

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G456	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/15/2015
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NAME OF PROVIDER OR SUPPLIER DAMAR SERVICES INC--EL CAMIN	STREET ADDRESS, CITY, STATE, ZIP CODE 4912 EL CAMINO CT INDIANAPOLIS, IN 46221
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W 0000 Bldg. 00	<p>This visit was for the annual recertification and state licensure survey.</p> <p>Survey Dates: June 10, 11, 12 and 15, 2015,</p> <p>Facility Number: 000970 Aim Number: 100239760 Provider Number: 15G456</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 and interview 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 providing a safe and clean environment.</p> <p>Findings include:</p> <p>An observation of clients #1, #2, #3, #4, #5 and #6 (at the group home) was done</p>	W 0104	<p>1. The following environmental corrects have been made:</p> <ul style="list-style-type: none"> · The light bulbs have been replaced in the empty sockets · The bathroom mirrors have been replaced · The leaves have been removed from the area <p>2. All Group Homes work orders will be reviewed and outstanding</p>	07/15/2015

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>on 6/10/15 from 3:54p.m. to 6:03p.m. The observation included the following environmental conditions: The front bathroom had 2 missing lights over the sink (empty sockets), the mirror had a film on it that would not allow you to see yourself (in the mirror). The back bathroom had a black substance above the shower and a film on the mirror that blurred the images. The front porch area, at the main entrance to the home, had 3 piles of old leaves near the door.</p> <p>Interview of staff #1 on 6/12/15 at 12:38p.m. indicated the home was in need of some repairs/cleaning. Staff #1 indicated the bathroom mirrors had some cleaner used on them in the past that had left a film on the glass.</p> <p>9-3-1(a)</p>		<p>jobs will be completed.</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>Staff and residents received training/discussion on the importance of maintaining a clean environment. Easy house maintenance task such as changing a light bulb or raking the leaves are duties that can be done by staff and/or maintenance. Raking the leaves would be considered and extra chore and clients that complete the task would receive extra allowance money.</p> <p>4. Daily environmental house checks are completed by staff and</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 3 of 3 sampled clients (#1, #2, #3) and 3 additional clients (#4, #5, #6), the facility failed to ensure the clients had the right to keep/maintain their own personal hygiene item (body soap).</p> <p>Findings include:</p> <p>An observation was done on 6/11/15 from 6:40a.m. to 8:10a.m. at the group home. At 6:44a.m., staff #6 gave client #4 a small medicine cup of prepared body wash. The body wash was kept in the locked medication room. At 8:07a.m. staff #6 gave client #5 a prepared</p>	W 0137	<p>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> <ol style="list-style-type: none"> All Clients have received their individual hygiene box. Basic hygiene material is kept in each box. All Residential Managers have reviewed homes to ensure individuals have personal hygiene boxes and supplied with all items needed including soap. All Residential Managers and staff member have been trained on resident rights and how to ensure they are in place. Emphasis placed on <ol style="list-style-type: none"> Right to hold personal possessions 	07/15/2015

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	<p>medicine cup of body wash prior to his shower. Interview of staff #6 at 8:07a.m. indicated the body wash was kept in the locked medication room for clients #1, #2, #3, #4, #5 and #6. Staff #6 indicated they did not know why the body soap was kept locked.</p> <p>Record review for client #1 was done on 6/12/15 at 10:44a.m. Client #1's 9/30/14 individual support plan (ISP) did not indicate client #1's personal body soap would be kept locked in the medication room. Client #1 had no training program to address the locked personal hygiene item.</p> <p>Record review for client #2 was done on 6/12/15 at 11:45a.m. Client #2's 2/14/15 ISP did not indicate client #2's personal body soap would be kept locked in the medication room. Client #2 had no training program to address the locked personal hygiene item.</p> <p>Record review for client #3 was done on 6/12/15 at 11:05a.m. Client #3's 6/16/14 ISP did not indicate client #3's personal body soap would be kept locked in the medication room. Client #3 had no training program to address the locked personal hygiene item.</p> <p>Staff #1 was interviewed on 6/12/15 at</p>		<p>b. Rights to be provided with formal or informally training on skills not custodial care</p> <p>c. Expectation of staff responsibility to ensure dignity is upheld (hygiene acceptable, clothing fits and not torn)</p> <p>4. All staff within all Group Homes have been trained regarding residential rights and how to ensure they are in place (see above) Residential Manager, Lead staff and/or Dir. Of Group Home will monitor staff performance of upholding client rights weekly while at the homes. Any concerns during ones observations will be immediately addressed with staff by retraining and/or modeling of correct behaviors. Ongoing concerns during observations may be reviewed and communicated by utilizing several different documentations if warrant:</p> <p>a) 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. Positive Employee Performance report may be</p>	

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	12:38p.m. Staff #1 indicated the clients did not have nor did they need a training program to address the locked personal hygiene item. Staff #1 indicated the personal hygiene item (body soap) should not have been kept locked in the group home medication room. 9-3-2(a)		completed too to reinforce excellent or positive work performance. b) Staff Memo's – may be completed when overall staffs are demonstrating a need to improve a behavior or to reinforce and encourage positive work performance. c) 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. d) 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.		
W 0312 Bldg. 00	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed for 1 of 2 sampled clients (#3) who took behavior control	W 0312	1. Client #3 recently had a psychotropic review appointment and a new medication was	07/15/2015	

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	<p>drugs, to ensure the behavior control medication was part of the client's individual support plan (ISP)/behavior support plan (BSP) which included a plan of reduction.</p> <p>Findings include:</p> <p>Review of the record of client #3 was done on 6/12/15 at 11:05a.m. Client #3's 6/16/14 BSP indicated client #3's diagnoses included, but were not limited to, Resistive Attachment Disorder, Depression and Post -Traumatic Stress Disorder. Physician's Orders on 5/8/15 indicated client #3 received the behavior control medication Risperdal. The BSP failed to include this behavior control medication in a plan which included withdrawal criteria.</p> <p>Interview of professional staff #1 on 6/12/15 at 12:38p.m. indicated client #3 did not have his current behavior control medication (Risperdal) addressed in a plan of reduction.</p> <p>9-3-5(a)</p>		<p>prescribed. Typically, when a new medication is prescribed – a smaller (but effective) dosage is given and observations are made to ensure no side effects or adverse reactions occur. Upon return visit – if medication seems effective – the doctor and team develop one’s psychotropic increase/decrease plan. Client #3 return visit is late July. However, in the future upon initiating a new medication a plan will be developed at that appointment. This initial plan may state:</p> <ul style="list-style-type: none"> · Recommendation of effective dosage · Recommendation of increase in dosage(s) until therapeutic level is reach · Psychotropic/behavioral objectives that will be used to monitor effectiveness (i.e.: if behaviors of physical aggression should decrease to 1 incident or less for 6 consecutive months – will consider a reduction in medication in dosages as recommended by doctor) · List of side effects or adverse reactions that warrant a discontinuing of a medication. <p>2. All residential managers have received training regarding this new step when attending psychotropic</p>	

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W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.		reviews. 3. All psychotropic reviews are discussed at weekly meeting. Upon completing an appointment when a new medication is prescribed – the initial psychotropic plan will be reviewed and written into the plan by the QDIP. This plan will be approved by guardian and HRC. 4. Quarterly chart checks and home checks are completed by Lead staff. Psychotropic plans and approvals are an item checked. Missing items such as no psychotropic plan will be highlighted and corrected within the time line established. Quarterly checks are submitted to Quality Assurance team to verify corrections are in place. Failure to be in compliance with PQI standards (Quality Assurance) results in plan of correction implemented and monitored by Quality Assurance Director and/or Vice President	

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	<p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#2) with adaptive equipment, to ensure the facility furnished eyeglasses and addressed his identified training need for care of his eyeglasses.</p> <p>Findings include:</p> <p>Observations were done at the group home on 6/10/15 from 3:54p.m. to 6:03p.m. and on 6/11/15 from 6:40a.m. to 8:10a.m. During all the observation time, client #2 did not wear eyeglasses.</p> <p>Client #2 was interviewed on 6/12/15 at 11:45a.m. Client #2 indicated he had eyeglasses to wear but they were bent up and had scratches on them.</p> <p>Record review for client #2 was done on 6/12/15 at 11:45a.m. Client #2 had an eye exam on 10/14/14 that indicated "near sighted, eyeglasses constant wear." Client #2's 2/14/15 individual support plan (ISP) did not indicate client #2 had a history of not taking care of his eyeglasses and he had no training programs to address the care of his eyeglasses. There was no documentation about the current condition of client #2's eyeglasses.</p> <p>Staff #1 was interviewed on 6/12/15 at</p>	W 0436	<ol style="list-style-type: none"> Client #2 was a new admission from another home. Previous Residential Manager failed to identify that client #2 wore glasses. Client #2 does have a doctor's order to wear glasses and in the past independently wore them without staff monitoring. Client #2 glasses can not be found therefore, Residential Manager will secure prescription from doctor and purchase a new pair. All staff have been updated on the need for client #2 to wear glasses at all times Furthermore, client's #2 Program Incentive Sheet has been revised and includes the opportunity to earn daily points for wearing the eyeglasses as prescribed. Points earned are tallied up at the end of the week and exchange for a weekly allowance. All clients' charts will be reviewed to ensure adaptive equipment such as eyeglasses or braces are in place as prescribed. An addendum, if needed will be added to any clients ISP who has a prescription for eyeglasses or any adaptive equipment and demonstrates inconsistency with wearing or using them properly. Formal and informal training will be implemented according to one's individualized strategy. Residential Manager will provide all staff with training on 	07/15/2015

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	<p>12:38p.m. Staff #1 indicated they were not aware client #2 had eyeglasses and had not seen client #2 wear eyeglasses. Staff #1 indicated client #2's 10/14/14 eye exam indicated client #2 was to wear eyeglasses all the time. Staff #1 indicated client #2 may need training regarding the care of his eyeglasses.</p> <p>9-3-7(a)</p>		<p>appropriate way to monitor, support and document these objectives. Monthly reviews will provide statistical data and submitted to the QDDP to review. Revisions will occur as needed. 4. Doctor's notes are reviewed by the nurse and Residential Manager following each appointment. Residential Manager will sign off on each note ensuring that the information is read and will if needed update one's ISP to include an interactive guideline addendum and/or formal training to ensure doctor's orders are being followed. This interactive guideline will include steps that staff should take to encourage daily wearing of eye glasses. Staff will receive training by Residential Manager regarding these revisions. Furthermore - those who may misplace or break their adaptive equipment often, the following steps may be put in place</p> <ul style="list-style-type: none"> · monitoring the use of equipment will be also done on one's MAR sheet. When a resident's fails to have ones adaptive equipment during a check – an incident report will be completed and submitted to the Residential Manager for follow up · if a residents fails to have his equipment for 72 hours (or is known to be broken) – the Residential Manager will begin steps to replace the equipment. 	

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W 0488 Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 3 of 3 sampled clients (#1, #2, #3) and 2 additional clients (#4, #5), the facility failed to encourage clients to participate in meal preparation and family style dining to the extent they were capable.</p> <p>Findings include:</p> <p>An observation was done at the group home on 6/11/15 from 6:40a.m. to 8:10a.m. Staff #4 was observed to begin breakfast preparation at 6:49a.m. Staff #4 did not have any of the clients who were home at this time (#1, #2, #3, #4, #5) in the kitchen to assist with the meal preparation. Staff #4 was observed to: get out cups, bowls, spoons, butter, sausage patties, box of Cream of Wheat; use a</p>	W 0488	<ul style="list-style-type: none"> · If cost of item is not covered by one's insurance, the agency will provide the necessary funds to get the item repair. · Resident may be required to use his own funds to replace items not covered by insurance. In this case, guardian and HRC will be secured and the strategy admen to one's ISP. <p>1.All staff has received training on the importance of having a resident participate in the preparation of meals. This can be done by formal or informal training. Custodial care or staff preparing the whole meal is not acceptable. In addition, all ISP objectives were reviewed to ensure understanding of when formal and informal training could be done. Emphasis was placed on discussing those who have a cooking goal to ensure understanding of times they should be implemented. House Meal Preparation schedule was also reviewed. This schedule includes days each resident is assigned to help prepare meals or another meal time duty. Family style eating was reviewed</p>	07/15/2015

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	<p>measuring cup and put water into a pan; heat up the water, add cereal, stir the cereal and put the prepared cereal into each clients' cereal bowl; put cooking spray in the frying pan, opened the sausage and put them into the frying pan; prepared a sink of dishwater and washed the dishes used during the meal preparation. The clients were given prepared plates of food and ate breakfast at 7:48a.m.</p> <p>Interview of staff #1 on 6/12/15 at 12:38p.m. indicated all the clients were capable of assisting with the preparation of breakfast and serving themselves (family style) with some staff assistance. Staff #1 indicated the clients should have been more involved with breakfast preparation.</p> <p>9-3-8(a)</p>		<p>2. Residential Managers has provided training at each Group Home on the importance of having a resident participate in the preparation of meals. This can be done by formal or informal training. Custodial care or staff preparing the whole meal is not acceptable. House Meal Preparation schedule was also reviewed. This schedule includes days each resident is assigned to help prepare meals or another meal time duty. Family style eating was reviewed</p> <p>3. Residential Manager, Lead staff and/or Dir. of Group Home will observe staff weekly to ensure continual understanding and demonstration of providing all items on a menu is being implemented. Staff not performing at an acceptable level will be immediately addressed and provided retraining and/or modeling of correct behaviors.</p> <p>4. On going monitoring will occur and documentation of concerns may be done in the following manner:</p> <p>a. Employee Performance Report - completed for any repeat offenders of not showing ability to prepare meal time as established from the menu. Plan may state how to correct actions; training needed and a criteria of</p>	

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			<p>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>b. Staff Memo's – may be completed when overall staffs are demonstrating a need to improve a behavior or to reinforce and encourage positive work performance in one or several areas</p> <p>c. Yearly evaluations - with on staff's yearly evaluation. Knowing and ensuring programs are implemented as prescribed 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>	