

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  04/19/2016
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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 pre-determined full recertification and state licensure survey.</p> <p>Survey Dates: April 12, 13, 14, 15, 19, 2016</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. Quality Review of this report completed by #15068 on 4/25/16.</p>	W 0000		
W 0154  Bldg. 00	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>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 1 of 1 incident reviewed for allegations of (physical aggression) client to client abuse (clients #2, #4).</p> <p>Findings include:</p> <p>Record review of the facility's incident</p>	W 0154	<p>1.An investigation was conducted pertaining to an incident of physical aggression with injury involving client #2 and client #4. The investigation was incomplete. The Manager interviewed the staff witness and spoke to client #2 and #4 about using coping skills rather than acting out but failed to interview both client #2 and #4. In order to comply with this citation</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>reports was done on 4/12/16 at 2:58p.m. The review included the following incident for clients #2 and #4:</p> <p>An incident report on 12/7/15 indicated client #2 had physically aggressed client #4. The 12/7/15 "Incident Investigation Report" indicated client #4 had been "cussing and calling him (#2) names." Client #2 became upset with client #4, ran after him, and pushed and hit client #4 before staff could "split them up." The report indicated client #4 had a 3 centimeter contusion to the inside of his right forearm and a 0.5 centimeter bruise to right inner thumb. The report did not have any documented client interviews.</p> <p>Staff #1 was interviewed on 4/15/16 at 12:11pm. Staff #1 indicated there were no documented client interviews for the 12/7/15 client to client physical aggression.</p> <p>9-3-2(a)</p>		<p>client #2 and #4 was interviewed on5/4/16. The interviews have been documentedon our internal witness form and placed in the investigation file.</p> <p>2. A reviewof agency incident reports dating back 6 months will be completed and if thereare any items requiring additional investigation and documentation we will becomplete it immediatly. Moving forwardthe Damar PQI department will lead and oversee all investigations to ensurethoroughness and completion.</p> <p>3. Thepolicy for Medicaid Group Home investigations has been updated. Group Home Managers and the QIDP will receivedocumented training regarding the investigation procedure. The PQI departmentwill take lead over all investigations to ensure that a thorough investigationreport is completed (to include documented interviews for all staff and clientwitnesses).</p> <p>4.PQI has added a new indicator related to criticalincidents and investigations for greater oversight and monitoring.</p> <p>5.The systematic changes will be completed by 5/19/16.</p>		

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W 0159  Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the facility failed for 2 of 3 sampled clients (#1, #2) to ensure each client's active treatment programs were coordinated and monitored by the facility's qualified intellectual disabilities professional (QIDP), by the QIDP not ensuring a guardian's written consent for restrictive programs had been acquired and met training programs had been revised.</p> <p>Findings include:</p> <p>1. Record review for client #1 was done on 4/15/16 at 10:14a.m. Client #1's 10/22/15 individual support plan (ISP) indicated client #1 had a restrictive behavior plan that included the use of behavior medication for psychosis and post traumatic stress disorder. The ISP indicated client #1 had a guardian. The facility's human rights committee (HRC) had approved the ISP on 10/25/15. There was no documentation of written consent by client #1's legal guardian for the 10/22/15 ISP.</p>	W 0159	<p>1. In an effort to improve services and oversight of the Group Home programs, a new QIDP was hired and in place January 1, 2016. The QIDP has assessed areas of need and is actively working to correct program deficiencies. The QIDP will oversee the coordination of treatment team meetings for initial program plans as well as the yearly plan updates.</p> <p>2. A review of agency treatment programs dating back 6 months will be completed and if there are any missing legal guardian signatures the QIDP will obtain the missing signatures.</p> <p>3. The QIDP will ensure the legal guardian participates in all treatment team meetings either in person, by conference phone, or providing a copy of the proposed plan for review for input prior to writing. The signature of the legal guardian will be obtained in person, by email, or certified mail prior to treatment plan implementation.</p> <p>4. The Group Home Director conducted a training for the Group Home Manager regarding the process for monitoring goal progress, discontinuing attained goals, and implementing projected goals. Moving forward</p>	05/19/2016

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	<p>Client #1's documented monthly training program data for 12/15 through 2/16 indicated client #1 had met at 100% every month the training programs to: identify personal information, write a check, make a purchase and floss his teeth. The training programs were documented to be considered met if client #1 had met the criteria for 3 consecutive months. The QIDP had documented on the 2/16 program review "goals met, continue to train."</p> <p>2. Record review for client #2 was done on 4/15/16 at 10:58a.m. Client #2's 10/12/15 ISP indicated client #2 had a restrictive behavior plan that included the use of behavior medication for depression and mood disorder. The ISP indicated client #2 had a guardian. The facility's human rights committee (HRC) had approved the ISP on 10/25/15. There was no documentation of written consent by client #2's legal guardian for the 10/12/15 ISP.</p> <p>Client #2's documented monthly training program data for 12/15 through 2/16 indicated client #2 had met at 100% every month the training programs to: identify personal information, identify his medication and complete a simple meal</p>		<p>the Group Home Director will review all monthly reports for accuracy and updates. Once a goal has been met the monthly treatment review report will clearly state that the goal was attained and a new goal (from the list of projected goals on the treatment plan) will be added. All following annual treatment plans will include a year summary of all attained goals throughout the year along with the date of attainment.</p> <p>5. The systematic changes will be completed by 5/19/16.</p>	

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W 0255  Bldg. 00	<p>task. The training programs were documented to be considered met if client #2 had met the criteria for 3 consecutive months. The QIDP had documented on the 2/16 program review "goals met, continue to train."</p> <p>Staff #1 was interviewed on 4/15/16 at 12:11p.m. Staff #1 indicated he did not have documented guardian program consents for clients #1 and #2 10/15 restrictive programs. Staff #1 indicated there was no documentation the QIDP had followed up on obtaining the guardian signature for the ISP/BSPs. Staff #1 indicated the QIDP was responsible for the coordination and monitoring and revising of client training programs.</p> <p>9-3-3(a)</p> <p>483.440(f)(1)(i) PROGRAM MONITORING &amp; CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Based on interview and record review of</p>	W 0255	1.In an effort to improve	05/19/2016			

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	<p>2 of 3 sampled clients (#1, #2), the Qualified Intellectual Disabilities Professional (QIDP), failed to revise the Individual Support Plan (ISP) in regards to the clients having successfully completed objectives identified in their ISP.</p> <p>Findings include:</p> <p>Client #1's record review was completed on 4/15/16 at 10:14a.m. Client #1's documented monthly training program data for 12/15 through 2/16 indicated client #1 had met at 100% every month the training programs to: identify personal information, write a check, make a purchase and floss his teeth. The training programs were documented to be considered met if client #1 had met the criteria for 3 consecutive months. The QIDP had documented on the 2/16 program review "goals met, continue to train."</p> <p>Client #2's record review was completed on 4/15/16 at 10:58a.m. Client #2's documented monthly training program data for 12/15 through 2/16 indicated client #2 had met at 100% every month the training programs to: identify personal information, identify his medication and complete a simple meal task. The training programs were</p>		<p>services and oversight of the Group Home programs, a new QIDP was hired and in place January 1,2016. The QIDP has assessed areas of need and is actively working to correct program deficiencies. The QIDP will review all monthly treatment plan reviews to ensure timely discontinuation of attained ISP treatment goals. The QIDP will also ensure the implementation of replacement or projected goals.</p> <p>2.A review of agency monthly treatment reviews dating back 6 months will be completed and any attained goals that have been continued will be discontinued and recognized as attained during the review of April monthly reports that are due by 5/10/16.</p> <p>3.The Group Home Director conducted a training with the Group Home Manager regarding the process for monitoring goal progress, discontinuing attained goals, and the implementation of projected goals. Once a goal has been met the monthly will clearly state that the goal was attained and a new goal (from the list of projected goals within the treatment plan) will be added. All future annual treatment plans will include a summary of all attained goals throughout the year along with the date of attainment.</p> <p>4.Moving forward the Group Home Director will review all monthly reports for accuracy and</p>	

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W 0263 Bldg. 00	<p>documented to be considered met if client #2 had met the criteria for 3 consecutive months. The QIDP had documented on the 2/16 program review "goals met, continue to train."</p> <p>Staff #1 was interviewed on 4/15/16 at 12:11p.m. Staff #1 indicated none of client #1 and #2's training programs had been revised since their 10/15 ISPs. Staff #1 indicated client #1 and #2's goals should have been considered met and revised by the QIDP.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview, the facility's human rights committee (HRC) failed for 2 of 3 sampled clients (#1, #2) with a guardian, to ensure the facility had received written informed consent from the guardian, in regards to the clients' restrictive programs which included behavior medication, prior to HRC approval.</p>	W 0263	<p>updates. The Director will meet with the Group HomeManager if revisions are necessary prior to implementation. 5.The systematic changes will be completed by5/19/16.</p> <p>1.In an effort to improve services and oversightof the Group Home programs, a new QIDP was hired and in place January 1,2016. The QIDP has assessed areas ofneed and is actively working to correct program deficiencies. The QIDP will oversee the coordination oftreatment team meetings for initial program plans, yearly plan updates, theoversight and review</p>	05/19/2016	

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	<p>Findings include:</p> <p>Record review for client #1 was done on 4/15/16 at 10:14a.m. Client #1's 10/22/15 individual support plan (ISP) indicated client #1 had a restrictive behavior plan that included the use of behavior medication for psychosis and post traumatic stress disorder. The ISP indicated client #1 had a guardian. The facility's human rights committee (HRC) had approved the ISP on 10/25/15. There was no documentation of written consent by client #1's legal guardian for the 10/22/15 ISP.</p> <p>Record review for client #2 was done on 4/15/16 at 10:58a.m. Client #2's 10/12/15 ISP indicated client #2 had a restrictive behavior plan that included the use of behavior medication for depression and mood disorder. The ISP indicated client #2 had a guardian. The facility's human rights committee (HRC) had approved the ISP on 10/25/15. There was no documentation of written consent by client #2's legal guardian for the 10/12/15 ISP.</p> <p>Staff #1 was interviewed on 4/15/16 at 12:11p.m. Staff #1 indicated the facility</p>		<p>of monthly treatment reviews, as well as all behavioral and restrictive plans.</p> <p>2.A review of agency behavior programs, restrictive plans, and ISP's dating back 6 months will be completed and if there are any missing written consents by legal guardians the QIDP will obtain guardian written consent.</p> <p>3.The QIDP will ensure that the legal guardian's input is valued and considered before the writing of all behavior plans, restrictive plans, and ISP's.</p> <p>4.The QIDP will ensure that all completed behavior plans, restrictive plans, and ISP's are reviewed with the legal guardian. The legal guardian's written consent will be obtained in person, by email, or certified mail prior to HRC review, HRC approval, and behavior, restrictive plan, or ISP implementation.</p> <p>5. The systematic changes will be completed by 5/19/16.</p>				

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W 0336 Bldg. 00	<p>did not have written informed consent from client #1 and client #2's guardians, in regards to their restrictive behavior programs. Staff #1 indicated the facility's HRC had approved clients #1 and #2's restrictive behavior program during 10/15 without written informed consent from the clients' guardians.</p> <p>9-3-4(a)</p> <p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview, the facility failed for 2 of 3 sampled clients (#1, #2) to provide the clients with quarterly health status reviews during the past twelve months (4/1/15 to 4/15/16).</p> <p>Findings include:</p> <p>1. The record of client #1 was reviewed on 4/15/16 at 10:14a.m. Client #1 was admitted to the facility during 9/15. Client #1's documented quarterly nursing reviews indicated quarterly reviews were completed during 9/15 and 12/15. Client #1's 3/30/16 Physician's Orders indicated</p>	W 0336	<p>1.Client#1 was seen for his quarterly assessment and it was completed on 4/17/16. Director of Nursing and Assistant Director ofNursing are aware of these deficiencies and group home nurse was updated onpolicy.</p> <p>2.MonthlyReview of the charts will be conducted at each group homes to ensurecompliance.</p> <p>3.TheDirector of Nursing, Assistant Director of Nursing or appointed nurse willfollow up on assessments and appointments when assigned group home nurse is notavailable for any reason.</p> <p>4.Regularmonthly visits to review charts in the group homes will be conducted monthly</p>	05/19/2016

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W 0436 Bldg. 00	<p>client #1 was not on a medical care plan.</p> <p>2. The record of client #2 was reviewed on 4/15/16 at 10:58a.m. Client #2's documented quarterly nursing reviews indicated quarterly reviews were completed during 6/15, 9/15, and 12/15. Client #2's 4/1/16 Physician's Orders indicated client #2 was not on a medical care plan.</p> <p>Interview of staff #2 (nurse) on 4/15/16 at 11:48a.m., indicated clients #1 and #2 were not on a medical care plan. Staff #2 indicated the nursing quarterly reviews for clients #1 and #2 were due during 3/16. Staff #2 indicated the 3/16 quarterly nursing reviews had not been completed as of this date (4/15/16).</p> <p>9-3-6(a)</p> <p>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. Based on observation, record review and</p>	W 0436	<p>tomaintain compliance and ensure clients health. Group homes will have a back-upnurse when one is on leave, sick or on workman's compensation.</p> <p>5.The systematic changes will be completed by 5/19/16.</p> <p>1.An addendum will be added</p>	05/19/2016	

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	<p>interview, the facility failed for 1 of 3 sampled clients (#1) with adaptive equipment, to provide client #1 with training for the care of his prescribed eyeglasses.</p> <p>Findings include:</p> <p>An observation was done at the group home on 4/13/16 from 6:07a.m. to 8:02a.m. At 6:24a.m., client #1 received his medication. At this time, staff #4 gave client #1 his eyeglasses that had been kept in the locked medication room. At 6:24a.m., staff #4 indicated client #1's eyeglasses were kept locked overnight due to his past history of bending them.</p> <p>Record review of client #1 was done on 4/15/16 at 10:14a.m. Client #1's 3/18/16 eye exam indicated client #1 had prescribed eyeglasses. Client #1 had a 10/25/15 individual support plan (ISP). Client #1's ISP did not have documentation of a training program in place to address client #1's need to have his prescribed eyeglasses kept locked in the facility medication room.</p> <p>Interview on 4/15/16 at 12:11p.m. of staff #1 indicated client #1 had eyeglasses. Staff #1 indicated client #1 kept his eyeglasses in the locked medication room overnight due to his inability to care for</p>		<p>to each affected client'sISP who wears glasses to include a formal training objective for wearing and caring for eyeglasses. Staff in the homewill receive documented training on the appropriate way to monitor and documentthese objectives.</p> <p>2.An addendum will be added to every client'sIndividual Support Plan who wears glasses to include a formal trainingobjective on wearing and caring for his eyeglasses. Staff in the home will receive documentedtraining on the appropriate way to monitor and document these objectives.</p> <p>3.Goal tracking sheets will be developed andmonitored by the Group Home Manager and QIDP regularly for each client to teacheach client how to use and make informed choices about the use of their eyeglasses. The Group Home Manager willreview goal books weekly to ensure that data is being recorded on a daily basisfor each client. The QIDP will reviewdata each month to determine if the client is meeting the criteria objective. Every clients ISP will be reviewed annuallyand if there is a need for a formal self-help skill in the area of caring forand wearing their eyeglasses it will be added to the client's ISP.</p> <p>4.Every client's ISP will be reviewed annually andif there is a need for a formal self- help skill in the area of caring for andwearing their eyeglasses it will be added</p>	

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	<p>them at night time. Staff #1 indicated client #1 did not have a training program in place to address the care of his eyeglasses.</p> <p>9-3-7(a)</p>		<p>to the client's ISP. The QIDP will monitor each ISP regularly to identify potential client needs. The Group Home Manager will review goal books weekly to ensure the data is being recorded on the use of care of eyeglasses for each client that wears eyeglasses in the home. Staff in the home will receive documented training on the importance of recording data for the client's ISP objectives. Future deficiencies in this area identified by gaps in the testing and training sheets or supervisory observations will be followed up by additional documented training and/or disciplinary action.</p> <p>5. The systematic changes will be completed by 5/19/16.</p>		