STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/03/18 Facility Number: 000996 Provider Number: 15G482 AIM Number: 100235460 At this Emergency Preparedness survey, Damar Services Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475. The facility has 6 certified beds. At the time of the survey the census was 6. Quality Review completed on 08/07/18 - DA	E 0000		
E 0007 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed the special needs of its client population, including, but not limited to, persons at-risk; the type of services the ICF/IID facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.475(a)(3). This deficient practice could affect all occupants. Findings include:	E 0007	E007 – 483.475(a)(3) 1. The current emergency preparedness plan will be revised to include what services the facility would be able to provide in an emergency, continuity of operations and delegations of authority as well as succession plans. 2. All clients have the potential to be affected by this deficiency. 3. The emergency preparedness plan (EPP) will be	09/02/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Based on record review on 08/03/18 at 11:30 a.m. with the Administrator the emergency preparedness plan (EPP) did not address: a) What services the facility would be able to provide, b) Continuity of operations and c) Delegations of authority and succession plans. Based on interview concurrent with record review it was acknowledged by the Administrator the EPP did not address items a, b and c above.		reviewed/revised at least annually by the Director of Community Living and Support Services (CLaSS) and the Director of Performance and Quality Improvement. The Qualified Intellectual Disability Professional (QIDP) will ensure the EPP binder in each home is up to date. 4. The emergency preparedness plan (EPP) will be reviewed/revised at least annually by the Director of CLaSS and the Director of PQI. The QIDP will ensure the EPP binder in each home is up to date. Upon new admissions or major decline in health status of the clients in the home, the EPP will be reviewed and revised as needed. 5. September 2, 2018	
E 0013 Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:32 a.m. with the Administrator there was limited information concerning policies and procedures based on the emergency plan set forth in paragraph (a) of this section, risk assessment at	E 0013	E013 – 483.475(b) 1. The Director of CLaSS, Director of PQI and the QIDP will ensure the EPP binder is complete and up to date. The current risk assessment will be reviewed and revised as at least annually by the Director of CLaSS and the Director of PQI. The policies and procedures addressing emergencies and communication will be reviewed and revised based on the findings from the risk assessment. All emergency policies and	09/02/2018

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	paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. Based on interview concurrent with record review it was acknowledged by the Administrator, policies and procedures based on the emergency plan set forth did not address risk assessment or communication.		procedures will be reviewed at least annually. The EPP will be developed based on the findings and revisions. 2. All clients have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually by the Director of CLaSS and the Director of PQI. 3. The current risk assessment will be reviewed and revised as at least annually by the Director of CLaSS, Director of PQI and the QIDP. The policies and procedures addressing emergencies and communication will be reviewed and revised based on the findings from the risk assessment. All emergency policies and procedures will be reviewed at least annually. The EPP will be developed based on the findings and revisions. 4. The Director of CLaSS, and the Director of PQI will ensure the policies and procedures are reviewed and revised a needed. The QIDP will ensure the EPP binder is complete and up to date in the homes. 5. September 2, 2018	
E 0015 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and	E 0015	E015 – 483.475(b)(1) 1. The policies and procedures addressing emergencies and communication, will include but	09/02/2018

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	clients, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.475(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/18 at 11:35 a.m. with the Administrator the emergency preparedness plan did not address 1) food, water, medical, pharmaceutical needs 2) alternative sources of energy, 3) temperature extremes, 4) emergency lighting, 5) proper disposal of sewage and waste. Based on interview concurrent with record review with the Administrator it was stated this policy did not contain information concerning items 1,2,3,4 and 5.		not be limited to; food, water, pharmaceutical, sources of energy, temperature extremes, emergency lighting, and proper disposal of sewage and waste. They will be reviewed and revised based on the findings from the risk assessment. All emergency policies and procedures will be reviewed at least annually. The EPP will be developed based on the findings and revisions. 2. All clients in the homes have the potential to be affected by the deficiency. The Director of CLaSS, and the Director of PQI will ensure the policies and procedures are reviewed and revised as needed at least annually. The QIDP will ensure the EPP binder is complete and up to date in the homes. 3. The policies and procedures addressing emergencies and communication, will include but not be limited to; food, water, pharmaceutical, sources of energy, temperature extremes, emergency lighting, and proper disposal of sewage and waste. They will be reviewed and revised based on the findings from the risk assessment. All emergency policies and procedures will be reviewed at least annually. The EPP will be developed based on the findings and revisions. 4. The Director of CLaSS, and the Director of PQI will ensure the policies and procedures are	

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			reviewed and revised as needed, at least annually. The QIDP will ensure the EPP binder is complete and up to date in the homes. 5. September 2, 2018	
E 0018 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered clients in the ICF/IID facility's care during and after an emergency. If on-duty staff and sheltered clients are relocated during the emergency, the ICF/IID facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.475(b)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:36 a.m. with the Administrator there was nothing in the Emergency Preparedness policy which addressed a system to track staff and clients during an emergency. Based on interview concurrent with record review with the Administrator it was acknowledged there was nothing in the policy which addressed the tracking of staff and clients.	E 0018	E018 – 483.475(b)(2) 1. The EPP will contain a spreadsheet to track the individuals and staff being relocated. It will contain the names of the clients and staff, the name of the relocation site and the relocation address. The relocation information will also be in the CLaSS data base. The QIDP and the Director of CLaSS will ensure that the spreadsheet is up to date. 2. All clients have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually by the Director of CLaSS and the Director of PQI. 3. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS, and the Director of PQI. The spreadsheet is part of the EPP. The QIDP will ensure the EPP binder is correct and up to date. 4. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS, and the Director of PQI.	09/02/2018

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			The spreadsheet is part of the EPP. The QIDP will ensure the EPP binder is correct and up to date. 5. September 2, 2018	
E 0020 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include information for safe evacuation from the ICF/IID facility, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance in accordance with 42 CFR 483.475(b)(3). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:37 a.m. with the Administrator the Emergency Preparedness Plan (EPP) did not include: a) Care and treatment needs of evacuees. b) Staff responsibility. c) Transportation. d) Means of communication with external assistance. Based on interview concurrent with record review with the Administrator it was acknowledged the EPP did not include items a, b, c and d.	E 0020	E020 – 483.475(b)(3) 1. The EPP will include policies and procedures that address the safe evacuation from the facility. Information regarding the care and treatment of the clients will be added to the EPP. The staff's responsibility, transportation and communication with external assistance will be revised for clarity. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually by the Director of CLaSS and the Director of PQI. 3. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS, and the Director of PQI. The QIDP will ensure the EPP binder is correct and up to date. 4. The emergency preparedness plan (EPP) will be reviewed/revised at least annually by the Director of CLaSS and the Director of PQI. The QIDP will ensure the EPP binder in each home is up to date. Upon new admissions or major decline in	09/02/2018

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			health status of the client(s) that could affect the plan, the EPP will be reviewed and revised as needed. 5. September 2, 2018	
E 0022 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for clients, staff, and volunteers who remain in the facility in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/18 at 11:42 a.m., a policy and procedure that included a means to shelter in place for residents, staff, and volunteers who remain in the facility was not available for review. Based on interview at the time of review it was acknowledged by the Administrator the Emergency Preparedness Plan did not include a means to shelter in place for clients, staff, and volunteers who remain in the facility	E 0022	E022 – 483.475(b)(4) 1. The policy and procedure that addresses sheltering in place for residents, staff and volunteers who are in the facility will be added to the EPP. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually by the Director of CLaSS and the Director of PQI. 3. The policy and procedure that addresses sheltering in place for residents, staff and volunteers who are in the facility will be added to the EPP. The EPP will be reviewed and revised as needed, at least annually by the Director of CLaSS and the Director of PQI. The QIDP will ensure that the binder is correct and up to date. 4. The policy and procedure that addresses sheltering in place for residents, staff and volunteers who are in the facility will be added to the EPP. The EPP will be reviewed and revised as needed, at least annually by the Director of CLaSS and the Director	09/02/2018

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			of PQI. 5. September 2, 2018	
E 0023 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves client information, protects confidentiality of client information, and secures and maintains the availability of records in accordance with 42 CFR 483.475(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:45 a.m. with the Administrator the facility did not address a system to preserve, protect and secure medical documentation. Based on interview concurrent with record review with the Administrator, nothing could be found in the emergency preparedness plan which addressed preserving, protecting and securing medical documentation.	E 0023	E023 – 483.475(b)(5) 1. The policy and procedure that addresses the preservation, protection, and security of medical information and documentation will be added to the EPP. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The policy and procedure that addresses the preservation, protection, and security of medical information and documentation will be added to the EPP. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure that the binder is correct and up to date. 4. The policy and procedure that addresses the preservation, protection, and security of medical information and documentation will be added to the EPP. The EPP will be reviewed and revised as needed, at least annually by, the Director of CLaSS and the Director of PQI. 5. September 2, 2018	09/02/2018

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E 0024 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.475(b)(6). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:46 a.m. with the Administrator (PS) the emergency preparedness plan (EPP) did not address the use of volunteers in an emergency. Based on interview at the time of record review with the Administrator it was confirmed the plan did not address use of volunteers.	E 0024	E024 – 483.475(b)(6) 1. The policy and procedure that addresses the use of volunteers will be added to the EPP. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The policy and procedure that addresses the use of volunteers will be added to the EPP. It will include staffing procedures of volunteers. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure that the binder is correct and up to date. 4. The policy and procedure that addresses the use of volunteers will be added to the EPP. The EPP will be reviewed and revised as needed, at least annually by, the Director of CLaSS and the Director of PQI. 5. September 2, 2018	09/02/2018
E 0025 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of	E 0025	E025 – 483.475(b)(7) 1. The EPP will include contractual agreements with other	09/02/2018

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	arrangements with other ICF/IID facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to ICF/IID clients in accordance with 42 CFR 483.475(b)(7). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:50 a.m. with the Administrator the emergency preparedness plan (EPP) did not include contractual arrangements with other facilities to receive clients. Based on interview concurrent with record review with the Administrator it was acknowledged the EPP did not include arrangements with other facilities to receive clients to ensure continuity of care.		facilities, etc., to be used for relocation. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include contractual agreements with other facilities, etc., to be used for relocation. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure that the binder is correct and up to date. 5. September 2, 2018	
E 0026 Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the ICF/IID facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.475(b)(8). This deficient practice could affect all clients. Findings include: Based on record review and interview on 08/03/18 at 11:53 a.m. with the Administrator there was	E 0026	E026 – 483.475(b)(8) 1. The EPP will include policies and procedures that describe how the facility will provide care and treatment at an alternate site under the 1135 waiver. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include policies and procedures that describe how	09/02/2018

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	nothing in the emergency preparedness manual which addressed compliance with the 1135 waiver declared by the Secretary. Based on interview concurrent with record review with the Administrator it was stated she was not aware this waiver needed to be addressed and stated the policy would be updated to include the 1135 waiver.		the facility will provide care and treatment at an alternate site under the 1135 waiver. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure that the binder is correct and up to date. 5. September 2, 2018	
E 0029 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Clients' physicians (iv) Other ICF/IID facilities (v) Volunteers in accordance with 42 CFR 483.475(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review on 09/03/18 at 11:54 p.m. with the Administrator, the communication portion of the Emergency Preparedness Plan (EPP) did not include contact information for contracted entities, client physicians, other ICFs and volunteers. Based on interview concurrent with record review with the Administrator it was acknowledged the EPP did not include all contact information in the communication section for contracted entities, client physicians, other ICFs	E 0029	E029 – 483.475(c) 1. The policies and procedures in the EPP addressing emergencies and communication, will include but not be limited to; contact information for contracted entities, client physicians, other ICFs and volunteers. All EPP policies and procedures will be reviewed at least annually. The EPP will be developed based on the findings and revisions. 2. All clients in the homes have the potential to be affected by the deficiency. The Director of CLaSS, and the Director of PQI will ensure the policies and procedures are reviewed and revised as needed at least annually. The QIDP will ensure the EPP binder is complete and up to date in the homes.	09/02/2018

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	and volunteers.		3. The policies and procedures in the EPP addressing emergencies and communication, will include but not be limited to; contact information for contracted entities, client physicians, other ICFs and volunteers. They will be reviewed and revised based on the findings from the risk assessment. All emergency policies and procedures will be reviewed at least annually. The EPP will be developed based on the findings and revisions. 4. The Director of CLaSS, and the Director of PQI will ensure the policies and procedures are reviewed and revised as needed, at least annually. The QIDP will ensure the EPP binder is complete and up to date in the homes. 5. September 2, 2018	
E 0031 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff (ii) Other sources of assistance (iii) The State Licensing and Certification Agency (iv) The State Protection and Advocacy Agency in accordance with 42 CFR 483.475(c)(2). This deficient practice could affect all occupants. Findings include:	E 0031	E031 – 483.475(c)(2) 1. The policies and procedures in the EPP addressing emergencies and communication, will include contact information for the following: Federal, State, Local emergency preparedness staff; Indiana Bureau of Developmental Disabilities Services; Indiana Protection and Advocacy Services. All emergency policies and procedures will be reviewed at least annually.	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review on 08/03/18 at 11:55 a.m. with the Administrator the emergency preparedness plan (EPP) did not include how to communicate with: a. Federal, State, Local emergency preparedness staff. b. Indiana Bureau of Development Disability Services. c. Indiana Protection and Advocacy Services. Based on interview concurrent with record review with the Administrator it was acknowledged the EPP did not include items a, b and c in the communication portion of the EPP.		2. All clients in the homes have the potential to be affected by the deficiency. The Director of CLaSS, and the Director of PQI will ensure the policies and procedures are reviewed and revised as needed at least annually. The QIDP will ensure the EPP binder is complete and up to date in the homes. 3. The policies and procedures in the EPP addressing emergencies and communication, will include contact information for the following: Federal, State, Local emergency preparedness staff; Indiana Bureau of Developmental Disabilities Services; Indiana Protection and Advocacy Services. The EPP will be reviewed at least annually. 4. The Director of CLaSS, and the Director of PQI will ensure the policies and procedures of the EPP are reviewed and revised as needed, at least annually. The QIDP will ensure the EPP binder is complete and up to date in the homes. 5. September 2, 2018	
E 0032 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) ICF/IID facility's staff (ii) Federal, State, tribal, regional, or local emergency	E 0032	E032 – 483.475(c)(3) 1. The EPP will include the designated primary, and an alternate means for communication with staff and federal, state, and local	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

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DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

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	management agencies in accordance with 42 CFR 483.475(c)(3). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:56 a.m. with the Administrator the emergency preparedness policy (EPP) did not include primary and alternate means for communication of Emergency officials nor was staff able to show or demonstrate equipment. Based on interview concurrent with EPP review it was acknowledged the plan did not include primary and alternate means for communication of Emergency officials nor was staff able to show or demonstrate equipment.		emergency management agencies. The primary and alternate means will be determined, and the staff will be able to show or demonstrate the equipment. 2. All clients in the home have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include the designated primary and alternate means for communication with staff and federal, state, and local emergency officials. The primary and alternate means will be determined, and the staff will be able to show or demonstrate the equipment. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure the binder in the home is correct and up to date. 5. September 2, 2018	
E 0033 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (4) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as	E 0033	E033 – 483.475(c)(4)-(6) 1. The EPP will include policies and procedures to share medical information and documentation with other healthcare providers to	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

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DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

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	necessary, with other health care providers to maintain the continuity of care; (5) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); (6) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:57 a.m. with the Administrator the Emergency Preparedness Plan (EPP) did not include: a) A method for sharing information and medical documentation for clients under the ICF/IID facility's care, as necessary, with other health care providers to maintain the continuity of care; b) A means, in the event of an evacuation, to release client information as permitted under 45 CFR 164.510(b)(1)(ii); c. c) A means of providing information about the general condition and location of clients under the facility's care as permitted under 45 CFR 164.510(b)(4) in accordance with 42 CFR 483.475(c)(4). Based on interview concurrent with record review with the Administrator it was confirmed the EPP did not include items a, b or c.		continue care and release general information regarding the clients and their locations. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include policies and procedures to share medical information and documentation with other healthcare providers to continue care and release general information regarding the clients and their locations. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure the binder in the home is correct and up to date. 5. September 2, 2018	
E 0034 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a means of providing information about the ICF/IID facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction or	E 0034	E034 – 483.475(c)(7) 1. The EPP will include policies and procedures to share occupancy and to aid the Authority Having Jursidiction or IC. 2. All clients in the homes have	09/02/2018

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	15G482	A. BUILDING -- B. WING	08/03/2018

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DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

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	the Incident Command Center, or designee in accordance with 42 CFR 483.475(c)(7). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:57 a.m. with the Administrator the emergency preparedness policy (EPP) did not include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction (AHJ) or IC. Based on interview cocurrent with record review with the Administrator it was acknowledged the EPP did not include a method to share occupancy needs and ability to provide assistance to the Authority Having Jurisdiction (AHJ) or IC.		the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include policies and procedures to share occupancy and to aid the Authority Having Jurisdiction or IC. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure the binder in the home is correct and up to date. 5. September 2, 2018	
E 0035 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with clients and their families or representatives in accordance with 42 CFR 483.475(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:58 a.m. with the Administrator the emergency preparedness policy (EPP) did not include a method to share information the facility has deemed appropriate with clients and their families	E 0035	E035 – 483.475(c) (8) 1. The EPP will include policies and procedures to share the information from the EPP, with clients and their families or representatives. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include policies and procedures to share the information from the EPP, with clients and their families or	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

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	or representatives. Based on interview cocurrent with record review with the Administrator it was acknowledged the EPP did not include a method to share appropriate information with clients and their families or representatives.		representatives. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. The QIDP will ensure the binder in the home is correct and up to date. 5. September 2, 2018	
E 0036 Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 11:59 a.m. with the Administrator the emergency preparedness policy (EPP) did not include a training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.475(d). Based on interview cocurrent with record review with the Administrator it was acknowledged the EPP did not include a training and testing program.	E 0036	E036 – 483.475(d) 1. The EPP will include policies and procedures on training and testing. All staff will receive training and testing on the EPP during new hire orientation and annually. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include policies and procedures on training and testing. Staff will receive training and testing on the EPP during new hire orientation and annually. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, and training and testing at least	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

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			annually, by the Director of CLaSS, the Director of Training and the Director of PQI. The QIDP will ensure the binder in the home is correct and up to date. 5. September 2, 2018	
E 0037 Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review and interview on 08/03/18 at 11:59 a.m. with the Administrator the emergency preparedness policy (EPP) did not include initial training and testing for new employees, documented annual staff training, staff demonstrating their knowledge of the emergency preparedness program by taking a test on the subject and staff able to provide knowledge of the training program. Based on interview concurrent with record review with the Administrator it was stated the EPP had not been updated yet and did not contain information concerning initial training	E 0037	E037 – 483.475(d)(1) 1. The EPP will include policies and procedures on training and testing. All staff will receive training and testing on the EPP during new hire orientation and annually. Evacuations drills will be completed as required. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include policies and procedures on training and testing. Staff will receive training and testing on the EPP during new hire orientation and annually. Evacuation drills will be completed as required. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, and training and testing at least annually, by the Director of CLaSS, the Director of Training and the Director of PQI. The QIDP	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

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DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

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	and testing for new employees, documented annual staff training, staff demonstrating their knowledge of the emergency preparedness program by taking a test on the subject and staff able to provide knowledge of the training.		will ensure the binder in the home is correct and up to date. 5. September 2, 2018	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The ICF/IID facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IIC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.	E 0039	E039 – 483.475(d)(2) 1. The EPP will include policies and procedures to conduct a full scale, community-based exercise annually. Response to the exercise will be documented. 2. All clients in the homes have the potential to be affected by this deficiency. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 3. The EPP will include policies and procedures to conduct a full scale, community-based exercise annually. Response to the exercise will be documented. The EPP will be reviewed and revised as needed, at least annually, by the Director of CLaSS and the Director of PQI. 4. The EPP will be reviewed and revised as needed, and at least annually, by the Director of CLaSS, and the Director of PQI. The responses to the community-based exercise will be reviewed by the Director of CLaSS and the Director of PQI. The QIDP will ensure the binder in the home is correct and up to date.	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING -- B. WING	08/03/2018

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	Findings include: Based on record review on 08/03/18 at 12:00 p.m. with the Administrator the emergency preparedness policy (EPP) did not include the participation in a full scale community based exercise for the past year. Based on interview concurrent with record review with the Administratotr it was stated the facility had not participated in a full scale disaster drill for the past year.		5. September 2, 2018	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 08/03/18 Facility Number: 000996 Provider Number: 15G482 AIM Number: 100235460 At this Life Safety Code survey, Damar Services Inc-Camby Rd was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies. This one story building was determined to sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in common living areas and hard wired detectors in the resident bedrooms. The facility has a capacity of 6 and had a census of 6 at the time of this	K 0000		

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	survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.24. Quality Review completed on 08/07/18 - DA			
K S100 Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview; the facility failed to ensure 1 of 1 battery operated emergency lights in the facility was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 08/03/18 at 12:13 p.m., with the Administrator there was a battery	K S100	K0100 1. Maintenance had a change in staff and the monthly and 90-minute battery checks were not completed. The new Director of Maintenance will ensure that monthly and 90-minute battery checks are completed as required. 2. All clients have the potential to be affected by this deficiency. The Director of Maintenance will ensure the monthly and 90-minute checks are completed. 3. Maintenance had a change in staff and the monthly and 90-minute battery checks were not completed. The Director of Maintenance will ensure that monthly and 90-minute battery checks are completed as required.	09/02/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING 01 B. WING	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

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	powered light located in the Community room on the south side of the building and monthly battery operated emergency light documentation was not available for review. Additionally, no ninety minute test documentation was available for review. Based on interview at the time of record review, the Administrator acknowledged there was no documentation for monthly 30 seconds check and a 90 minute annual check.		4. The Director of Maintenance will ensure the battery checks are completed and documented as required. The QIDP will monitor the documentation sheets. 5. September 2, 2018	
K S222 Bldg. 01	NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	483.470(j)(1)(ii) Based on observation and interview, the facility failed to ensure 1 of 3 client room doors were arranged such that staff can rescue clients in an emergency if the client room doors were locked from within. This deficient practice could affect any occupant in the facility. Findings include: Based on observation on 08/03/18 at 12:35 p.m. with the Administrator the first client bedroom on the north side of the building had a doorknob with a lock and staff was unable to locate a key to unlock the door. Based on interview at the of observation it was acknowledged by the Administrator no keys were available to unlock the client rooms door on the north side of the building.	K S222	K0222 1. The keys to the client's doors are on the staff ring. The key needed for the designated client's room had come off the ring and was on top of the refrigerater in the staff office. A new key ring will be purchased, and the keys will be clearly marked for the associated doors. 2. All clients have the potential to be affected due to this deficiency. A new key ring will be purchased. 3. The keys to the client's doors are on the staff ring. The key needed for the designated client's room had come off the ring and was on top of the refrigerater in the staff office. A new key ring will be purchased, and the keys will be clearly marked for the associated doors. The QIDP will purchase a new ring and clearly mark the keys associated with the doors. 4. The QIDP will purchase a new ring and clearly mark the keys associated with the doors. Staff will check on each shift that all keys are present. 5. September 2, 2018	09/02/2018
K S346 Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm System - Out of Service 2012 EXISTING (Prompt) Where a required fire alarm system is out of service for more than four hours in a 24-hour			

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	15G482	A. BUILDING 01 B. WING	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DAMAR SERVICES INC--CAMBY RD	10600 E CR 700 S CAMBY, IN 46113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 33.2.3.4.1, 9.6.1.3, 9.6.1.5, 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written fire watch policy for when the fire alarm system is out of service for more than 4 hours in a 24-hour period. This deficient practice affects all clients, staff and visitors. Findings include: Based on record review on 08/03/18 at 12:40 p.m., with the Administrator, the facility provided a fire watch plan but it was incomplete. The plan failed to include the duties of the fire watch personnel being they would be assigned no other duties while on fire watch. Furthermore, the policy did not include contacting all entities at the conclusion of the fire watch to verify full funtion of the fire alrm system. Based on interview concurrent with policy review with the Administrator it was confirmed the fire watch policy was incomplete.	K S346	K0346 1. The policies and procedures of the fire watch policy will the reviewed and revised to ensure the staff designated to perform a fire watch, is not assigned any other duties during that time. At the end of the watch, the Director of CLaSS and/or the QIDP will contact all entities to inform them the system is fully functional. 2. All clients in the homes have the potential to be affected due to this deficiency. The policy and procedure will be reviewed and revised by the Director of CLaSS and the Director of PQI. 3. The fire watch policy will the reviewed and revised to ensure the staff designated to perform a fire watch, is not assigned any other duties during that time. At the end of the watch, the Director of CLaSS and/or the QIDP will contact all entities to inform them the system is fully functional. 4. The Fire Watch policy will be reviewed and revised annually by the Director of CLaSS and the Director of PQI. 5. September 2, 2018	09/02/2018

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K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 EXISTING (Prompt) NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25: 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to			

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	freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system. _____ (Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.) 33.2.3.5.3, 33.2.3.5.8, 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	1. Based on record review, and interview, the facility failed to document monthly sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be	K S353	K0353 1. 1, Maintenance had a change in staff and the monthly checks of the sprinkler gauge and valves were not completed. Also, there were missed quarterly sprinkler inspections. The new	09/02/2018

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	inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 08/03/18 at 12:07 p.m. with the Administrator, there was no documentation the sprinkler gauge and valves had been inspected on a monthly basis for the past year. Based on interview concurrent with record review it was acknowledged by the Administrator the wet sprinkler gauge and valves were not inspected and documented on a montly basis and were unaware of this requirement. 2. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure		Director of Maintenance will ensure that monthly checks of the sprinkler gauge and valves are completed. The new Director of Maintenance will also ensure the quarterly sprinkler inspections are completed as well. 2. 2. All clients have the potential to be affected by this deficiency. The Director of Maintenance will ensure the monthly and 90-minute checks are completed. 3. 3. Maintenance had a change in staff and the monthly checks of the sprinkler gauge and valves were not completed. Also, there were missed quarterly sprinkler inspections. The new Director of Maintenance will ensure that monthly checks of the sprinkler gauge and valves are completed as required. The new Director of Maintenance will also ensure the quarterly sprinkler inspections are completed as well. 4. 4. The new Director of Maintenance will ensure that monthly checks of the sprinkler gauge and valves are completed. The new Director of Maintenance will also ensure the quarterly sprinkler inspections are completed as well. The QIDP will monitor the documentation 5. September 2, 2018	

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	used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff. Findings include: Based on record review on 08/03/18 at 12:09 p.m., there was no first quarter sprinkler inspection for 2018 available for review. In addition, there was no sprinkler inspection available for review for the quarter of 2017. Lastly, there was no sprinkler inspection available for review for the second quarter of 2017. Based on an interview at the time of record review, the Administrator was unable to produce the inspections mentioned for the past year.			
K S354 Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service 2012 EXISTING (Prompt) Where a required automatic sprinkler system is out of service for more than 10 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 33.2.3.5.3, 9.7.6.1, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy when the automatic sprinkler system is out of service for more than 10 hours in a 24-hour period. NFPA 25, 15.5.2 (4) requires where a required fire protection system is out of service for more than 10 hours in	K S354	K0354 1. The policies and procedures of the Fire Watch Policy will the reviewed and revised to include notification of the insurance carrier and owner/operator. The policy will	09/02/2018

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	a 24-hour period, the impairment coordinator shall arrange for one of the following: (5) the fire department has been notified and (6) the insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. This deficient practice could affect all clients in the facility. Findings include: Based on record review on 08/03/18 at 12:10 p.m. with the Administrator the written Fire Watch Policy for the automatic sprinkler system lacked notification of the the insurance carrier, and owner/operator and there was nothing in the policy to indicate all entities were called back when the sprinkler system was restored to normal. This was acknowledged by the Administrator at the time of record review.		also include notification to all entities when the sprinkler system is restored to normal. 2. All clients in the homes have the potential to be affected due to this deficiency. The policy and procedure will be reviewed and revised by the Director of CLaSS and the Director of PQI. The notification to the entities when the system is restored to normal will be performed by the Director of Maintenance, the Director of CLaSS or the QIDP. 3. The policies and procedures of the Fire Watch Policy will the reviewed and revised to include notification of the insurance carrier and owner/operator. The policy will also include notification to all entities when the sprinkler system is restored to normal by the Director of CLaSS, the Director of Maintenance or the QIDP. 4. The Fire Watch policy will be reviewed and revised annually by the Director of CLaSS and the Director of PQI. 5. September 2, 2018	