

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G456		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2012	
NAME OF PROVIDER OR SUPPLIER DAMAR SERVICES INC--EL CAMIN				STREET ADDRESS, CITY, STATE, ZIP CODE 4912 EL CAMINO CT INDIANAPOLIS, IN 46221			
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W0000	<p>This visit was for the investigation of complaint #IN00111297.</p> <p>Complaint #IN00111297: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W240, W264 and W289.</p> <p>Dates of Survey: 7/3, 7/9, 7/10 and 7/11/12</p> <p>Facility Number: 000970 AIMS Number: 100239760 Provider Number: 15G456</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 7/12/12 by Tim Shebel, 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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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (A and B). The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect and/or abuse of clients. The governing body failed to ensure the facility completed through investigations.</p> <p>Findings include:</p> <p>1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 3 sampled clients (A and B). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect and/or sexual abuse of a client. The governing body failed to ensure the facility's investigations included a summary which substantiated and/or unsubstantiated the allegation being made, and/or included recommendations with the investigation. Please see W122.</p> <p>2. The governing body failed to exercise general policy and operating direction</p>	W0102	<p>1. A thoroughly documented investigation of the incident involving [Client #A and #B] on 6/29/12 has been completed. The investigation was completed by the Residential Manager on 7/11/12, which includes an interview of all clients in the home, a summary of the findings, and the plan for increased supervision. Damar Services, Inc. has a written Policy and procedure in place for client abuse and neglect. The Group Home manager and QDDPD will ensure that all safeguards are in place prior to the admission for any client that has sexually maladaptive behaviors and that a specific written plan for supervision is in place. Staff will ensure that all visual supervision is completed as written in the client's BSP and any suspected incidents are reported clearly and accurately to the group home manager and QDDPD. If nursing notification is warranted the Group Home Residential Manger will notify the nurse for medical advisement. 2. Incident reports from the home have been reviewed by the QDDP to identify the potential need for reporting additional follow-up and/or further investigation. At this time, all other incidents have been</p>	08/10/2012			

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	<p>over the facility to ensure the facility implemented its written policy and procedures to prevent neglect and abuse of clients in regard to a sexual incident for clients A and B.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in regard to a sexual incident involving clients A and B. Please see W104.</p> <p>This federal tag relates to complaint #IN00111297.</p> <p>9-3-1(a)</p>		<p>documented and reported appropriately. All documentation will be completed, including an agency Incident Report (immediately), BDDS Incident Report (within 24 hours) and a thorough investigation including a summary of the findings (within 5 days) for all incidents requiring a BDDS reportable. 3. The agency policy regarding Abuse and Neglect has been reviewed to ensure it complies with current State and Federal regulations and ensures appropriate safeguards for the individuals currently being served. All agency policies and procedures are reviewed at least annually and revised as needed. The Residential Manager and group home staff will receive documented training by the QDDP on the Agency Policy for Abuse and Neglect and the Policy and Procedure for Incident Reporting. The Residential Manager and QDDP 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 including a summary of the findings within 5 working days of the incident. The Group Home Incident Investigation form has been revised to ensure complete and thorough investigations are</p>		

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			<p>performed without involvement of individuals involved in 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 that have the potential to jeopardize the health and safety of a client will be reported to the Residential Manager, QDDPD, QDDP, Group Home Administrator and group home nurse 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 by the Residential Manager. BDDS incident report notifications regarding closure or the need for additional follow-up are received electronically from the State by the Group Home Administrator and disseminated to the QDDP and Home Manager for appropriate action. 5. Systemic changes will be completed by: August 10, 2012</p>		

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review, the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect and/or abuse of clients. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility completed through investigations.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect and abuse of clients in regard to a sexual incident for clients A and B. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted a thorough investigation in regard to a sexual incident involving clients A and B. Please see W154.</p> <p>This federal tag relates to complaint</p>	W0104	<p>1. Damar Services, Inc. has a written Policy and Procedure in place for client abuse and neglect. The Group Home manager and QDDPD will ensure that all safeguards are in place prior to the admission for any client that has sexually maladaptive behaviors and that a specific written plan for supervision is in place. Staff will ensure that all visual supervision is completed as written in the client's BSP and any suspected incidents are reported clearly and accurately to the group home manager and QDDPD immediately. A thoroughly documented investigation of the incident involving [Client #A and #B] on 6/29/12 has been completed. The investigation was completed by the Residential Manager on 7/11/12, which includes an interview of all clients in the home, a summary of the findings, and the plan for increased supervision. 2. Incident reports from the home have been reviewed by the QDDP to identify the potential need for reporting additional follow-up and/or further investigation. At this time, all other incidents have been documented and reported appropriately. All documentation will be completed, including an</p>	08/10/2012

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	#IN00111297. 9-3-1(a)		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 agency policy regarding Abuse and Neglect has been reviewed to ensure it complies with current State and Federal regulations and provides appropriate safeguards for the individuals currently being served. All agency policies and procedures are reviewed at least annually and revised as needed. The Residential Manager and group home staff will receive documented training by the QDDP on the Agency Policy for Abuse and Neglect and the Policy and Procedure for reporting incidents. The Residential Manager and QDDP 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 without involvement of individuals involved in the incident. The group home investigation/reporting policy has been reviewed to ensure it is current and reflective of the		

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			regulatory standards and agency needs. 4. All incidents of sexually inappropriate behavior will be reported to the Residential Manager, QDDPD, Group Home Administrator, and if necessary, the group home nurse 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 Services by the Residential Manager. BDDS incident report notifications regarding closure or the need for additional follow-up are received electronically from the State by the Group Home Administrator and disseminated to the QDDP and Home Manager for appropriate action. 5. Systemic changes will be completed by: August 10, 2012		

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (A and B). The facility failed to implement its policy and procedures to prevent neglect and/or sexual abuse of a client. The facility failed to ensure the facility's investigations included a summary which substantiated, and/or unsubstantiated the allegation being made and/or included recommendations with the investigation.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The facility failed to failed to implement its written policy and procedures to prevent neglect and abuse of clients in regard to a sexual incident for clients A and B. Please see W149. 2. The facility failed to conduct a thorough investigation in regard to a sexual incident involving clients A and B. Please see W154. <p>This federal tag relates to complaint #IN00111297.</p> <p>9-3-2(a)</p>	W0122	<ol style="list-style-type: none"> 1. Damar Services, Inc. has a written Policy and procedure in place for client abuse and neglect. The Group Home manager and QDDPD will ensure that all safeguards are in place prior to the admission for any client that has sexually maladaptive behaviors and that a specific written plan for supervision is in place. Staff will ensure that all visual supervision is completed as written in the client's BSP and any suspected incidents are reported clearly and accurately to the group home manager and QDDPD. If nursing notification is warranted the Group Home Residential Manger will notify the nurse for medical advisement.A thoroughly documented investigation of the incident involving [Client #A and #B] on 6/29/12 has been completed. The investigation was completed by the Residential Manager on 7/11/12, which includes an interview of all clients in the home, a summary of the findings, and the plan for increased supervision. 2. Incident reports from the home have been reviewed by the QDDP to identify the potential need for reporting additional follow-up and/or further investigation. At this time, all other incidents have been documented and reported 	08/10/2012	

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			appropriately. All documentation will be completed, including an agency Incident Report (immediately), BDDS Incident Report (within 24 hours) and a thorough investigation including a summary of the findings (within 5 days) for all incidents requiring a BDDS reportable. 3. The agency policy regarding Abuse and Neglect has been reviewed to ensure it complies with current State and Federal regulations and ensures appropriate safeguards for the individuals currently being served. All agency policies and procedures are reviewed at least annually and revised as needed. The Residential Manager and group home staff will receive documented training by the QDDP on the Agency Policy for Abuse and Neglect and the Policy and Procedure for Incident Reporting. The Residential Manager and QDDP 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 including a summary of the findings within 5 working days of the incident. The Group Home Incident Investigation form has been revised to ensure complete and thorough investigations are performed without involvement of individuals involved in the incident. The		

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			group home investigation/reporting policy has been reviewed to ensure it is current and reflective of the regulatory standards. 4. All incidents that have the potential to jeopardize the health and safety of a client will be reported to the Residential Manager, QDDPD, QDDP, Group Home Administrator and group home nurse 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 by the Residential Manager. BDDS incident report notifications regarding closure or the need for additional follow-up are received electronically from the State by the Group Home Administrator and disseminated to the QDDP and Home Manager for appropriate action. 5. Systemic changes will be completed by: August 10, 2012		

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (A and B), the facility neglected to implement its written policy and procedures to prevent neglect and abuse of clients in regard to a sexual incident.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, facility incident reports and/or investigations were reviewed on 7/3/12 at 3:05 PM. The facility's 6/28/12 reportable incident report indicated "A consumer [client A] came to staff and informed him his roommate [client B] attempted to put his penis in his [buttock]. The consumer [client A] stated his roommate was lying on his own bed rubbing himself and asking him if he wanted to have sex. The consumer [client A] stated he was lying on his own bed and his roommate came to his side of the room and pulled his arm trying to get him out of bed with his pants half way off his [buttock]. The consumer (client A) stated he stood up in an attempt to get away from him as his roommate grabbed him from behind, wrapped one of his legs around his and threw him onto his</p>	W0149	<p>1. Damar Services, Inc. has a written Policy and Procedure in place for client abuse and neglect. The Group Home manager and QDDPD will ensure that all safeguards are in place prior to the admission for any client that has sexually maladaptive behaviors and that a specific written plan for supervision is in place. Staff will ensure that all visual supervision is completed as written in the client's BSP and any suspected incidents are reported clearly and accurately to the group home manager and QDDPD immediately.</p> <p>2. Incident reports from the home have been reviewed by the QDDP to identify the potential need for reporting additional follow-up and/or further investigation. At this time, all other incidents have been documented and reported appropriately. 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</p>	08/10/2012			

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	<p>roommate's (client B's) bed. The consumer (client A) stated he fell onto the roommate's bed landing on his stomach and the roommate pulled his pants down and placed his penis in the crack of his [buttock]. The consumer [client A] stated he (client B) did not put his penis in his [rectum] hole. The consumer stated he got up and went to tell staff what happened. The RM (residential manager) instructed that one of the individuals sleep on the couch for the night with close supervision on both parties. The RM switched bedrooms and roommates to better accommodate everyone. The perpetrator will have a room of his own to ensure this can not happen again. The RM is seeking professional help to help provide the victim with professional counseling to deal with the incident. [Client B] has inappropriate sexual behavior in his BSP (Behavior Support plan) and will continue to be trained in this area. Staff will continue bed checks on all parties every fifteen minutes. No further incidents have occurred. Counseling sessions have been offered to both parties."</p> <p>The facility's 6/28/12 Incident Report indicated "At approximately 9:40 PM, peer 1 (client A) informed staff 2 (peer (client B) tried grabbing peer 1 in the closet of their bedroom. Peer 1 told peer</p>		<p>BDDS reportable.</p> <p>3. The agency policy regarding Abuse and Neglect has been reviewed to ensure it complies with current State and Federal regulations and provides appropriate safeguards for the individuals currently being served. The Residential Manager and group home staff will receive documented training by the QDDP on the Agency Policy for Abuse and Neglect and the Policy and Procedure for reporting incidents.</p> <p>4. All incidents of sexually inappropriate behavior will be reported to the Residential Manager, QDDPD, Group Home Administrator, and if necessary, the group home nurse 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 Services by the Residential Manager. BDDS incident report notifications regarding closure or the need for additional follow-up are received electronically from</p>		

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	<p>2 to let him out. Peer 2 grabbed peer 1 out of his bed. Peer 1 stood up and 2nd (second) peer 2 grabbed peer 1 from behind, tripped him with his leg causing them to fall on peers (sic) 2 bed. peer 2 pulled down peers (sic) 1 pants and attempted to place his penis in peers (sic) 1 rectum. Peer 1 informed staff."</p> <p>The facility's 6/29/12 Group Home Incident Investigation Form indicated when client B was interviewed in regard to how the incident started, "...[Client B] stated he started the conversation about sex. He stated he asked his roommate do he want to have sex. He stated his roommate stated okay...." The report indicated client B denied pulling his roommate out of his bed and denied attempting to put his penis in client A's rectum. The facility's investigation indicated "...[Client B] stated he was playing around with his roommate trying to trap him in their bedroom closet. He stated he was not aware he was not allowed to have sex with the other boys of the home. He stated he won't do it again...." The facility's 6/29/12 investigation did not indicate any additional clients were interviewed in regard to the sexual incident to ensure they had not been touched and/or approached sexually. The 6/29/12 investigation indicated facility staff had</p>		<p>the State by the Group Home Administrator and disseminated to the QDDP and Home Manager for appropriate action.</p> <p>5. Date Systemic changes will be completed: August 10, 2012</p>	

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	<p>completed a 15 minute check prior to the 6/28/12 incident. The facility's 6/29/12 investigation summary neglected to indicate if the allegation of sexual abuse was substantiated, and neglected to indicate if any additional corrective measures/actions were put in place other than to move client B to a bedroom by himself.</p> <p>During the 7/3/12 observation period between 4:05 PM and 6:22 PM, at the group home, 2 staff and the RM were present in the group home with clients A, B, C, D, E and F. At 4:16 PM, client A and B were in the dining room of the group home. Staff #1 was in the kitchen getting the snacks together, staff #2 was passing medications in the medication room and the RM was at door of the medication room in the hallway. Client B was standing next to client A. Clients A and B were together in the dining room, without staff, for less than 1 minute. At 6:00 PM, while the clients were eating dinner, clients A and B sat next to each other while they ate their dinner. Even though facility staff were present in the dining room, facility staff did not redirect client A and/or B to sit separate from each other.</p> <p>The facility's Visual (fifteen minute) Check book was reviewed on 7/3/12 at</p>			

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	<p>6:20 PM. The visual check book indicated the facility was conducting 15 minute checks on client B. The visual check book indicated the facility had conducted 15 minute checks on 6/28/12 at 9:30 PM prior to the incident which occurred at 9:40 AM when client A came out and told staff.</p> <p>Client B's record was reviewed on 7/9/12 at 1:37 PM. Client B's undated face sheet indicated client B was admitted to the group home on 5/18/12. Client B's 4/9/10 Comprehensive Psychological and Behavioral Risk Evaluation (pre-admission papers) indicated client B had a history of behaviors which included "...sexual acting out with others...." The 4/9/10 pre-admission paper work indicated client B's demonstrated "...problematic, dangerous and extreme behavior problems...." The 4/9/10 report indicated "...Regarding sexually maladaptive behaviors, [client B's] history of sexual reactivity including the violations of the rights of others started early in his life. He has exhibited a number of sexually acting out behaviors at home and in the community. He has a recent history of acting out sexually with other boys at [name of facility]-even while living on a highly supervised locked unit." The pre-admission report indicated client B had very poor "self regulation."</p>			

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	<p>Client B's 6/18/12 Individual Support Plan (ISP) indicated client B had an objective in place for "Good/Bad Touch." The ISP defined good touch as "wanted approved touch; this person gives you permission to touch them." The ISP objective defined bad touch as "unwanted touch-A touch that is inappropriate/sexual without permission."</p> <p>Client B's 6/18/12 Behavior Support Plan (BSP) indicated client B demonstrated "Inappropriate sexual behavior includes but is not limited to touching his genitalia in front of others, humping the air, showing others his genitalia, making sexual references to or about others...." Client B's 6/18/12 BSP also indicated client B demonstrated "Inappropriate Space includes but is not limited to hugging, touching others without permission, entering into others rooms or the staff's office without permission, getting within arm's length and refusing to leave a designated area when asked...." Client B's 6/18/12 ISP and/or BSP neglected to indicate how client B was to be monitored/supervised to prevent the client from demonstrating sexual aggression/inappropriate sexual behavior toward others. Client B's 6/18/12 ISP/BSP indicated the facility and/or the client's interdisciplinary team (IDT)</p>			

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	<p>neglected to meet/review the 6/28/12 sexual incident to ensure the facility had adequate staffing to monitor/supervise the clients, and to review the 15 minute checks (which were already in place) to ensure the checks met the client's required level of supervision. Client B's 6/18/12 ISP/BSP neglected to include the 15 minute checks/restrictive procedure the facility was utilizing/documenting.</p> <p>Client A's record was reviewed on 7/9/12 1:08 PM. Client A's 7/2/12 Medical Order/Medical Visit Form indicated client A started seeing a counselor/therapist in regard to the sexual incident on 7/2/12.</p> <p>Client A's 8/19/11 ISP/BSP indicated the facility and/or the client's IDT neglected to meet and/or document their review of the 6/28/12 sexual incident to ensure client B would be protected from client A.</p> <p>Interview with client A on 7/3/12 at 4:55 PM indicated client B used to be client B's roommate. When asked why client A was no longer client B's roommate, client A stated, "He (client B) stuck his private (penis) up my [buttock] in a bad way. I have to go to therapy to deal with it." When asked if client B stuck his private part in client A's buttock/rectum, client A stated, "He put his penis close to [anus]. He did not get it in." Client A stated</p>			

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	<p>client B tried to "trap me in the closet." Client A indicated client B had his penis out when he was in the closet, but he (client A) was able to get away from client B. Client A indicated client B grabbed his arm and placed client B's legs around him which caused client A to fall onto client B's bed. Client A indicated client B then pulled his (client A's) pants done and placed client B's penis near client A's [rectum]. Client A indicated he was able to get up off the bed and went and told staff what had happened. Client A indicated he did not want client B to touch him. When asked how the incident made client A feel, client A stated "After what he did, not so good." Client A indicated the 6/28/12 incident was the first time client B had attempted to touch him in a sexual way.</p> <p>Interview with client B on 7/3/12 at 5:10 PM stated the client demonstrated "inappropriate behavior." When asked what client B meant by inappropriate behavior, client B stated I get nervous and touch other peers." When asked how often client B demonstrated the inappropriate behavior, client B stated "First time doing it."</p> <p>Interview with staff #2 on 7/3/12 at 5:32 PM indicated she worked on 6/28/12 from 9:00 AM to 9:00 PM. Staff #2 indicated</p>			

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	<p>she had work before the 6/28/12 incident occurred. Staff #2 indicated she normally worked 3:00 PM to 11 PM and staff #1 worked 4 PM to 12 midnight. Staff #2 indicated she got off early on 6/28/12 as she had been at work since 9:00 AM that morning. Staff #2 indicated when she returned to work the next day, client A came to her and told her what happened. Staff #2 stated "[Client A] will say he is upset about it." Staff A stated "They (clients A and B) are friends. [Client B] acts like nothing happened." Staff #2 indicated client A was moved to the opposite end of the hall with a new roommate and client B was placed in a room by himself. Staff #2 indicated she was aware client B had demonstrated inappropriate sexual behaviors towards others in the past. Staff #2 indicated client B had not physically tried to have sex with anyone since he was admitted to the group home, but would make inappropriate sexual comments toward others. Staff #2 indicated the facility was conducting 15 minute checks prior to the incident due to the client's elopement behavior. Staff #2 indicated clients were not allowed to be in each other's bedroom. Staff #2 indicated client B was not allowed to close his bedroom door at night, so staff could monitor him. Staff #2 stated client B was "no allowed to cross over to back hallway" (where client</p>			

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	<p>A's bedroom was located).</p> <p>Interview with staff #1 on 7/3/12 at 5:40 PM indicated staff #1 worked the night the incident occurred. Staff #1 indicated the incident occurred at 9:40 PM on 6/28/12. When asked how many staff were working on 6/28/12 at 9:40 PM, staff #1 stated "Myself." Staff #1 indicated client A came out of his room and told him client B had tried to put his penis in his buttock. Staff #1 stated client A told staff #1 he went to the closet and client B followed him and "blocked the doorway." Staff #1 indicated client A stated client B pulled his pants down and showed client A his penis. Staff #1 indicated client A stated client A was able to "get out of the closet and (client B) pulled his penis out again." Staff #1 indicated client A reported client B did not insert his penis into client A, but that client A could "feel it up against him." Staff #1 stated client B was "monitored throughout the day." Staff #1 indicated 15 minute checks were being done prior to the incident. When asked if the 15 minute checks had changed, staff #1 stated "No." Staff #1 stated client B was no longer client A's roommate and as "They have been separated and closely watched." When asked what closely watched meant, staff #1 stated "Watch everywhere [client B] goes." Staff #1</p>			

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	<p>indicated client B demonstrated inappropriate sexual behavior.</p> <p>Interview with the RM on 7/3/12 at 6:00 PM indicated the RM conducted the investigation of the 6/28/12 incident. The RM stated the 6/28/12 allegation of abuse was "substantiated." The RM stated "He did it. [Client A] denied and then apologized he would not do that again." The RM indicated she did not document whether the investigation was substantiated or not in the summary. The RM indicated she did not interview any other clients. The RM indicated she changed client A and B's bedrooms. The RM indicated both clients were receiving counseling due to the 6/28/12 incident. The RM indicated client B demonstrated inappropriate sexual behavior and inappropriate space. When asked how often client B demonstrated the above mentioned inappropriate behaviors, The RM stated "Every other day." The RM stated client B had not touched a client sexually but would walk past staff and touch their leg and/or "rub up against staff." The RM indicated client B would make sexual comments toward others. The RM stated "What comes out of his mouth is sexually oriented." The RM indicated client B had a history of demonstrating inappropriate sexual behaviors in previous placements. The</p>			

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	<p>RM indicated client B did not place his penis into client A's rectum so client A was not examined. The RM indicated 15 minutes checks had ben done prior to the 6/28/12 incident and 15 minute checks were still being done as of 7/3/12. The RM indicated 15 minute checks were being done on all clients in the group home due to elopement behaviors. The RM indicated client B demonstrated elopement behavior. The RM indicated Damar policy only indicated staff needed to conduct 30 minute checks. The RM indicated client B was not to be alone with any client without staff being around. When asked how staff were to monitor clients A and B, the RM stated "Staff need to be with them in the same area." When asked if client B's IDT met to review the incident and/or review how the client was to be monitored/supervised, the RM indicated she spoke with the parents and got the clients into counseling. The RM indicated client B's ISP/BSP did not specifically indicate how client A was to be monitored/supervised. When asked how client A felt about client B, The RM stated "Ok to stay with him (in the same home) but feels it was not right."</p> <p>Interview with administrative staff #1 and #2 on 7/9/12 at 3:05 PM indicated client B had a history of inappropriate sexual</p>			

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	<p>behavior/acting out toward others.</p> <p>Administrative staff #1 indicated client B had sexual incidents in his prior placements. Administrative staff #1 and #2 indicated Damar's policy required staff to monitor clients every 30 minutes. Administrative staff #1 and #2 indicated the group home was conducting 15 minute checks due to clients' elopement behaviors at the group home. Administrative staff #1 and #2 indicated the 15 minute checks were not part of client A and/or B's BSP. Administrative staff #2 indicated client B was placed in a room by himself after the 6/28/12 incident occurred to protect the other clients. Administrative staff #2 indicated client B was placed on 10 minute checks on 7/3/12 after the complaint survey was opened. Administrative staff #2 indicated facility staff were also trained on the 10 minute checks. Administrative staff #2 indicated client A and B's IDT did not meet after the 6/28/12 incident occurred. Administrative staff #1 and #2 indicated prior to the 6/28/12 incident, client B's ISP/BSP did not specifically indicate how facility staff were to monitor client B at the group home, and/or out in the community to ensure the client did not demonstrate inappropriate sexual behavior toward others.</p> <p>The facility's policy and procedures were</p>			

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	<p>reviewed on 7/10/12 at 1:00 PM. The facility's 11/7/11 policy entitled Abuse and Neglect of Children indicated "Damar's highest priority is to ensure the safety and to protect the well-being and human rights of all clients in care..."</p> <p>The facility's 11/7/11 policy indicated "Child Abuse can take at least six different forms:...a. Neglect: the failure of a parent or caregiver to provide a child with adequate food, clothing, shelter, medical care, education nor supervision. c. Sexual abuse: generally defined as any physical conduct with a child by an adult or older child in a position of power for the sexual gratification of the adult or older child. Other terms for for child sexual abuse include...child molestation,..."</p> <p>This federal tag relates to complaint #IN0011297.</p> <p>9-3-2(a)</p>				

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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 interview and record review for 1 of 5 allegations of abuse and/or neglect reviewed, the facility failed to conduct a thorough investigation in regard to a sexual incident.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, facility incident reports and/or investigations were reviewed on 7/3/12 at 3:05 PM. The facility's 6/28/12 reportable incident report indicated "A consumer [client A] came to staff and informed him his roommate [client B] attempted to put his penis in his [buttock]. The consumer [client A] stated his roommate was lying on his own bed rubbing himself and asking him if he wanted to have sex. The consumer [client A] stated he was lying on his own bed and his roommate came to his side of the room and pulled his arm trying to get him out of bed with his pants half way off his [buttock]. The consumer (client A) stated he stood up in an attempt to get away from him as his roommate grabbed him from behind, wrapped one of his legs around his and threw him onto his roommate's (client B's) bed. The</p>	W0154	<p>1. Damar Services, Inc. has completed and documented a thorough investigation of the incident involving [Client #A and #B] on 6/29/12. The investigation was completed by the Residential Manager on 7/11/12. 2. Incident reports from the home have been reviewed by the QDDP to identify the potential 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 through investigation (within 5 days) for all incidents requiring a BDDS reportable. 3. The Residential Manager and QDDP 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 without involvement of individuals involved in the incident. The</p>	08/10/2012	

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	<p>consumer (client A) stated he fell onto the roommate's bed landing on his stomach and the roommate pulled his pants down and placed his penis in the crack of his [buttock]. The consumer [client A] stated he (client B) did not put his penis in his [rectum] hole. The consumer stated he got up and went to tell staff what happened...."</p> <p>The facility's 6/28/12 Incident Report indicated "At approximately 9:40 PM, peer 1 (client A) informed staff 2 (peer (client B) tried grabbing peer 1 in the closet of their bedroom. Peer 1 told peer 2 to let him out. Peer 2 grabbed peer 1 out of his bed. Peer 1 stood up and 2nd (second) peer 2 grabbed peer 1 from behind, tripped him with his leg causing them to fall on peers (sic) 2 bed. peer 2 pulled down peers (sic) 1 pants and attempted to place his penis in peers (sic) 1 rectum. Peer 1 informed staff."</p> <p>The facility's 6/29/12 Group Home Incident Investigation Form indicated when client B was interviewed in regard to how the incident started, "...[Client B] stated he started the conversation about sex. He stated he asked his roommate do he want to have sex. He stated his roommate stated okay...." The report indicated client B denied pulling his roommate out of his bed and denied</p>		<p>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, QDDP 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 Services. The Residential Manager and QDDP will be responsible for completing the thoroughly 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: August 10, 2012</p>				

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	<p>attempting to put his penis in client A's rectum. The facility's investigation indicated "...[Client B] stated he was playing around with his roommate trying to trap him in their bedroom closet. He stated he was not aware he was not allowed to have sex with the other boys of the home. He stated he won't do it again...." The facility's 6/29/12 investigation did not indicate any additional clients were interviewed in regard to the sexual incident to ensure they had not been touched and/or approached sexually. The facility's 6/29/12 investigation summary failed to indicate if the allegation of sexual abuse was substantiated.</p> <p>Interview with the RM on 7/3/12 at 6:00 PM indicated the RM conducted the investigation of the 6/28/12 incident. The RM stated the 6/28/12 allegation of abuse was "substantiated." The RM stated "He did it. [Client A] denied and then apologized he would not do that again." The RM indicated she did not document whether the investigation was substantiated or not in the summary. The RM indicated she did not interview any other clients.</p> <p>This federal tag relates to complaint #IN00111297.</p>			

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (B), the client's Individual Support Plan (ISP) did not indicate how facility staff were to monitor and/or supervise the client to ensure the client did not demonstrate inappropriate sexual behavior toward others.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, facility incident reports and/or investigations were reviewed on 7/3/12 at 3:05 PM. The facility's 6/28/12 reportable incident report indicated "A consumer [client A] came to staff and informed him his roommate [client B] attempted to put his penis in his [rectum]. The consumer [client A] stated his roommate was lying on his own bed rubbing himself and asking him if he wanted to have sex. The consumer [client A] stated he was lying on his own bed and his roommate came to his side of the room and pulled his arm trying to get him out of bed with his pants half way off his [buttock]. The consumer (client A) stated he stood up in an attempt to get away from him as his roommate grabbed him</p>	W0240	<p>1. The Behavior Support plan (BSP) for Client #B regarding Inappropriate Sexual Behavior have been revised to include specific reactive strategies for how the facility staff are to handle the supervision of client #B within the home, in the community and at school. The revision also addresses the increased supervision levels at night and when in his room. Verbal approval for this BSP has been obtained from the respective Legal Guardians and Human Rights approval has been obtained for the revised BSP. 2. The BSP's for all clients at the El Camino group home have been reviewed to ensure there is no need for revisions within the plans. The QDDP and Group Home Manager will review and monitor all BSP's to ensure that all plans specifically indicate how the facility staffs are to handle specific client behaviors, including inappropriate sexual behavior. The QDDP and Group Home Manager will review each plan monthly to ensure it is effective for the client's current needs and make revisions as needed. 3. The QDDP and Group Home Manager will review and monitor all BSP's for effectiveness and</p>	08/10/2012

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	<p>from behind, wrapped one of his legs around his and threw him onto his roommate's (client B's) bed. The consumer (client A) stated he fell onto the roommate's bed landing on his stomach and the roommate pulled his pants down and placed his penis in the crack of his [buttock]. The consumer [client A] stated he (client B) did not put his penis in his [anus] hole. The consumer stated he got up and went to tell staff what happened. The RM (residential manager) instructed that one of the individuals sleep on the couch for the night with close supervision on both parties. The RM switched bedrooms and roommates to better accommodate everyone. The perpetrator will have a room of his own to ensure this can not happen again...[Client B] has inappropriate sexual behavior in his BSP (Behavior Support plan) and will continue to be trained in this area. Staff will continue bed checks on all parties every fifteen minutes...."</p> <p>The facility's 6/28/12 Incident Report indicated "At approximately 9:40 PM, peer 1 (client A) informed staff 2 (peer) (client B) tried grabbing peer 1 in the closet of their bedroom. Peer 1 told peer 2 to let him out. Peer 2 grabbed peer 1 out of his bed. Peer 1 stood up and 2nd (second) peer 2 grabbed peer 1 from behind, tripped him with his leg causing</p>		<p>update and revise as needed to accommodate the needs of each individual client. The QDDP and Group Home Manager will review each plan monthly through monthly documented reviews of progress to ensure the plan is effective for the client's current needs and make revisions as necessary. 4. The QDDP and Group Home Manager will review and monitor all BSP's to ensure that all plans specifically indicate how the facility staffs are to handle specific client behaviors, including inappropriate sexual behavior. The QDDP and Group Home Manager will review each plan monthly to ensure it is effective for the Client's current needs and make revisions as needed. The Group Home Manager and QDDP will ensure that parent/guardian and HRC approval is updated at least annually and prior to the implementation of any new plan. 5. Systemic changes will be completed by: August 10, 2012</p>	

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	<p>them to fall on peers (sic) 2 bed. peer 2 pulled down peers (sic) 1 pants and attempted to place his penis in peers (sic) 1 rectum. Peer 1 informed staff."</p> <p>The facility's 6/29/12 Group Home Incident Investigation Form indicated facility staff had completed a 15 minute check prior to the 6/28/12 incident.</p> <p>During the 7/3/12 observation period between 4:05 PM and 6:22 PM, at the group home, 2 staff and the RM were present in the group home with clients A, B, C, D, E and F. At 4:16 PM, client A and B were in the dining room of the group home. Staff #1 was in the kitchen getting the snacks together, staff #2 was passing medications in the medication room and the RM was at door of the medication room in the hallway. Client B was standing next to client A. Clients A and B were together in the dining room, without staff, for less than 1 minute. At 6:00 PM, while the clients were eating dinner, clients A and B sat next to each other while they ate their dinner. Even though facility staff were present in the dining room, facility staff did not redirect client A and/or B to sit separate from each other.</p> <p>The facility's Visual (fifteen minute) Check book was reviewed on 7/3/12 at</p>			

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	<p>6:20 PM.</p> <p>The visual check book indicated the facility was conducting 15 minute checks on client B. The visual check book indicated the facility had conducted 15 minute checks on 6/28/12 at 9:30 PM prior to the incident which occurred at 9:40 AM when client A came out and told staff.</p> <p>Client B's record was reviewed on 7/9/12 at 1:37 PM. Client B's 6/18/12 Behavior Support Plan (BSP) indicated client B demonstrated "Inappropriate sexual behavior includes but is not limited to touching his genitalia in front of others, humping the air, showing others his genitalia, making sexual references to or about others...." Client B's 6/18/12 BSP also indicated client B demonstrated "Inappropriate Space includes but is not limited to hugging, touching others without permission, entering into others rooms or the staff's office without permission, getting within arm's length and refusing to leave a designated area when asked...." Client B's 6/18/12 ISP and/or BSP did not indicate how client B was to be monitored/supervised to prevent the client from demonstrating sexual aggression/inappropriate sexual behavior toward others.</p> <p>Interview with staff #2 on 7/3/12 at 5:32</p>			

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	<p>PM indicated she was aware client B had demonstrated inappropriate sexual behaviors towards others in the past. Staff #2 indicated client B had not physically tried to have sex with anyone since he was admitted to the group home, but would make inappropriate sexual comments toward others. Staff #2 indicated the facility was conducting 15 minute checks prior to the incident due to the client's elopement behavior. Staff #2 indicated clients were not allowed to be in each other's bedroom. Staff #2 indicated client B was not allowed to close his bedroom door at night, so staff could monitor him. Staff #2 stated client B was "no allowed to cross over to back hallway" (where client A's bedroom was located).</p> <p>Interview with staff #1 on 7/3/12 at 5:40 PM indicated 15 minute checks were being done prior to the incident. When asked if the 15 minute checks had changed, staff #1 stated "No." Staff #1 stated client B was no longer client A's roommate and as "They have been separated and closely watched." When asked what closely watched meant, staff #1 stated "Watch everywhere [client B] goes."</p> <p>Interview with the RM on 7/3/12 at 6:00 PM indicated she changed client A and</p>			

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	B's bedrooms. The RM indicated both clients were receiving counseling due to the 6/28/12 incident. The RM indicated client B demonstrated inappropriate sexual behavior and inappropriate space. When asked how often client B demonstrated the above mentioned inappropriate behaviors, The RM stated "Every other day." The RM stated client B had not touched a client sexually but would walk past staff and touch their leg and/or "rub up against staff." The RM indicated client B would make sexual comments toward others. The RM stated "What comes out of his mouth is sexually oriented." The RM indicated client B had a history of demonstrating inappropriate sexual behaviors in previous placements. The RM indicated 15 minutes checks had ben done prior to the 6/28/12 incident and 15 minute checks were still being done as of 7/3/12. The RM indicated Damar policy only indicated staff needed to conduct 30 minute checks. The RM indicated client B was not to be alone with any client without staff being around. When asked how staff was to monitor clients A and B, the RM stated "Staff need to be with them in the same area." When asked if client B's IDT met to review the incident and/or reviewed how the client was to be monitored/supervised, the RM indicated she spoke with the parents and got the			

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	<p>clients into counseling. The RM indicated client B's ISP/BSP did not specifically indicate how client A was to be monitored/supervised.</p> <p>Interview with administrative staff #1 and #2 on 7/9/12 at 3:05 PM indicated client B had a history of inappropriate sexual behavior/acting out toward others. Administrative staff #1 indicated client B had sexual incidents in his prior placements. Administrative staff #1 and #2 indicated Damar's policy required staff to monitor clients every 30 minutes. Administrative staff #1 and #2 indicated the group home was conducting 15 minute checks due to clients' elopement behaviors at the group home. Administrative staff #1 and #2 indicated the 15 minute checks were not part of client A's BSP. Administrative staff #2 indicated client B was placed in a room by himself after the 6/28/12 incident occurred to protect the other clients. Administrative staff #2 indicated client B was placed on 10 minute checks on 7/3/12 after the complaint survey was opened. Administrative staff #1 and #2 indicated prior to the 6/28/12 incident, client B's ISP/BSP did not specifically indicate how facility staff were to monitor client B at the group home, and/or out in the community to ensure the client did not demonstrate inappropriate sexual</p>			

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	<p>behavior toward others.</p> <p>This federal tag relates to complaint #IN00111297.</p> <p>9-3-4(a)</p>			

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on interview and record review for 3 of 3 sampled clients (A, B and C), the facility failed to ensure the systemic use of 15 minute checks were reviewed and/or approved by the facility's Human Rights Committee (HRC) to ensure the clients' rights were not violated.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, facility incident reports and/or investigations were reviewed on 7/3/12 at 3:05 PM. The facility's 6/28/12 reportable incident report indicated "A consumer [client A] came to staff and informed him his roommate [client B] attempted to put his penis in his [rectum]. The consumer [client A] stated his roommate was lying on his own bed rubbing himself and asking him if he wanted to have sex. The consumer [client A] stated he was lying on his own bed and his roommate came to his side of the room and pulled his arm trying to get him</p>	W0264	<p>1. The Group Home has ensured that Client #A, B and C has a behavior support plan addendum written for increased supervision under every 30 minutes due to elopement and/or inappropriate sexual behavior. These BSP plans have been revised under their respective maladaptive behavior. Verbal approval has been obtained from all Legal Guardians and had been reviewed and approved by the Damar HRC. 2. The QMRP or Group Home Manager will review all other plans to ensure that no plan is intrusive to the clients' rights and will ensure that HRC approval is obtained for any plan that is deemed restrictive or intrusive to the clients' rights. All other plans that require increased visual checks due to elopement and/or inappropriate sexual behavior were revised to include the every 15 minute visual checks under their elopement or ISB section of the BSP. Verbal approval has been obtained for these revised BSP's from the respective Legal Guardians and</p>	08/10/2012

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	<p>out of bed with his pants half way off his [buttock]. The consumer (client A) stated he stood up in an attempt to get away from him as his roommate grabbed him from behind, wrapped one of his legs around his and threw him onto his roommate's (client B's) bed. The consumer (client A) stated he fell onto the roommate's bed landing on his stomach and the roommate pulled his pants down and placed his penis in the crack of his [anus]. The consumer [client A] stated he (client B) did not put his penis in his [rectum] hole. The consumer stated he got up and went to tell staff what happened. The RM (residential manager) instructed that one of the individuals sleep on the couch for the night with close supervision on both parties. The RM switched bedrooms and roommates to better accommodate everyone. The perpetrator will have a room of his own to ensure this can not happen again...Staff will continue bed checks on all parties every fifteen minutes...."</p> <p>The facility's 6/29/12 Group Home Incident Investigation Form indicated facility staff had completed a 15 minute check prior to the 6/28/12 incident.</p> <p>The facility's Visual (fifteen minute) Check book was reviewed on 7/3/12 at 6:20 PM.</p>		<p>Human Rights approval has been obtained for all BSP revisions. 3. Any plan including the use of increased supervision under every 30 minutes is considered intrusive or restrictive to a clients rights will have parent/legal guardian approval and be reviewed and approved by the Human Rights Committee (HRC) prior to implementation. The HRC meets at least 1 time monthly and is available for emergency approvals as needed for any plans that are deemed immediately necessary. parent/guardian approval is required prior to the scheduled HRC meeting that month. If an item is deemed restrictive and requires HRC approval the Group Home Manager or QDDPD will obtain verbal and written parent/guardian approval. Once the Legal Guardian has given approval for the plan it must be submitted to HRC for approval prior to implementation. 4. The HRC monitors and documents all restrictive items at Damar Services, Inc. The HRC meets one time monthly to review items that are deemed restrictive to a client's rights. The HRC is also available for emergency approvals for items that occur between regularly scheduled meetings. The HRC requires verbal or written consent from all Legal Guardians prior to giving approval on any item. The Group Home Manager or QMRP</p>				

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	<p>The visual check book indicated the facility was conducting 15 minute checks on client B.</p> <p>Client B's record was reviewed on 7/9/12 at 1:37 PM. Client B's 6/18/12 Behavior Support Plan (BSP) indicated client B demonstrated "Inappropriate sexual behavior includes but is not limited to touching his genitalia in front of others, humping the air, showing others his genitalia, making sexual references to or about others...." Client B's 6/18/12 BSP also indicated client B demonstrated "Inappropriate Space includes but is not limited to hugging, touching others without permission, entering into others rooms or the staff's office without permission, getting within arm's length and refusing to leave a designated area when asked...." Client B's 6/18/12 ISP and/or BSP did not indicate the facility's HRC reviewed and/or approved the use of 15 minute checks.</p> <p>2. The facility's Visual (fifteen minute) Check book was reviewed on 7/3/12 at 6:20 PM. The visual check book indicated the facility was conducting 15 minute checks on clients A and C.</p> <p>Client A's record was reviewed on 7/9/12 1:08 PM. Client A's 8/19/11 BSP</p>		<p>must obtain verbal approval from the legal guardian. Once the Legal Guardian has given approval for the item, it can be submitted to HRC for approval. Once HRC approval is given, the restrictive measure can go into effect. No restrictive intervention should be put into effect without both parent/legal guardian and HRC approval. 5. Systemic changes will be completed by: August 10, 2012</p>		

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	<p>indicated client A demonstrated inappropriate verbalizations, physical aggression, non compliance and obsessing. Client A's 8/19/11 ISP/BSP did not indicate the facility's HRC reviewed and/or approved the use of 15 minute checks.</p> <p>Client C's record was reviewed on 7/9/2 at 2:15 PM. Client C's 11/7/11 ISP/BSP indicated client C demonstrated physical aggression, property destruction, elopement, self-injurious behavior and inappropriate verbalization. Client C's 11/7/11 BSP did not indicate the facility's HRC reviewed and/or approved the use of 15 minute checks.</p> <p>Interview with the RM on 7/3/12 at 6:00 PM indicated 15 minutes checks had been done prior to the 6/28/12 incident and 15 minute checks were still being done as of 7/3/12. The RM indicated 15 minute checks were being done on all clients in the group home due to elopement behaviors.</p> <p>Interview with administrative staff #1 and #2 on 7/9/12 at 3:05 PM indicated client B had a history of inappropriate sexual behavior/acting out toward others. Administrative staff #1 indicated client B had sexual incidents in his prior placements. Administrative staff #1 and</p>			

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	<p>#2 indicated Damar's policy required staff to monitor clients every 30 minutes. Administrative staff #1 and #2 indicated the group home was conducting 15 minute checks due to clients' elopement behaviors at the group home. Administrative staff #1 and #2 indicated the 15 minute checks had not been reviewed and/or approved by the facility's HRC.</p> <p>This federal tag relates to complaint #IN00111297.</p> <p>9-3-4(a)</p>			

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on interview and record review for 3 of 3 sampled clients, the facility failed to ensure the use of 15 minute checks/restrictive interventions were part of each client's Behavior Support Plans.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, facility incident reports and/or investigations were reviewed on 7/3/12 at 3:05 PM. The facility's 6/28/12 reportable incident report indicated "A consumer [client A] came to staff and informed him his roommate [client B] attempted to put his penis in his [buttock]. The consumer [client A] stated his roommate was lying on his own bed rubbing himself and asking him if he wanted to have sex. The consumer [client A] stated he was lying on his own bed and his roommate came to his side of the room and pulled his arm trying to get him out of bed with his pants half way off his [buttock]. The consumer (client A) stated he stood up in an attempt to get away from him as his roommate grabbed him</p>	W0289	<p>1. 1. The Group Home has ensured that Client #A, B and C have a behavior support plan (BSP) addendum written for increased supervision under every 30 minutes due to elopement and/or inappropriate sexual behavior. These BSP's have been revised under their respective maladaptive behavior. Verbal approval has been obtained from all Legal Guardians and addendums have been reviewed and approved by the Damar HRC.</p> <p>2. The QMRP or Group Home Manager will review all other plans to ensure that no plan is intrusive to the clients' rights and will ensure that HRC approval is obtained for any plan that is deemed restrictive or intrusive to the clients' rights. All other plans that require increased visual checks due to elopement and/or inappropriate sexual behavior were revised to include 15 minute visual checks under their elopement or ISB section of the BSP. Verbal approval has been obtained for these revised BSP's from the respective Legal</p>	08/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G456		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/11/2012	
NAME OF PROVIDER OR SUPPLIER DAMAR SERVICES INC--EL CAMIN				STREET ADDRESS, CITY, STATE, ZIP CODE 4912 EL CAMINO CT INDIANAPOLIS, IN 46221			
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	<p>from behind, wrapped one of his legs around his and threw him onto his roommate's (client B's) bed. The consumer (client A) stated he fell onto the roommate's bed landing on his stomach and the roommate pulled his pants down and placed his penis in the crack of his [buttock]. The consumer [client A] stated he (client B) did not put his penis in his [rectum]. The consumer stated he got up and went to tell staff what happened. The RM (residential manager) instructed that one of the individuals sleep on the couch for the night with close supervision on both parties. The RM switched bedrooms and roommates to better accommodate everyone. The perpetrator will have a room of his own to ensure this can not happen again...Staff will continue bed checks on all parties every fifteen minutes...."</p> <p>The facility's 6/29/12 Group Home Incident Investigation Form indicated facility staff had completed a 15 minute check prior to the 6/28/12 incident.</p> <p>The facility's Visual (fifteen minute) Check book was reviewed on 7/3/12 at 6:20 PM. The visual check book indicated the facility was conducting 15 minute checks on client B.</p> <p>Client B's record was reviewed on 7/9/12</p>		<p>Guardians and Human Rights approval has been obtained for all BSP revisions.</p> <p>3. Any plan including the use of increased supervision under every 30 minutes is considered intrusive or restrictive to a client's rights and will have parent/legal guardian approval and be reviewed and approved by the Human Rights Committee (HRC) prior to implementation. The HRC meets at least 1 time monthly and is available for emergency approvals as needed for any plans that are deemed immediately necessary. Parent/guardian approval is required prior to the scheduled HRC meeting that month. If an item is deemed restrictive and requires HRC approval, the Group Home Manager or QDDPD will obtain verbal and written parent/guardian approval. Once the Legal Guardian has given approval for the plan, it must be submitted to HRC for approval prior to implementation.</p> <p>4. The QDDP and Group Home Manager will review and monitor all BSP's to ensure that all plans specifically indicate how the facility staff are to handle specific client behaviors, including inappropriate sexual behavior. The QDDP and Group Home Manager will review each plan monthly to ensure it is effective for the Client's current needs and make revisions as needed. The</p>				

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	<p>at 1:37 PM. Client B's 6/18/12 Behavior Support Plan (BSP) indicated client B demonstrated "Inappropriate sexual behavior includes but is not limited to touching his genitalia in front of others, humping the air, showing others his genitalia, making sexual references to or about others...." Client B's 6/18/12 BSP also indicated client B demonstrated "Inappropriate Space includes but is not limited to hugging, touching others without permission, entering into others rooms or the staff's office without permission, getting within arm's length and refusing to leave a designated area when asked...." Client B's 6/18/12 ISP and/or BSP did not indicate facility staff were to conduct 15 minute checks due to client B's behaviors.</p> <p>2. The facility's Visual (fifteen minute) Check book was reviewed on 7/3/12 at 6:20 PM. The visual check book indicated the facility was conducting 15 minute checks on clients A and C.</p> <p>Client A's record was reviewed on 7/9/12 1:08 PM. Client A's 8/19/11 BSP indicated client A demonstrated inappropriate verbalizations, physical aggression, non compliance and obsessing. Client A's 8/19/11 ISP/BSP indicated the client's ISP/BSP did not</p>		<p>Group Home Manager and QDDP will ensure that parent/guardian and HRC approval is updated at least annually and prior to the implementation of any new plan or revision.</p> <p>5. Systemic changes will be completed by: August 10, 2012</p>	

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	<p>indicate the use of 15 minute checks had not been incorporated into the client's BSP.</p> <p>Client C's record was reviewed on 7/9/2 at 2:15 PM. Client C's 11/7/11 ISP/BSP indicated client C demonstrated physical aggression, property destruction, elopement, self-injurious behavior and inappropriate verbalization. Client C's 11/7/11 BSP did not indicate the use of 15 minutes had been incorporated into the client's BSP.</p> <p>Interview with the RM on 7/3/12 at 6:00 PM indicated 15 minutes checks had been done prior to the 6/28/12 incident and 15 minute checks were still being done as of 7/3/12. The RM indicated 15 minute checks were being done on all clients in the group home due to elopement behaviors.</p> <p>Interview with administrative staff #1 and #2 on 7/9/12 at 3:05 PM indicated client B had a history of inappropriate sexual behavior/acting out toward others. Administrative staff #1 indicated client B had sexual incidents in his prior placements. Administrative staff #1 and #2 indicated Damar's policy required staff to monitor clients every 30 minutes. Administrative staff #1 and #2 indicated the group home was conducting 15</p>			

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	<p>minute checks due to clients' elopement behaviors at the group home. Administrative staff #1 and #2 indicated the 15 minute checks were not part of client A, B and/or C's BSP.</p> <p>This federal tag relates to complaint #IN00111297.</p> <p>9-3-5(a)</p>			