

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G482	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/19/2016
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NAME OF PROVIDER OR SUPPLIER  DAMAR SERVICES INC--CAMBY RD	STREET ADDRESS, CITY, STATE, ZIP CODE 10600 E CR 700 S CAMBY, IN 46113
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W 0000  Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: April 14, 15, 18, 19, 2016</p> <p>Provider Number: 15G482 Aims Number: 100235460 Facility Number: 000996</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/26/16.</p>	W 0000		
W 0124  Bldg. 00	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, #3) to ensure the clients' guardians were informed of cameras installed in the facility common areas.</p>	W 0124	<p>1. The Group Home Manager and QIDP will inform the client's legal guardian of cameras installed in the facility common area. The Group Home Manager and QIDP will include documentation that the legal guardian has been informed of</p>	05/19/2016

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>An observation was done on 4/14/16 at the group home from 3:28p.m. to 5:18p.m. Upon entering the group home there were people (workers) in the group home installing cameras in the common areas of the group home. At 4:12p.m., staff #1 indicated the cameras were being installed in the common areas due to a facility policy/decision a long time ago and they were just now being installed.</p> <p>Client record reviews and interviews at the facility were done on 4/18/16. The cameras were installed in the group home common areas. At 2:38p.m. staff #1 and a person who identified himself as involved with getting the cameras working, were in the facility office. Staff #1 and the technological person both indicated the facility cameras were fully installed and currently working.</p> <p>The record for client #1 was reviewed on 4/18/16 at 11:38a.m. Client #1's 2/18/16 individual support plan (ISP) indicated client #1 had a guardian. Client #1's record did not have any documentation that client #1's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's</p>		<p>the camera installation in the clienttraining chart located in the home. The QIDPwill obtain documentation that the Human Rights Committee has reviewed the useof cameras. This documentation will be kept in the HRCbinder located in the agency's administration office and in each client'straining chart located in the home.</p> <p>2.A review of all client training charts will takeplace and in all 4 group home settings. The Group Home Manager and QIDP will include documentation that thelegal guardian has been informed of the camera installation as well asdocumentation that the HRC has reviewed the use of the cameras for every clientchart that does not have this information completed and available.</p> <p>3.To remain in place, all restrictive items willbe reviewed and approved by the HRC on a yearly basis. Parent or legal guardian approval will beobtained yearly prior to HRC review and prior to introducing any modificationthat is a restriction.</p> <p>4.The QIDP will review all client records andcharts to ensure that items deemed restrictive include written consent from theparent or legal guardian and the Human Rights Committee prior toimplementation. The QIDP will ensurethat all restrictive plans are reviewed and approved by the HRC at leastannually to continue</p>		

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	<p>Human Rights Committee (HRC) had reviewed the use of the cameras.</p> <p>The record for client #2 was reviewed on 4/18/16 at 12:02p.m. Client #2's 8/24/15 ISP indicated client #2 had a guardian. Client #2's record did not have any documentation that client #2's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p> <p>The record for client #3 was reviewed on 4/18/16 at 11:11a.m. Client #3's 9/18/15 ISP indicated client #3 had a guardian. Client #3's record did not have any documentation that client #3's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p> <p>Staff #1 was interviewed on 4/18/16 at 2:38p.m. Staff #1 indicated the cameras located in the common areas of the group home were currently working. Staff #1 indicated there was no documentation client #1, client #2 and client #3's guardians had been informed of the</p>		<p>their use.</p> <p>5.All systemic changes will be completed by5/19/16.</p>	

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W 0154 Bldg. 00	<p>facility's practice to use cameras in the common areas and no documentation of HRC review.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate 2 of 3 incidents reviewed for allegations of (physical aggression) client to client abuse (clients #1, #2, #5).</p> <p>Findings include:</p> <p>Record review of the facility's incident reports was done on 4/14/16 at 1:50p.m. The review included the following incidents for clients #1, #2 and #5:</p> <p>1. An incident report on 2/24/16 indicated client #2 had physically aggressed client #5. The 2/24/16 "Incident Report" indicated client #5 had been talking to a staff and client #2 became upset with client #5 and chased him down the hallway and kicked client #5 in "private area." The report indicated client #5 "denied pain or injury." The report did not have any documented</p>	W 0154	<p>1. On 2/24/16 an incident of physical aggression without injury occurred involving client #2 and #5. On 3/10/16 an incident of physical aggression without injury occurred involving client #1, #2, and #5. Staff #1 was interviewed but there were no documented client interviews although staff #1 stated that he had talked to clients but did not document his interviews. Client #1, #2, and #5 will be interviewed for each incident in which they were involved. The interviews will be documented on our internal witness form and placed in the investigation file.</p> <p>2. A review of agency incident reports dating back 6 months will be completed and if there are any items requiring additional investigation and documentation we will complete it immediately. Moving forward the Damar PQI department will lead and oversee all investigations to ensure thoroughness and</p>	05/19/2016

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W 0159 Bldg. 00	<p>client interviews.</p> <p>2. An incident report on 3/10/16 indicated client #5 was upset it was time to go to school and punched client #1 who had sat by him on the van. Client #2 was sitting in the front seat. Client #2 heard client #5 hit client #1 and client #2 then hit client #5. The report indicated no client injury or client complaints of pain. The report did not have any documented client interviews.</p> <p>Staff #1 was interviewed on 4/18/16 at 1:10pm. Staff #1 indicated there were no documented client interviews for the 2/24/16 and 3/10/16 client to client physical aggression. Staff #1 indicated he had talked to the clients but did not document his interviews.</p> <p>9-3-2(a)</p> <p>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. Based on observation, record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, #3) to ensure each client's active treatment program was coordinated and monitored by the</p>	W 0159	<p>completion.</p> <p>3. The policy for Medicaid Group Home investigations has been updated. Group Home Managers and the QIDP will receive documented training regarding the investigation procedure. The PQI department will take lead over all investigations to ensure that a thorough investigation report is completed (to include documented interviews for all staff and client witnesses).</p> <p>4. PQI has added a new indicator related to critical incidents and investigations for greater oversight and monitoring.</p> <p>5. The systematic changes will be completed by 5/19/16.</p> <p>1. The Group Home Manager and QIDP will inform the client's legal guardian of the facilities practice of using cameras in the homes common areas. The Group Home Manager and QIDP</p>	05/19/2016			

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	<p>facility's qualified intellectual disabilities professional (QIDP), by the QIDP not ensuring the clients' guardians had given written consent for the facility's use of cameras in the common areas of the group home and to ensure the camera use was presented to the facility's Human Rights Committee (HRC).</p> <p>Findings include:</p> <p>An observation was done on 4/14/16 at the group home from 3:28p.m. to 5:18p.m. Upon entering the group home there were people (workers) in the group home installing cameras in the common areas of the group home. At 4:12p.m., staff #1 indicated the cameras were being installed in the common areas due to a facility policy/decision a long time ago and they were just now being installed.</p> <p>Client record reviews and interviews at the facility were done on 4/18/16. The cameras were installed in the group home common areas. At 2:38p.m. staff #1 and a person who identified himself as involved with getting the cameras working, were in the facility office. Staff #1 and the technological person both indicated the facility cameras were fully installed and currently working.</p> <p>The record for client #1 was reviewed on</p>		<p>will include documentation that the legal guardian has been informed of the practice of using cameras in the client training chart located in the home. The QIDP will obtain documentation that the Human Rights Committee has reviewed the use of cameras. This documentation will be kept in the HRC binder located in the agency's administration office and in each client's training chart located in the home.</p> <p>2. A review of all client training charts will take place and in all 4 group home settings. The Group Home Manager and QIDP will include documentation that the legal guardian has been informed of the practice of using cameras in the home as well as documentation that the HRC has reviewed the use of the cameras for every client chart that does not have this information completed and available.</p> <p>3. To remain in place, all restrictive items will be reviewed and approved by the HRC on a yearly basis. Parent or legal guardian approval will be obtained yearly prior to HRC review and prior to introducing any modification that is a restriction.</p> <p>4. The QIDP will review all client records and charts to ensure that items deemed restrictive include written consent from the parent or legal guardian and the Human Rights Committee prior to implementation. The QIDP will ensure that all restrictive plans are</p>				

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	<p>4/18/16 at 11:38a.m. Client #1's 2/18/16 individual support plan (ISP) indicated client #1 had a guardian. Client #1's record did not have any documentation that client #1's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p> <p>The record for client #2 was reviewed on 4/18/16 at 12:02p.m. Client #2's 8/24/15 ISP indicated client #2 had a guardian. Client #2's record did not have any documentation that client #2's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p> <p>The record for client #3 was reviewed on 4/18/16 at 11:11a.m. Client #3's 9/18/15 ISP indicated client #3 had a guardian. Client #3's record did not have any documentation that client #3's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p>		<p>reviewed and approved by the HRC at leastannually to continue their use.</p> <p>5.All systemic changes will be completed by5/19/16.</p>		

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W 0264 Bldg. 00	<p>Professional staff #1 was interviewed on 4/18/16 at 2:38p.m. Staff #1 indicated the cameras located in the common areas of the group home were currently working. Staff #1 indicated there was no documentation client #1, client #2 and client #3's guardians had been informed of the facility's practice to use cameras in the common areas and no documentation of HRC review.</p> <p>9-3-3(a)</p> <p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 5 of 5 clients (#1, #2, #3, #4, #5) residing in the group home, to ensure the use of cameras in the facility's common areas had been presented to and reviewed by the facility's HRC.</p> <p>Findings include:</p>	W 0264	<p>1. The Group Home Manager and QIDP will inform the client's legal guardian of the facility's practice of using cameras in the common areas. The Group Home Manager and QIDP will include documentation that the legal guardian has been informed of the practice of using cameras in the client training chart located in the home. The QIDP will obtain documentation</p>	05/19/2016

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	<p>An observation was done on 4/14/16 at the group home from 3:28p.m. to 5:18p.m. Upon entering the group home there were people in the group home installing cameras in the common areas of the group home. At 4:12p.m., staff #1 indicated the cameras were being installed in the common areas due to a facility policy/decision a long time ago and was just now being installed.</p> <p>Client record reviews and interviews at the facility were done on 4/18/16. The cameras were installed in the group home common areas. At 2:38p.m., staff #1 and a person who identified himself as involved with getting the cameras working, were in the facility office. Staff #1 and the technological person both indicated the facility cameras were fully installed and currently working.</p> <p>The record for client #1 was reviewed on 4/18/16 at 11:38a.m. Client #1's 2/18/16 individual support plan (ISP) indicated client #1 had a guardian. Client #1's record did not have any documentation that client #1's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p>		<p>that the HumanRights Committee has reviewed the use of cameras. This documentation will bekept in the HRC binder located in the agency's administration office and ineach client's training chart located in the home.</p> <p>2.A review of all client training charts will takeplace and in all 4 group home settings. The Group Home Manager and QIDP will include documentation that thelegal guardian has been informed of the practice of using cameras in the home aswell as documentation that the HRC has reviewed the use of the cameras forevery client chart that does not have this information completed andavailable.</p> <p>3.To remain in place, all restrictive items willbe reviewed and approved by the HRC on a yearly basis. Parent or legal guardian approval will beobtained yearly prior to HRC review and prior to introducing any modificationthat is a restriction.</p> <p>4.The QIDP will review all client records andcharts to ensure that items deemed restrictive include written consent from theparent or legal guardian and the Human Rights Committee prior toimplementation. The QIDP will ensurethat all restrictive plans are reviewed and approved by the HRC at leastannually to continue their use.</p> <p>5.All systemic changes will be completed by5/19/16.</p>	

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	<p>The record for client #2 was reviewed on 4/18/16 at 12:02p.m. Client #2's 8/24/15 ISP indicated client #2 had a guardian. Client #2's record did not have any documentation that client #2's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p> <p>The record for client #3 was reviewed on 4/18/16 at 11:11a.m. Client #3's 9/18/15 ISP indicated client #3 had a guardian. Client #3's record did not have any documentation that client #3's guardian had been informed of the facility's practice to use cameras in the facility common areas. There was no documentation the facility's Human Rights Committee (HRC) had reviewed the use of the cameras.</p> <p>Staff #1 was interviewed on 4/18/16 at 2:38p.m. Staff #1 indicated the cameras located in the common areas of the group home were currently working. Staff #1 indicated there was no documentation that indicated the facility's HRC had reviewed the practice to use cameras in the common areas of the group home.</p>			

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W 0392  Bldg. 00	<p>9-3-4(a)</p> <p>483.460(m)(3) DRUG LABELING</p> <p>Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#3) to ensure client #3's physician ordered discontinued medication (Therems M) had been immediately removed from his current medication supply.</p> <p>Findings include:</p> <p>An observation was done on 4/15/16 at the group home from 5:44a.m. to 7:37a.m. At 6:18a.m. client #3 received his medication. Client #3 had prepackaged morning medications for the next 2 weeks. Client #3 had the vitamin Therems M in his prepackaged morning medications for the next 2 weeks. Record review of client #3's 4/16 medication administration record (MAR) was done on 4/15/16 at 6:21a.m. The MAR indicated client #3's physician had discontinued his Therems M on 4/14/16. Staff #4, who administered the medication on 4/15/16, indicated on</p>			W 0392	<p>1.Client #3 Therems vitamin was removed from the packages (ATC packs) for the following two weeks. Pharmacy had already been notified on 4/14/16 of the discontinuation of Therems.</p> <p>2.All medication delivered from the pharmacy will be checked by a nurse. Any discontinued medications will be pulled out of ATC packs by nurse or re-packaged with current ordered medication. Medication destruction policy will be followed.</p> <p>3.All medication policies will be followed. Monthly review of the medication administration records for each client in each group home will be conducted.</p> <p>4.Pharmacy reviews will continue to be quarterly. Monthly review of the medication administration records will be conducted in order to ensure health and safety of all clients.</p> <p>5.Systemic changes will be completed by May 19, 2016.</p>		05/19/2016

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W 0440 Bldg. 00	<p>4/15/16 at 6:21a.m. the facility staff knew what the pill (Therems M) looked like and would pull it each morning for disposal.</p> <p>Interview of staff #2 (Nurse) was done on 4/15/16 at 11:05a.m. Staff #2 indicated the physician had discontinued client #3's Therems M on 4/14/16. Staff #2 indicated client #3's morning medication came prepacked with all his morning pills in 1 package. Staff #2 indicated client #3's discontinued medication had not been immediately removed from his current medication supply. Staff #2 indicated the discontinued medication should have been removed when the discontinued order was received.</p> <p>9-3-6(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 5 of 5 clients (#1, #2, #3, #4, #5) to ensure evacuation drills were completed quarterly, for each of the facility's personnel shifts, from 4/1/15 through 4/18/16.</p> <p>Findings include:</p>			W 0440	<p>1.All fire and tornado drills for the home have beencompleted in accordance with regulatory standards. The evacuation drills have been documented on a tracking sheet for each shift and are located in the Fire/Tornado Drillbinder located in the home office.</p> <p>2.All residents will be assessed annually andduring each</p>		05/19/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G482	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  04/19/2016
NAME OF PROVIDER OR SUPPLIER  DAMAR SERVICES INC--CAMBY RD			STREET ADDRESS, CITY, STATE, ZIP CODE 10600 E CR 700 S CAMBY, IN 46113		
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	<p>Record review of the facility's evacuation drills from 4/1/15 through 4/18/16 for clients #1, #2, #3, #4 and #5 was completed on 4/18/16 at 10:32a.m. The documented evening shift evacuation drills had a gap of no documented drills from 6/24/15 through 12/12/15. The night shift documented drills had a gap of no documented drills from 8/28/15 through 12/1/15.</p> <p>Interview of staff #1 on 4/18/16 at 1:10p.m. indicated he did not have any other documented evacuation drills for review. Staff #1 indicated evacuation drills should have been completed per each shift on a quarterly basis.</p> <p>9-3-7(a)</p>		<p>evacuation drill for their ability to evacuate the home. All fire and tornado drills for the home have been completed in accordance with regulatory standards. The evacuation drills are documented on a tracking sheet for each shift and are located in the Fire/Tornado Drill binder located in the home office.</p> <p>3. The Group Home Manager and staff will receive documented training regarding the regulatory requirements for evacuation drills. The Group Home Manager and QIDP will assign designated times and dates for drills to occur and monitor the completion and documentation of each drill.</p> <p>4. PQI has added a new indicator to monitor fire and tornado drill compliance for greater oversight and monitoring. The Damar safety committee also reviews data regarding fire and tornado drill completion and compliance. Systemic changes will be completed by May 19, 2016</p>		