

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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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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W 0000 Bldg. 00	<p>This visit was for an extended recertification and state licensure survey.</p> <p>Survey Dates: April 21, 22, 23, 27, 2015</p> <p>Facility Number: 000629 Aim Number: 100239570 Provider Number: 15G088</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 6 of 6 clients (#1, #2, #3, #4, #5, #6) residing in the facility, the facility's governing body failed to exercise general policy and operating direction over the facility in regards to ensuring the clients received sufficient supervision to provide for identified supervision needs and to provide a safe and clean environment.</p>	W 0104	<p>1.Back screen door will be replaced by 5.22.15;Deck spindles have been replaced on 5.6.2015 Ceiling tiles and grid in bathroom havebeen replaced on 5/18/2015 – hole in wall will be patched and repainted by5.22.15 and upstairs bathroom door has been replaced.</p> <p>2.All Group Homes work orders will be reviewed andoutstanding jobs will be completed.</p>	05/27/2015

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>Findings include:</p> <p>1. An observation of clients #1, #2, #3, #5 and #6 (at the group home) was done on 4/21/15 from 3:49p.m. to 6:04p.m. The observation included the following environmental condition: the back screen door was bent and had the window broken out; the back deck had several missing side wall spindles; the downstairs bathroom had out of place ceiling tiles and rusted metal braces on the ceiling tile and had a large hole in the wall approximately 4 inches x (by) 6 inches; the upstairs bathroom had paint coming off the wall and the door had a large piece of plywood over a hole.</p> <p>Interview of staff #1 on 4/23/15 at 1:17p.m. indicated the bathrooms were in need of remodeling and painting. Staff #1 indicated the the back screen door had been broken since 3/30/15. Staff #1 indicated a work order had been requested for the door. Staff #1 indicated painting had been requested but had no idea when it would be done as requests go to a facility wide list and are prioritized by the facility maintenance department.</p> <p>2. Please see W149. The facility's governing body failed to implement</p>		<p>3. Works orders submitted by staff are reviewed by Maintenance Manager and placed into categories based on client safety and environmental damage. Urgent orders must be addressed within the closing of the day or 24 hours. These orders are also scan and communicated to the Maintenance Manager. Response of the plan should immediately follow. Prompt orders are to be done as soon as possible once any needed material and/or equipment is secured; others work orders are to be complete as soon as possible but must be completed within the month. Maintenance staff members complete a house maintenance/environmental checklist monthly (roughly during last week of month).</p> <p>4. Daily environmental house checks are completed by staff and reviewed by Residential Manager before submitting to Dir. Of Maintenance. Work orders that have been submitted for a concern area are indicated on the house check form but additional work orders may still be submitted. Additional Maintenance staff members will be hired and/or work will be contracted out to ensure timely completion of work orders.</p>		

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W 0122 Bldg. 00	<p>written policy and procedures to provide services (supervision) to prevent neglect of clients #1, #2, #3, #4, #5, #6.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed for 6 of 6 clients (#1, #2, ##3, #4, #5, #6, #7) residing in the facility, to meet the Condition of Participation: Client Protections by: failing to implement written policy and procedure to ensure a sufficient number of direct care staff worked at the facility to supervise and monitor client behavior to prevent neglect and to prevent reoccurrence.</p> <p>Findings include:</p> <p>See W149. The facility failed to implement written policy and procedures to prevent neglect of clients #1, #2, #3, #4, #5 and #6 in regards to ensuring sufficient staffing at the facility to</p>	W 0122	<p>1.Damar Services, Inc. has a written Policy and Procedures in placefor reporting incidents to Governing Bodies (BDDS). Residential Manager willensure a complete investigation occurs within the 5 day requirement. Dir. Of Group Home will ensure that acomplete and thorough investigation isdone if the Residential Manager is involved. The staffing pattern has beenadjusted to ensure two staff members are working when more than 3 resident areawake. Effective immediately - 1stshift is 6am – 2:00pm (was 7:00am – 3:00pm); 3rd shift continues tobe 11pm – 7am. One resident wakes up at5:30am. Two more residents awake at6:00am. The remaining two awake at 6:30am. The client that requires being in eye sight is assigned to</p>	05/27/2015

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	<p>provide monitoring and supervision of client behavior.</p> <p>See W154. The facility failed to ensure a thorough investigation was documented in regards to an incident of sufficient staff supervision to provide identified client supervision for clients #1, #2, #4 and #5.</p> <p>See W156. The facility failed to ensure investigation results of allegations of abuse/neglect for clients #1, #2, #4 and #5 were completed within 5 working days from the date of the incident.</p> <p>9-3-2(a)</p>		<p>the 1stshift beginning at 6:00am. Two residentsleave for school before 7:00am.</p> <p>2.All Residential Manager and LeadStaff have been retrained on the policy and how to implement. Emphasis placed on</p> <ol style="list-style-type: none"> 1. Identifying reportable incidents 2. Requirements of timely investigation and who implements 3. Initiation investigation and documentation of allegations made 4. Responsibility of investigation and reporting of incidents occurring at other locations <p>3. The agency policy regarding Incidents Reporting to governing bodies has been reviewed to ensure it complies with State and Federal regulations. Documented retraining for all Residential Manager and Lead Staff will receive from the Director of Group Home Additional review by Dir. of Group Home during weekly incident report review meeting will be done to ensure investigation is completed and submitted with all incidents.</p> <p>4. All reportable incidents investigations will occur as directed by agency policy regarding Incidents Reporting. All Incident Reports, BDDS reportable and investigation are reviewed weekly by IDT and member of Quality Assurance team (PQI).</p>		

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W 0137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (#1, #2) and 2 additional clients (#5, #6), the facility failed to ensure the clients had the right to keep/maintain their own personal hygiene items.</p> <p>Findings include:</p> <p>An observation was done on 4/22/15 from 6:02a.m. to 7:58a.m. at the group home. At 6:07a.m., on the dining room table, there were small medicine cups of prepared body wash and mouth wash. On the dining room table, there was also a can of deodorant and a plastic container</p>	W 0137	<p>Documentations are reviewed for severity and trends and plans developed to addressed. Dir. of Group Homes will ensure weekly that all allegations have been investigated and documented.</p> <p>1. All Clients have received their individual hygiene box. Basic hygiene material is kept in each box.</p> <p>2. All Residential Managers will review homes to ensure individuals have personal hygiene boxes and are not locked unless stated in ones ISP/BSP.</p> <p>3. All Residential Managers and staff member have been trained on resident rights and how to ensure they are in place. Emphasis placed on</p> <ul style="list-style-type: none"> · Right to hold personal possessions · Rights to be provided with formal or informally training on skills not custodial care · Expectation of staff 	05/27/2015

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	<p>with clients #1, #2, #5 and #6's toothbrushes and one tube of toothpaste stored in it. Clients #1, #2, #5 and #6 were observed to use the same can of deodorant, get their tooth brush and put toothpaste on it at the dining room table and get a mouth wash container. Staff #4 was interviewed on 4/22/15 at 7:22a.m. Staff #4 indicated the mouth wash, deodorant, toothbrushes and body wash were kept in the locked staff office. Staff #4 indicated the items were locked to make sure the clients would get the right amount. Staff #4 indicated client #3 kept his own hygiene supplies in his bedroom. Staff #4 indicated only staff had a key to the office.</p> <p>Record review for client #1 was done on 4/23/15 at 11:40a.m. Client #1's 9/12/14 individual support plan (ISP) did not indicate client #1's personal hygiene container would be kept locked in the office. Client #1 had no training program to address the locked personal hygiene items.</p> <p>Record review for client #2 was done on 4/23/15 at 12:44p.m. Client #2's 10/14/14 ISP did not indicate client #2's personal hygiene container would be kept locked in the office. Client #2 had no training program to address the locked personal hygiene items.</p>		<p>responsibility to ensure dignity is upheld (hygiene acceptable, clothing fits and not torn)</p> <p>4. All staff within all Group Home were received training during the <i>May 19th program meeting</i> regarding residents rights and how to ensure they are in place (see above) <i>At least one time weekly</i>, Residential Manager, Lead staff and/or Dir. of Group Home will monitor staff's interaction to ensure client rights are being upheld. Any concerns during ones observations will be immediately addressed with staff by retraining and/or modeling of correct behaviors. Concerns during observations may be reviewed and communicated by utilizing several different documentations if warrant:</p> <p>1. Employee Performance Report - completed for any repeat offenders of not showing ability to uphold client rights. Plan may state how to correct actions; training needed and a criteria of performance level expected. Corrective action may include a written warning and/or termination for those failing to comply.</p> <p>Positive Employee Performance report may be completed too to reinforce excellent or positive work performance.</p> <p>2. Staff Memo's – may be completed when overall staffs are demonstrating a need to improve a behavior or to reinforce</p>	

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W 0149 Bldg. 00	<p>Staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated the clients did not have nor did they need a training program to address the locked personal hygiene items. Staff #1 indicated the personal hygiene items should not have been kept locked in the group home office.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review, the facility failed for 2 of 4 allegations of client neglect reviewed, to implement policy and procedures to prevent neglect (failure to provide identified services) (#1, #2, #3, #4, #5, #6) which resulted in client injury (#5) and to ensure the facility completed thorough investigations of alleged neglect and completed the investigations within 5 working days.</p>	W 0149	<p>and encourage positive work performance.</p> <p>3. Yearly evaluations - with on staff's yearly evaluation. Knowing and ensuring client rights are upheld is one of the many work behavior scored on each evaluations. Those receiving a poor rating may be required to receive retraining by a deadline date. Those receiving good or excellent ratings (in all areas) will be compensated with a greater percentage of increase.</p> <p>4. Staff Annual require training – annually (during January) all staff are required to receive new and/or dated training on many areas such as, new policies, new procedures, client rights, nutritional training and others.</p> <p>1. Damar Services, Inc. has a written Policy and Procedures in place for reporting and investigating abuse, neglect and mistreatment of clients. This policy follows the requirements established by BDDS. Residential Manager and Lead Staff have been retrained on the policy and how to implement. Emphasis placed on · Identifying reportable incidents · Requirements of timely</p>	05/27/2015

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	<p>Findings include:</p> <p>Record review of the facility's incident reports/investigations was done on 4/22/15 at 10:28a.m.</p> <p>(1) An incident report on 4/11/15 indicated clients #1, #2, #4 and #5 were outside with one staff and another staff was in the house with clients #3 and #6. The report indicated the one staff outside needed to use the restroom and went inside to tell the other staff to cover for him outside. The report indicated the staff said there were no issues when he went inside. This left the clients outside unsupervised. The report indicated after the staff went inside "almost immediately" client #1 came in and reported client #4 was having a behavior. The report indicated staff went outside and found client #4 with a belt in his hand. The report indicated client #5 was hit on the back with the belt before staff were able to intervene. Client #5 had a raised reddened area on his back. There was no formal documented investigation with documented interviews of staff and clients involved.</p> <p>(2) Client #1 had an inappropriate sexual incident report on 2/12/15. The report indicated an investigation had begun on</p>		<p>investigationand who implements</p> <ul style="list-style-type: none"> ·Initiation investigation and documentation of allegations made ·Responsibility of investigation and reporting of incidents occurring at otherlocations ·Timely reporting of an incident asrequired within 15 minutes of incident. ·Chain of command to report ifResidential Manager cannot be reached ·Completion of Incident Repot by endof shift ·Submitting and securing administration signature at completion ofinvestigation <p>Staffing shifts have beenrevised to ensure at least two staff members are on duty when more than threeclients are present. The investigation hasbeen completed and documented along with administration signature.</p> <p>1.All staff has received trainingduring program meeting regarding staff/client ratio; documentation; completingincident reports and individual behavior plans. Emphasis was placed on client #1 plan. Clarification was given when in eye sight and/or arm distance from staff.</p> <p>2.All Resident managers have beentraining on importance of timely investigation and reporting</p>	

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	<p>2/12/15. The investigation summary was undated and there was no indication when the summary report was sent to the administrator.</p> <p>An observation was done at the group home on 4/22/15 from 6:02a.m. to 7:58a.m. During the observation from 6:02a.m. to 7:34a.m. there was one staff on duty to supervise clients #1, #2, #3, #5 and #6. Client #1 was observed to receive his medication at 6:02a.m. Client #1 was observed to move throughout the downstairs areas: kitchen, dining room, living room and bathroom without constant staff monitoring (line of sight). The one staff on duty was observed to stay around the dining room and medication room (was part of the dining room area). Staff #4 was in the medication room and passed medication to client #3 at 6:24a.m. Staff #4 monitored the clients getting personal hygiene items that were kept on the dining room table. At 7:15a.m. client #1 went to front of the house and got the mail and brought it to the dining room. A second staff came on duty at 7:34a.m.</p> <p>Record review for client #1 was done on 4/23/15 at 11:40a.m. Client #1 had a 2/12/15 behavior support plan (BSP) addendum. The BSP indicated client #1 was to have an assigned staff to monitor</p>		<p>incidents (seenu number one).</p> <p>4. All Incident Reports, BDS reportable and investigation are reviewed weekly by IDT and member of Quality Assurance team (PQI). Documentations are reviewed for severity and trends and plans developed to address. Dir. of Group Home has developed a checklist to ensure all components of a report are completed before submitted</p>	

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	<p>him (line of sight) at all times for sexual maladaptive behavior.</p> <p>The facility's policy and procedures were reviewed on 4/27/15 at 12:30p.m. The facility's 11/1/11 policy and procedure "Abuse and Neglect of Children and Adults" indicated the "highest priority is to ensure safety and to protect the well being and human rights of all clients in care." The policy defined Neglect as : "the failure of a caregiver to provide an endangered adult with adequate food, clothing, shelter, medical care or supervision." The policy indicated "investigations of abuse/neglect are coordinated through or arranged by the Vice President of Programs and Services and will be completed within five days of the reported incident. The Vice President of Programs and Services is responsible for informing the President and COO, and when directed by the President and COO, the Chairman and CEO and the Board of Directors of abuse incidents, reports, and/or dispositions of investigations.</p> <p>Professional staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated there should have been 2 staff on duty during the morning on 4/22/15, starting at 6a.m., to assist with medication pass, bathing/toileting, dining and</p>			

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	<p>programming. Staff #1 indicated client #1 was to be kept in line of sight per his current behavior support plan. Staff #1 indicated during the incident on 4/11/15, the staff outside with the clients, even though it was short time, should not have left the clients unsupervised outside. Staff #1 indicated the staff should have sent a client in to get the other staff to come out with the clients (which included client #1). Staff #1 indicated they had conducted an investigation on 4/12/15. Staff #1 indicated interviews had been done but there were no documented client and staff interviews for the 4/11/15 alleged neglect incident. Staff #1 also indicated there was no documentation to indicate the 2/12/15 and 4/12/15 investigations had been completed within 5 working days.</p> <p>Please see W186. The facility failed to ensure sufficient staffing at the facility to provide monitoring and supervision of client behavior (clients #1, #2, #3, #4, #5 and #6).</p> <p>9-3-2(a)</p>			

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W 0154 Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed for 1 of 4 reported incidents of alleged abuse/neglect (supervision of clients #1, #2, #4, #5) to ensure that all allegations were thoroughly investigated.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports/investigations was done on 4/22/15 at 10:28a.m. An incident report on 4/11/15 indicated clients #1, #2, #4 and #5 were outside with one staff and another staff was in the house with clients #3 and #6. The report indicated the one staff outside needed to use the restroom and went inside to tell the other staff to cover for him outside. The report indicated the staff said there were no issues when he went inside. This left the clients outside unsupervised. The report indicated after the staff went inside "almost immediately" client #1 came in and reported client #4 was having a behavior. The report indicated staff went outside and found client #4 with a belt in</p>	W 0154	<p>1.DamarServices, Inc. has a written Policy and Procedures in place for IncidentsReporting to Governing Bodies (BDDS). Residential Manager will ensure acomplete investigation occurs within the 5 day requirement. Dir. Of Group Home will ensure that acomplete and thorough investigation is done if the Residential Manager isinvolved in incident. Incident notedduring survey has a complete documented investigation.</p> <p>2. All Residential Manager and Lead Staff havebeen retrained on the policy and how to implement. Emphasis placed on</p> <ol style="list-style-type: none"> 1. Identifying reportable incidents 2. Requirements of timely investigation and who implements 3. Initiation investigation anddocumentation of allegations made 4. Responsibility of investigation and reporting of incidents occurring at other locations <p>3. Theagency policy regarding Incidents Reporting to governing bodies has beenreviewed to ensure it complies with State and</p>	05/27/2015

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 04/27/2015
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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W 0156 Bldg. 00	<p>his hand. The report indicated client #5 was hit on the back with the belt before staff were able to intervene. The report indicated client #5 had a raised reddened area on his back. There was no formal documented investigation with documented interviews of staff and clients involved.</p> <p>Professional staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated they had conducted an investigation on 4/12/15. Staff #1 indicated interviews had been done but there were no documented client and staff interviews for the 4/11/15 alleged neglect incident.</p> <p>9-3-2(a)</p> <p>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. Based on record review and interview, the facility failed for 2 of 4 reportable incident investigations reviewed to</p>	W 0156	<p>Federal regulations. Additional review by Dir. of Group Homeduring weekly incident report review meeting will be done to ensure investigation is completed and submitted with all incidents.</p> <p>4.Allreportable incidents investigationswill occur as directed by agency policy regarding Incidents Reporting. AllIncident Reports, BDDS reportable and investigation are reviewed weekly by IDTand member of Quality Assurance team (PQI). Documentations are reviewed for severity and trends and plans developedto addressed. Dir. of Group Homes will ensure weekly that all allegations havebeen investigated and documented.</p> <p>1.DamarServices, Inc. has a written Policy and Procedures in place for IncidentsReporting to Governing Bodies (BDDS).</p>	05/27/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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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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	<p>ensure reportable incident investigation results were reported to the administrator within five working days.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports/investigations was done on 4/22/15 at 10:28a.m.</p> <p>(1) Client #1 had an inappropriate sexual incident report on 2/12/15. The report indicated an investigation had begun on 2/12/15. The investigation summary was undated and there was no indication when the summary report was sent to the administrator.</p> <p>(2) An incident report on 4/11/15 indicated clients #1, #2, #4 and #5 were outside with one staff and another staff was in the house with clients #3 and #6. The report indicated the one staff outside needed to use the restroom and went inside to tell the other staff to cover for him outside. The report indicated the staff said there were no issues when he went inside. This left the clients outside unsupervised. The report indicated after the staff went inside "almost immediately" client #1 came in and reported client #4 was having a behavior. The report indicated staff went outside and found client #4 with a belt in his</p>		<p>Residential Manager will ensure acomplete investigation occurs within the 5 day requirement. Dir. Of Group Home will ensure that acomplete and thorough investigation is done if the Residential Manager isinvolved in incident. Incident notedduring survey has a complete documented investigation.</p> <p>2. All Residential Manager and Lead Staff havebeen retrained on the policy and how to implement. Emphasis placed on</p> <p>3. Identifying reportable incidents</p> <p>4. Requirements of timely investigation and who implements</p> <p>5. Initiation investigation anddocumentation of allegations made</p> <p>6. Responsibility of investigation and reporting of incidents occurring at other locations</p> <p>7. Theagency policy regarding Incidents Reporting to governing bodies has beenreviewed to ensure it complies with State and Federal regulations. Additional review by Dir. of Group Homeduring weekly incident repot review meeting will be done to ensureinvestigation is completed and submitted with all incidents.</p> <p>8. Allreportable incidents investigationswill occur as directed by agency policy regarding Incidents Reporting. AllIncident Reports, BDDS reportable and investigation are reviewed weekly by IDTand</p>	

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 04/27/2015	
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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	<p>hand. The report indicated client #5 was hit on the back with the belt before staff were able to intervene. The investigation was documented to have begun on 4/12/15. There was no documentation the investigation results/summary was submitted to the administrator in 5 working days.</p> <p>Professional staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated the investigation for the 2/12/15 incident had begun on 2/12/15 and the 4/11/15 incident investigation had begun on 4/12/15. Staff #1 indicated there was no documentation of the completion date (sent to administrator) for either investigation. Staff #1 indicated the investigation documentation does not indicate the investigations were completed in 5 working days.</p> <p>9-3-2(a)</p>		<p>member of Quality Assurance team (PQI). Documentations are reviewed for severity and trends and plans developed to address. Dir. of Group Homes will ensure weekly that all allegations have been investigated and documented.</p>				
W 0186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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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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	<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, record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, #3) and three non-sample clients (#4, #5, #6) to ensure a sufficient number of direct care staff worked in the home to supervise and manage the clients to meet their needs.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports/investigations was done on 4/22/15 at 10:28a.m. (1) Client #1 had an inappropriate sexual incident report on 2/12/15. The report indicated client #1 was put on constant staff supervision with an assigned staff to be in line of sight of client #1. (2) an incident report on 4/11/15 indicated clients #1, #2, #4 and #5 were outside with one staff while another staff was in the house with clients #3 and #6. The report indicated the one staff outside needed to use the restroom and went inside to tell the other staff to cover for him outside. The report indicated the staff said there were no issues when he went inside. This left the clients outside unsupervised. The report indicated after the staff went inside "almost immediately" client #1 came in</p>	W 0186	<p>1.The staffing pattern has beenadjusted to ensure two staff members are working when more than 3 resident areawake. Effective immediately - 1stshift is 6am – 2:00pm (was 7:00am – 3:00pm); 3rd shift continues tobe 11pm – 7am. One resident wakes up at5:30am. Two more residents awake at6:00am. The remaining two awake at 6:30am. The client that requires being in eye sight is assigned to the 1stshift beginning at 6:00am. Two residentsleave for school before 7:00am.</p> <p>A complete investigationhas been concluded. Disciplinary actionand retraining has occurred with involved staff member</p> <p>1. All homes staffing pattern have been reviewed toensure adequate client/staff ratio is in place. Residential Managers and Dir. Of Group home have review all ISP/BSP toensure all items within ones plan are available and staffing is in place tomeet the needs.</p> <p>2.Overall review of staffing pattern inconjunction with program needs will be reviewed quarterly with Vice Presidentof Programs. An additional "float"position has been added to the staffing. Staffing needs</p>	05/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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	<p>and reported client #4 was having a behavior. The report indicated staff went outside and found client #4 with a belt in his hand. The report indicated client #5 was hit on the back with the belt before staff were able to intervene.</p> <p>An observation was done at the group home on 4/22/15 from 6:02a.m. to 7:58a.m. During the observation from 6:02a.m. to 7:34a.m. there was one staff on duty to supervise clients #1, #2, #3, #5 and #6. Client #1 was observed to receive his medication at 6:02a.m. Client #1 was observed to move throughout the downstairs areas: kitchen, dining room, living room and bathroom without constant staff monitoring (line of sight). The one staff on duty was observed to stay around the dining room and medication room (was part of the dining room area). Staff #4 was in the medication room and passed medication to client #3 at 6:24a.m. Staff #4 monitored the clients getting personal hygiene items that were kept on the dining room table. At 7:15a.m. client #1 went to front of the house and got the mail and brought it to the dining room. A second staff came on duty at 7:34a.m.</p> <p>Professional staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated there should have been 2 staff on duty</p>		<p>revisions due to behavioral needs will be done ongoing when required and approved by Vice President of Program.</p> <p>3.All Incident Reports, BDS reportable and investigation are reviewed weekly by IDT and member of Quality Assurance team (PQI). Documentations are reviewed for severity and trends and plans developed to address. In addition, staffing levels will now be reviewed within incidents such as but not limited to physical aggression, property destruction, elopement and inappropriate sexual behaviors</p>	

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 04/27/2015
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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W 0249 Bldg. 00	<p>during the morning on 4/22/15, starting at 6a.m., to assist with medication pass, bathing/toileting, dining and programming. Staff #1 indicated client #1 was to be kept in line of sight per his current behavior support plan. Staff #1 indicated during the incident on 4/11/15, the staff outside with the clients, even though it was short time, should not have left the clients unsupervised outside. Staff #1 indicated the staff should have sent a client in to get the other staff to come out with the clients (which included client #1).</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#1) to ensure the client's identified behavior (#1) training program</p>	W 0249	1.1. The staffing pattern has been adjusted to ensure two staff members are working when more than 3 resident area awake. Effective immediately - 1stshift is	05/27/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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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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	<p>was implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done at the group home on 4/22/15 from 6:02a.m. to 7:58a.m. During the observation from 6:02a.m. to 7:34a.m. there was one staff on duty to supervise clients #1, #2, #3, #5 and #6. Client #1 was observed to receive his medication at 6:02a.m. Client #1 was observed to move throughout the downstairs areas: kitchen, dining room, living room and bathroom without constant staff monitoring (line of sight). The one staff on duty was observed to stay around the dining room and medication room (was part of the dining room area). Staff #4 was in the medication room and passed medication to client #3 at 6:24a.m. Staff #4 monitored the clients getting personal hygiene items that were kept on the dining room table. At 7:15a.m. client #1 went to front of the house and got the mail and brought it to the dining room. A second staff came on duty at 7:34a.m.</p> <p>Record review for client #1 was done on 4/23/15 at 11:40a.m. Client #1 had a 2/12/15 behavior support plan (BSP) addendum. The BSP indicated client #1 was to have an assigned staff to monitor</p>		<p>6am – 2:00pm (was 7:00am – 3:00pm); 3rd shift continues to be 11pm – 7am. Staff is assigned to monitor the client in 4 hour shifts – documentation of staff assigned is completed on the sheet daily. Furthermore, the guidelines have been revised to included new monitoring strategies such as:</p> <ul style="list-style-type: none"> ·Resident must be in front seat when riding with others in van ·Resident must be within arm distance if in a room with others ·Resident must by directly by staff when in a store ·Resident must be monitor while in his bed room – cease 10minutes checks ·Residents may not sleep in bed room if window sensor and/oralarms are not working. Work order mustbe completed and alert Resident Manager if not fixed within 24 hours. Resident will sleep in living room area andremain in staff vision throughout the night. ·2. All homesstaffing pattern have been reviewed to ensure adequate client/staff ratio is inplace. Residential Managers and Dir. Of Group home have review all ISP/BSPto ensure all items within ones plan are available and staffing ratio is in placeto meet the needs. 3. Overall review of staffing pattern in conjunctionwith program needs will be reviewed quarterly with Vice President of 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/27/2015
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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W 0460 Bldg. 00	<p>him (line of sight) at all times for sexual maladaptive behavior.</p> <p>Professional staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated client #1 was to have an assigned staff and be kept in line of sight per his current BSP. Staff #1 indicated client #1's BSP training program should have been implemented during the morning before he left for school.</p> <p>9-3-4(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, #3) and 2 non-sampled clients (#5, #6) to ensure the clients received all the menued items at mealtime.</p> <p>Findings include:</p> <p>An observation was done at the group home on 4/21/15 from 3:49p.m. to 6:04p.m. Clients #1, #2, #3, #5 and #6</p>	W 0460	<p>Programs. An additional "float" position has been added to the staffing. Staffing needs revisions due to behavioral needs will be done ongoing when required and approved by Vice President of Program.</p> <p>4. All Incident Reports, BDDS reportable and investigation are reviewed weekly by IDT and member of Quality Assurance team (PQI). Documentations are reviewed for severity and trends and plans developed to address. In addition, staffing levels will now be reviewed within incidents such as but not limited to physical aggression, property destruction, elopement and inappropriate sexual behaviors</p> <p>1. During the week of the survey, the group home was trying to use the remaining food items available from the <u>three day emergency food supply</u> as, it was time to replenish. Attempt was made to use up the food instead of throwing it out. Therefore, the menu was not being followed but substitution of food items should have been documented and the guidelines for substitution followed. Residential Manager, Lead staff and staff members have been retrained on the</p>	05/27/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>were served a supper which consisted of a grilled cheese sandwich and chicken noodle soup. The facility menu, reviewed on 4/21/15 at 5:32p.m., indicated supper on 4/21/15 was to include Lasagne, corn, fruit (pears). The clients were not offered a vegetable. The clients were not offered pears nor a substitute item for the fruit.</p> <p>Professional staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated the clients should have been offered the menued/diet items or an equal substitute.</p> <p>9-3-8(a)</p>		<p>function of the menu. Emphasis was placed on</p> <ul style="list-style-type: none"> ·Substitution of items (pork for pork; green vegetable with green vegetable, etc.) ·How to document when substitutions occur ·How to complete the menu count ·Importance of having everything on menu present to be offered ·Creating a weekly grocery list based on menu ·Eating family style <p>2. Residential Managers will review the above at all upcoming program meeting as scheduled within each Group Home.</p> <p>1. Monthly all menus are submitted to Dir. Of Dietary for review. Corrections or revisions needed are sent back to the home. Residential Managers review these incident and provide retraining to staff. Quarterly, Dietician reviews all clients plan and makes adjustment if needed. During this time the dietician reviews with staff any new policy or dietary concerns.</p> <p>2. Quarterly all homes receive a review by the dietician and Dir. Of Dietary regarding kitchen cleanliness, food storage and menu documentation. All items out of compliance must be corrected within establish time line. All staff receive annually, Dietary retraining. Items discuss are as listed but not limited to:</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G088	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/27/2015
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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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W 0481 Bldg. 00	<p>483.480(c)(2) MENUS Menus for food actually served must be kept on file for 30 days.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, #3) and 2 non-sampled clients (#5, #6) to ensure the clients received all the menued items at mealtime and the food substitutes that were served to the clients were documented.</p> <p>Findings include:</p> <p>An observation was done at the group home on 4/21/15 from 3:49p.m. to 6:04p.m. Clients #1, #2, #3, #5 and #6 were served a supper which consisted of a grilled cheese sandwich and chicken noodle soup. The facility menu, reviewed on 4/21/15 at 5:32p.m., indicated supper on 4/21/15 was to include Lasagne, corn, fruit (pears). The clients were not offered a vegetable. The clients were not offered pears nor a substitute item for the fruit. The substituted supper items (grilled cheese and chicken noodle soup) were not documented to indicate what the clients were actually served.</p>	W 0481	<p>food preparation, sanitation, portion size, menu substitution, documentation and different types of diets.</p> <p>1. During the week of the survey, the group home was trying to use the remaining food items available from the <u>three day emergency food supply</u> as, it was time to replenish. Attempt was made to use up the food instead of throwing it out. Therefore, the menu was not being followed but substitution of food items should have been documented and the guidelines for substitution followed. Residential Manager, Lead staff and staff members have been retrained on the function of the menu. Emphasis was placed on</p> <ul style="list-style-type: none"> ·Substitution of items (pork for pork; green vegetable with green vegetable, etc.) ·How to document when substitutions occur ·How to complete the menu count ·Importance of having everything on menu present to be offered ·Creating a weekly grocery list based on menu ·Eating family style <p>2. Residential Managers will review the above at all</p>	05/27/2015

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 04/27/2015	
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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	Professional staff #1 was interviewed on 4/23/15 at 1:17p.m. Staff #1 indicated the clients should have been offered the menued/diet items or an equal substitute. Staff #1 indicated all menu changes are to documented. 9-3-8(a)		upcoming program meeting as scheduled within each Group Home. 1. Monthly all menus are submitted to Dir. Of Dietary for review. Corrections or revisions needed are sent back to the home. Residential Managers review these incident and provide retraining to staff. Quarterly, Dietician reviews all clients plan and makes adjustment if needed. During this time the dietician reviews with staff any new policy or dietary concerns. 2. Quarterly all homes receive a review by the dietician and Dir. Of Dietary regarding kitchen cleanliness, food storage and menu documentation. All items out of compliance must be corrected within establish time line. All staff receive annually, Dietary retraining. Items discuss are as listed but not limited to: food preparation, sanitation, portion size, menu substitution, documentation and different types of diets.				