

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  06/10/2015
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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 a post certification revisit (PCR) to the recertification and state licensure survey completed on 4/27/15.</p> <p>Survey Date: June 8, 9, 10, 2015</p> <p>Provider Number: 15G088 Aims Number: 100239570 Facility Number: 000629</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0122  Bldg. 00	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed for 1 of 3 sample clients (#1) residing in the facility, to meet the Condition of Participation: Client Protections by failing to implement written policy and procedure to ensure the facility provided supervision to monitor client behavior (#1) to prevent neglect and to prevent reoccurrence of elopement.</p>	W 0122	<p>1. Client #1 was a fairly new admit to the home and had a great transition displaying relatively low level behaviors. Per history, client #1 had incidents of elopement therefore; window alarms were included upon admission and included in his BSP for precaution measure. Client #1 began to exhibit sexually inappropriate behaviors (acting as the perpetrator) and bedroom door alarms were put in place along with an addendum to</p>	07/10/2015

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>Please see W149. The facility failed to implement written policy and procedures to prevent neglect of client #1 in regards to ensuring the facility provided monitoring and supervision of client behavior.</p> <p>This condition was cited on 4/27/15. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p>		<p>address these behaviors.</p> <p>Included in the addendum was to have client in line of sight always and checking that alarms were in place daily. This was further revised to have client #1 in arm's length of staff when others were present or in the community and ten minutes checks while in bedroom. While sexually maladaptive behaviors and stealing incidents were eliminated – Client #1 began to exhibit incidents of elopement. During the investigation of the first incident – it appears that the staff did not consistently complete ten minutes checks while client was in his bedroom allowing time to elope. This staff no longer works at Damar. Window and door alarms were replaced to prevent tampering by the client. Unfortunately, another elopement occurred. Further revisions were made to his plan to include numerous alarm checks throughout the day and supervision at all times during awake hours. Sleeping downstairs to occur if any alarm was not properly working. On May 28th, meeting with BDDS, DCS caseworker and Damar team was held to discuss concerns. It was recommended and agreed that Client #1 would return to Damar's Main Campus to participate in their "sexually maladaptive youth program" within a secure environment. Anticipated to occur upon next</p>		

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			<p>available opening. On June 10th – additional revisions were made to include one/one supervision at all times including while sleeping. June 16th, the client was admitted to the Damar campus program.</p> <p>2. On Friday, June 19th, an Admission Protocol meeting was held with various programs within Damar to review and revise its admission policy. Discussion was held on but not limited to:</p> <ul style="list-style-type: none"> <li>·Types of maladaptive behaviors unable to be adequately served in community programs</li> <li>·How to provide adequate ICAP information</li> <li>·Need to pass on all historical information</li> <li>·Participation in monthly meeting when client has been accepted to transfer to a community setting</li> </ul> <p>3. All Incident Reports, BDS reportable and investigation are reviewed weekly by IDT and/or members of Quality Assurance team (PQI). Documentations are reviewed for severity and trends and plans developed to address prevention of reoccurrences</p> <p>4 Monthly PQI/Quality Assurance meeting is held to review pertinent information; revise policy if needed and to monitor performance indicators within a program. Monitoring reportable incidents are also reviewed to ensure corrections in place are effective</p>	

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W 0149 Bldg. 00	<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 interview and record review, the facility failed for 2 of 3 allegations of client neglect reviewed, to implement policy and procedures to prevent neglect (failure to provide identified services) (#1) which resulted in client minor injury and theft.</p> <p>Findings include:</p> <p>Record review of the facility's incident reports/investigations was done on 6/9/15 at 10:08a.m.</p> <p>(1) An incident report on 5/16/15 indicated "around 6:30p.m." client #1 had a behavior (argumentative) and was sent to his bedroom to calm down. The report indicated facility staff had done periodical checks on client #1. The report indicated at 7:20p.m. client #1 was discovered to be missing from his bedroom and "the window was slightly open with the window alarm tampered</p>	W 0149	<p>or need for furtherrevision. Indicators scoring below thethreshold must have a POC submitted with 7 days and reviewed for effectiveness atnext meeting.</p> <p>1.As planned, client #1 was discharged from thegroup Home and re-admitted to Damar's main Campus. 2.On Friday, June 19th, an Admission Protocolmeeting was held with various programs within Damar to review and revise itsadmission policy. Discussion was held onbut not limited to: ·Types of maladaptive behaviors unable to be adequatelyserved in community programs ·How to provide adequate ICAP information ·Need to pass on all historical information ·Participation in monthly meeting when client hasbeen accepted to transfer to a community setting 1.All Incident Reports, BDS reportableand investigation are reviewed weekly by IDT and/or members of QualityAssurance team (PQI). Documentations are reviewed for severity and trendsand plans developed to addressed prevention of</p>	07/10/2015

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	<p>with and the roof guttering was bent from a person hanging on it." Police were notified and other facility staff were notified of client #1's elopement and a search had begun for client #1. The client could not be found until 3a.m. when he was located at the facility's main campus. Client #1 was transported back to the group home and slept downstairs with staff supervision. Client #1 was described to have scrapes and scratches on his stomach. The facility's 5/18/15 investigation indicated the staff on duty on 5/16/15 had not done 10 minute bed checks on client #1 (after he had gone to his bedroom at 6:30p.m.) as was indicated by his 2/12/15 behavior plan. The investigation indicated client #1 had eloped through his 2nd floor bedroom window onto the roof and hung from the gutter and dropped himself to the ground.</p> <p>(2) An incident report on 5/23/15 indicated client #1 had eloped from the facility. The report indicated client #1, who on line of (staff) sight supervision when out of his bedroom, had told his assigned staff he needed to use the restroom. The report indicated client #1 used the downstairs bathroom while staff #5 waited outside the restroom. The report indicated staff heard a noise in the bathroom and when they checked on client #1 he had eloped from the facility</p>		<p>reoccurrences. Discussion on appropriate intervention for behaviors such as elopement was held. Clarification was discussed regarding the role of alarms as a warning nota prevention; types of alarms should reflect one's functioning level; need to have ever elopement incident reviewed for revisions and those that are "escaping"(active and thought out plan on how to implement the elopement) should be inline of sight at all times, included sleep time.</p> <p>2. Monthly PQI/Quality Assurance meeting is held to review pertinent information; revise policy if needed and to monitor performance indicators within a program. Monitoring reportable incidents are also reviewed to ensure corrections in place are effective or need for further revision. Indicators scoring below the threshold must have a POC submitted with 7 days and reviewed for effectiveness at next meeting.</p>				

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	<p>through the downstairs bathroom window. The report indicated the elopement protocol was followed and client #1 was returned to the facility by the police who found client #1 on a bicycle. The report indicated client #1 had stolen a bicycle from a neighbor's garage.</p> <p>Record review for client #1 was done on 6/9/15 at 6:47a.m. Client #1 had addendums to his behavior plan on 5/21/15 and on 5/24/15. The behavior plan now included 1 to 1 staffing when out of his bedroom, 5 minute bedroom checks, documentation on each of the functioning door/window alarms and window alarms were added to bathroom windows. A 5/28/15 team meeting note indicated a bed at the main campus building had been acquired for client #1 and he would be moving back to a more secure placement.</p> <p>The facility's policy and procedures were reviewed on 6/9/15 at 2:30p.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,</p>			

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	<p>clothing, shelter, medical care or supervision."</p> <p>Professional staff #1 was interviewed on 6/9/15 at 1:17p.m. Staff #1 indicated the direct care staff person that was assigned to client #1 did not monitor client #1 per his plan (10 minute bedroom checks) on 5/16/15. Staff #1 indicated the staff no longer worked at the agency. Staff #1 indicated client #1's behavior plan had been followed during the 5/23/15 elopement. Staff #1 stated as of 6/9/15 client #1's elopement plan would include 1 to 1 staffing during waking hours, staff were to ensure all alarms are on and working by signing a sheet per each shift, client #1 will sleep downstairs and client #1 would be moving to the facility's main campus "within end of week or sooner."</p> <p>This deficiency was cited on 4/27/15. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p>			