11 individual support plan (ISP) indicated client #1 received the medication Seroquel for behaviors and he did not have a training program in place to address the administration of the medication. The ISP indicated client #1 was unable to self-medicate due to a lack of knowledge of medications.</p> <p>Interview on 11/19/12 at 11:02a.m. of professional staff #1, indicated client #1 was in need of medication administration training and did not have training in place at this time.</p> <p>9-3-6(a)</p>	W0371	<p>W371 483.460(k) (4) Drug Administration The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. 1. Client # 1's annual ISP/BSP was held on 1/30/12. A medication administration goal/outcome was added to client #1 ISP to ensure adequate training for medication administration was being implemented.</p> <p>2. All clients ISP/BSP will be reviewed by the Residential Director and Group Home Manager to ensure that there is a goal for medication administration in each residents Individual Support Plan within the Group Home. Any plan that needs to be revised due to not having a medication administration goal will be revised immediately. All Individual Support Plans will be revised at least annually for each client at the group home to address their individualized needs.</p> <p>3. The Residential Director will</p>	02/19/2012			

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			<p>provide documented training to the Group Home Manager on reviewing and addressing the individual needs of clients, per their ISP/BSP, when they have needs such as addendums of ISP/BSP to address certain needs or goals.</p> <p>4. The Residential Director will be responsible for ensuring that all goals are current and up to date with each client's individual needs. The Residential Director will ensure any concerns are addressed for new goals or any safety and well-being issues of the clients at the group home.</p> <p>5. Systemic changes will be completed by: February 19, 2012</p>	