

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 02/10/2012	
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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W0000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 2/7/12, 2/8/12, 2/9/12 and 2/10/12.</p> <p>Facility Number: 000996 Provider Number: 15G482 AIMS Number: 100235460</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on March 05, 2012 by Dotty Walton, Medical Surveyor III.</p>			W0000			

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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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 8 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed, the facility failed to immediately notify the administrator and Bureau of Developmental Disabilities Services (BDDS) in accordance with state law regarding client #2's alleged aggression toward and unspecified peer.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 2/7/12 at 1:45 PM. The review indicated the following facility internal incident report:</p> <p>-10/25/11, "[Client #2] took a knife out of the lockbox and made a false charge on another client. Staff confronted [Client #2] about the knife and [Client #2] put the knife back in the lockbox. [Client #2] was then escorted to his room to calm...."</p> <p>The review did not indicate the 10/25/11 incident had been reported to BDDS.</p>	W0153	<p>W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to the other officials in accordance with State law through established procedures. 1. Damar Services, Inc. has a written Policy and procedure in place for Incident Reporting to Governing Bodies (BDDS). The Residential Manager will ensure that any incidents of allegations of abuse/neglect or any other reportable incident is reported to BDDS within 24 hours of the incident occurring. Staff will notify the Residential Manager of the incident and ensure that all injuries or other reportable incidents are reported clearly and accurately. The BDDS report was completed for client #2 on 3/8/12 and additional follow ups have been completed per BDDS requests. BDDS has closed the incident. 2. Incident reports from the home have been reviewed by the Residential Director to identify the potential</p>	03/17/2012	

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	<p>Interview with AS #1 (Administrative Staff) and AS #2 on 2/7/12 at 2:00 PM indicated the incident, "as written was unclear" in describing the "false charge." AS #1 and AS #2 indicated the incident should have been considered an incident of client to client aggression and should have been reported.</p> <p>9-3-1(b)(5) 9-3-2(a)</p>		<p>need for additional follow up and/or further investigation. At this time, all other incidents have been documented completely. All documentation will be completed, including an agency Incident Report (immediately), BDDS Incident Report (within 24 hours) and a thorough investigation (within 5 days) for all incidents requiring a BDDS reportable. 3. The Residential Manager will receive documented training by the Group Home Administrator on the requirements of incident reporting and incident investigation documentation including the requirement to complete a BDDS report within 24 hours of the incident. The group home investigation/reporting policy has been reviewed to ensure it is current and reflective of the regulatory standards. 4. All incidents requiring an investigation will be reported to the Residential Manager, Residential Director and Group Home Administrator immediately following the incidents occurrence. The initial investigation will begin immediately in the form of an Agency Incident Report. Additional information will be gathered within 24 hours of the incidents occurrence and reported to the Bureau of Developmental Disabilities. The Residential Manager and Residential Director will also</p>		

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			complete a documented investigation including a summery for submission to the Group Home Administrator within 5 working days of the incident. 5. Date Systemic changes will be completed: March 17, 2012		

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W0154	<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 for 5 of 8 reviewed incidents of client to client aggression, medication omissions, and neglect, the facility failed to complete a thorough investigation regarding an allegation of staff neglect for clients #1, #2, #3, #4, #5 and #6. The facility failed to complete a thorough investigation regarding an incident of medication omission for client #3. The facility failed to complete a thorough investigation regarding an allegation of staff neglect for clients #1, #2, #3, #4, #5 and #6. The facility failed to complete a thorough investigation for an incident of client to client aggression regarding client # 2 and an unnamed housemates. The facility failed to complete a thorough investigation regarding an incident of medication administration error for client #5.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports were reviewed on 2/7/12 at 1:45 PM. The review indicated the following:</p> <p>-6/1/11 Internal Incident Report (IIR), "When I came to work at 7:00 AM on</p>	W0154	<p>W154-483.420(d) (3) Staff Treatment of Clients The facility must have evidence that all alleged violations are thoroughly investigated.1.</p> <p>Damar Services, Inc. has completed and documented a thorough investigation of the incident relating to the incident report dated 6/1/11 involving Clients #1, #2, #3, #4, #5 and #6. Damar Services, Inc. has completed and documented a thorough investigation of the incident relating to the incident report dated 6/5/11 involving client #3. Damar Services, Inc. has completed and documented a thorough investigation of the incident relating to the incident report 8/5/11 involving clients #1, #2, #3, #4, #5 and #6. Damar Services, Inc. has completed and documented a thorough investigation of the incident relating to the incident report 10/25/12 involving client #2. Damar Services, Inc. has completed and documented a thorough investigation of the incident relating to the incident report 11/12/11 involving client #5. 2. Incident reports from the Camby home have been reviewed by the QMRP to identify the potential need for additional follow up and/or further investigation. At this time, all</p>	03/17/2012			

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	<p>6/1/11 I walked through the house noticing that the responsibilities of third shift were not completed. I also suspect that third shift staff was sleeping while on her shift. Third shift staff is [staff #1]. Staff making the allegation is [staff #2]."</p> <p>The facility's 6/1/11 internal investigation report indicated staff #2 was interviewed regarding the 6/1/11 allegation of third shift staff sleeping while on duty. The internal investigation report did not include interviews or statements from staff #1 or the clients #1, #2, #3, #4, #5 and/or #6 who were present in the home at the time of the allegation. The internal investigation report did not include documents reviewed, policies reviewed, a summary of evidence to substantiate or unsubstantiate the allegation.</p> <p>Interview with AS #1 (Administrative Staff) and AS #2 on 2/7/12 at 2:00 PM indicated the investigation was not thorough.</p> <p>2. The facility's reportable incident reports were reviewed on 2/7/12 at 1:45 PM. The review indicated the following:</p> <p>-6/5/11 Bureau of Developmental Disabilities Services (BDDS) report, "On 6/5/11 [client #3] was on an outing with staff and did not receive his 4:00 PM</p>		<p>other incidents have been documented completely. All documentation will be completed, including an agency Incident Report (immediately), BDDS Incident Report (within 24 hours) and a through investigation (within 5 days) for all incidents requiring a BDDS reportable. 3. The Residential Manager and QMRP will receive documented training by the Group Home Administrator on the requirements of incident reporting and incident investigation documentation including the requirement to complete a thoroughly documented investigation within 5 working days of the incident .The Group Home Incident Investigation form has been revised to ensure complete and thorough investigations are performed. The group home investigation/reporting policy has been reviewed to ensure it is current and reflective of the regulatory standards. 4. All incidents requiring an investigation will be reported to the Residential Manager, QMRP and Group Home Administrator immediately following the incidents occurrence. The initial investigation will begin immediately in the form of an Agency Incident Report. Additional information will be gathered within 24 hours of the incidents occurrence and reported to the Bureau of</p>		

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	<p>medication...."</p> <p>The facility's 6/5/11 internal investigation report indicated one staff was interviewed regarding the 6/5/11 missed medication for client #3. The IIR did not include reviewed documentation or additional statements of relevant witness's.</p> <p>Interview with AS #1 and AS #2 on 2/7/12 at 2:00 PM indicated the investigation was not thorough.</p> <p>3. The facility's reportable incident reports were reviewed on 2/7/12 at 1:45 PM. The review indicated the following:</p> <p>-8/5/11 IIR, "On this day, manager came into home to find third shift asleep on couch with blanket covering her. Manager spoke staff name and staff did not wake up. Manager then shook staff by arm and she awoke with a fright. Manager then relieved staff of her duties. Staff stated this was the first time she had sleep (sic) while at work."</p> <p>The review did not indicate an internal investigation report was completed.</p> <p>Interview with AS #1 (Administrative Staff) and AS #2 on 2/7/12 at 2:00 PM indicated an investigation should have been completed following the alleged</p>		<p>Developmental Disabilities. The Residential Manager and QMRP will be responsible for completing the documented investigation including a summary for submission to the Group Home Administrator within 5 working days of the incident. 5. Date Systemic changes will be completed: March 17, 2012</p>				

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	<p>incident of staff neglect.</p> <p>4. The facility's reportable incident reports were reviewed on 2/7/12 at 1:45 PM. The review indicated the following:</p> <p>-10/25/11 IIR, "[Client #2] took a knife out of the lockbox and made a false charge on another client. Staff confronted [Client #2] about the knife and [Client #2] put the knife back in the lockbox. [Client #2] was then escorted to his room to calm...."</p> <p>The review did not indicate an investigation had been completed.</p> <p>Interview with AS #1 (Administrative Staff) and AS #2 on 2/7/12 at 2:00 PM indicated the incident, "as written was unclear" in describing the "false charge." AS #1 and AS #2 indicated the incident should have been considered an incident of client to client aggression and been investigated.</p> <p>5. The facility's reportable incident reports were reviewed on 2/7/12 at 1:45 PM. The review indicated the following:</p> <p>-11/12/11 BDDS report, "[Client #5] went on home visit for 11/12/11. Staff accidentally packed an extra Metadate capsule (Attention Deficit Hyperactivity Disorder) for [client #5] in 8am med</p>				

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	<p>pack. On 11/13/11, mother gave [client #5] medication as scheduled and client receive d one extra Metadate capsule of 30 milligrams. Upon returning to group home medication error was noticed...."</p> <p>The review did not indicate the medication error was investigated.</p> <p>Interview with AS #1 and AS #2 on 2/7/12 at 2:00 PM indicated the incident should have been investigated.</p> <p>9-3-2(a)</p>				

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W9999	<p>STATE FINDINGS:</p> <p>460 IAC 9-3-5 Resident behavior and facility practices.</p> <p>(c) In the event that one (1) or more resident of a children's facility shall have reached eighteen (18) years of age or older and shall no longer participate in a special education program, if it is determined by the interdisciplinary team that it is in the best interest of the residents to remain living as a family, then the provider shall submit a plan and request approval from the council to convert the program orientation of the facility to an appropriate licensure category for adults in a reasonable period of time. If this approval is given, children and adults may continue to reside together in the same facility.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client# 3) plus one additional client (#4), the facility failed to ensure children and adults did not reside in the same home.</p> <p>Findings Include:</p>	W9999	<p>W9999 FINAL OBSERVATIONS</p> <p>State Findings: (Failure to ensure children and adults did not reside in the same home)</p> <p>1. Damar Services, Inc. is actively working with the Bureau of Developmental Disability Services in order to secure appropriate adult placements for Client #3 and #4. The agency fully recognizes the importance of children who have reached the age of 18 and have graduated from a state accredited special education program, to be transitioned into an adult placement. Referrals and initial assessments have been completed and all efforts are being made to expedite this transition process for Client #3 and #4. 2. Per State and Federal regulations, all group home clients who have reached the age of 18, and have graduated from a school based Special Education program, must be transitioned into an adult residential placement, prior to the age of 22. Damar Services will continue to make every effort to abide by this regulation and will continue to take progressive measures in order to find the most individually appropriate placements for current and future group home clients. At this time, only Client #3 and #4 are deficient related to this finding. 3. Per State and Federal regulations, all</p>	03/17/2012			

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	<p>Observations were conducted in the group home on 2/7/12 from 4:10 PM through 5:45 PM client #3 and #4 were observed in the home throughout the observation period with client's #1, #2, #5 and #6. Observations were conducted in the group home on 2/8/12 from 5:45 AM through 7:45 AM. Clients #3 and #4 were observed in the home throughout the observation period. At 7:30 AM clients #1, #2, #5 and #6 exited the group home to board the school bus for transport to school. Client #3 and #4 remained in the home and did not attend school.</p> <p>The facility's Community Residential Surveyor Worksheet (CRSW) dated 2/7/12 was reviewed on 2/8/12 at 7:20 AM. The CRSW indicated client #3 and #4 had graduated from high school. The CRSW indicated client #2 attended a local middle school. The CRSW indicated client #1, #5 and #6 attended a local high school. The CRSW indicated the group home was a, "Child Rearing Residence w/ (with) Specialized Program." The CRSW indicated the following DOB (Date of Birth) for the clients residing in the home:</p> <p>-client #1's DOB: 3/9/94</p> <p>-client #2's DOB: 6/24/98</p>		<p>group home clients who have reached the age of 18, and have graduated from a school based Special Education program, must be transitioned into an adult residential placement, prior to the age of 22. Damar Services will continue to make every effort to abide by this regulation and will continue to take progressive measures in order to find the most individually appropriate placements for current and future group home clients. A list of group home clients including their date of birth and projected educational completion date has been created and forwarded to the local and central offices of the Bureau of Developmental Disabilities Services. 4. The QMRP will continue to monitor the ages and academic progress of all group home clients in order to ensure that appropriate programming is in place and the respective client is on track to be transitioned into an appropriate adult placement within the mandated time frames. The agency will engage in continued communication with the Bureau of Developmental Disability Services to initiate and actively participate in the transition process. 5. Systemic changes will be completed by: March 17, 2012</p>		

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	<p>-client 3's DOB: 9/9/92</p> <p>-client #4's DOB: 6/25/89</p> <p>-client #5's DOB: 3/15/94</p> <p>-client #6's DOB: 5/26/96</p> <p>1. Client #3's record was reviewed on 2/8/12 at 7:15 AM. Client #3's Physicians Order form dated 2/1/12 indicated client #3's date of birth was 9/9/92.</p> <p>Interview with Resident Manager (RM) #1 on 2/8/12 at 9:00 AM indicated client #3 had graduated from high school in May of 2011. RM #1 indicated client #3 had aged out of the group home. RM #1 indicated client #3's housemates, clients #1, #2, #5 and #6 were still in middle and high school. RM #1 indicated client #3 was considered an adult and should be moved to an adult group home.</p> <p>2. Client #5's record was reviewed on 2/8/12 at 12:46 PM. Client #5's ISP (Individual Support Plan) dated 1/8/12 indicated client #5's date of birth was 6/25/89. The facility's Community Residential Surveyor Worksheet dated 2/7/12 indicated client #5 had graduated from high school.</p> <p>Interview with Resident Manager (RM)</p>						

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	<p>#1 on 2/8/12 at 9:00 AM indicated client #5 had graduated from high school in June of 2011. RM #1 indicated client #5 had aged out of the group home. RM #1 indicated client #4's housemates, clients #1, #2, #5 and #6 were still in middle and high school. RM #1 indicated client #4 was considered an adult and should be moved to an adult group home.</p> <p>9-3-5(c)</p>						