STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G482	A. BUILDING 00 B. WING	12/08/2021

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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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00344871. This visit was done in conjunction with a pre-determined full annual recertification and state licensure survey and the Covid-19 focused infection control survey. Complaint #IN00344871: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at: W102, W104, W122, W149, W154, W157, W159, W214 and W227. Dates of Survey: 12/2/21, 12/3/21, 12/6/21, 12/7/21 and 12/8/21. Facility Number: 000996 Provider Number: 15G482 AIMS Number: 100235460 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/15/21.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 1 of 3 sampled clients (A). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its	W 0102	1. The QIDP and/or program management will be responsible to notify the Performance and Quality Improvement (PQI) department of all incidents of client-to-client aggression as well as	01/15/2022

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

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	policy and procedures to prevent neglect of client A regarding the prevention and investigation of his incidents of elopement behaviors and to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client A's active treatment program by failing to complete a re-assessment of client A's behavior management needs regarding a pattern of elopement behavior and failing to ensure client A's BSP (Behavior Support Plan) addressed client A's identified elopement behaviors. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (A). Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding the prevention and investigation of his incidents of elopement behaviors and to ensure the QIDP integrated, coordinated and monitored client A's active treatment program by failing to complete a re-assessment of client A's behavior management needs regarding a pattern of elopement behavior and failing to ensure client A's BSP addressed client A's identified elopement behaviors. Please see W104. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (A). Please see W122.		abuse/neglect/exploitation so that investigations can be performed for the incidents. The Director of CLaSS will be notified immediately regarding any incidents of aggression, abuse, neglect or exploitation and will notify the PQI department. 2. All clients have the potential to be affected by this deficiency. The Internal Reviewer/Liaison, who is independent of the CLaSS program, will complete a review of the BDDS secure portal for any incidents twice weekly and report any patterns to the CLaSS department leaders. 3. The QIDP will track behavioral incidents and report to the Interdisciplinary Team monthly. Behavior Support Plans will be reviewed and revised monthly as indicated, to include all behaviors of aggression, abuse, neglect, and exploitation. Staff will be trained/retrained on the BSPs as revisions are made. 4. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by PQI and CLaSS leadership. Behavior incidents will be reviewed at the monthly interdisciplinary team meeting. The Internal Reviewer/Liaison will conduct a review of all group home incidents including 1/1/2021-12/31/2021 to ensure appropriate follow up was completed.	

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	This federal tag relates to complaint #IN00344871. 9-3-1(a)			
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 3 sampled clients (A), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding the prevention and investigation of his incidents of elopement behaviors and to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client A's active treatment program by failing to complete a re-assessment of client A's behavior management needs regarding a pattern of elopement behavior and failing to ensure client A's BSP (Behavior Support Plan) addressed client A's identified elopement behaviors. Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A regarding the prevention and investigation of his incidents of elopement behaviors. Please see W149. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the QIDP integrated, coordinated and monitored client A's active treatment program	W 0104	1. The QIDP and/or program management will be responsible to notify PQI and of all incidents of client-to-client aggression as well as abuse/neglect/exploitation so that investigations can be performed for the incidents. The Director of CLaSS will be notified immediately regarding any incidents of aggression, abuse, neglect, or exploitation. 2. All clients have the potential to be affected by not having all behaviors noted in the BSP with interventions in attempts to prevent the behavior being displayed. 3. The QIDP will track the behaviors displayed on a monthly basis. Patterns identified will result in a re-assessment of the individual's needs. The interdisciplinary team will discuss interventions and revise the BSP with a plan to decrease/eliminate the behavior. 4. The Internal Reviewer/Liaison will complete a review of the BDDS secure portal for any incidents twice weekly. There are bi-weekly CLaSS Flash	01/15/2022

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	by failing to complete a re-assessment of client A's behavior management needs regarding a pattern of elopement behavior and failing to ensure client A's BSP addressed client A's identified elopement behaviors. Please see W159. This federal tag relates to complaint #IN00344871. 9-3-1(a)		meetings for on-going reviews of all incidents by PQI and CLaSS leadership. The QIDP will review the behavior support plans monthly and identify any patterns and bring the information from the re-assessment to the interdisciplinary team meeting.	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (A). The facility failed to implement its policy and procedures to prevent neglect of client A regarding the prevention and investigation of his incidents of elopement behaviors. Findings include: 1. The facility failed to implement its policy and procedures to prevent neglect of client A regarding the prevention and investigation of his incidents of elopement behaviors. Please see W149. 2. The facility failed to thoroughly investigate 4 incidents of client A's elopement behaviors. Please see W154. 3. The facility failed to develop and implement effective corrective measures to prevent incidents of client A's elopement behaviors. Please see W157.	W 0122	1. The QIDP and/or program management will ensure the client's rights are protected by notifying the Performance and Quality Improvement (PQI) department of all incidents of client-to-client aggression as well as abuse/neglect/exploitation so that investigations can be performed for the incidents. 2. All clients have the potential to be affected by not having behaviors noted in the BSP with interventions in attempts to prevent the behaviors being displayed. The QIDP will ensure that behaviors and interventions are noted in the BSP. 3. The QIDP will track the behaviors displayed monthly and as needed. Patterns identified will result in a re-assessment of the individual's needs. The interdisciplinary team will discuss interventions and revise the BSP with a plan to decrease/eliminate	01/15/2022

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	This federal tag relates to complaint #IN00344871. 9-3-2(a)		the behavior. 4. The Internal Reviewer/Liaison will complete a review of the BDDS secure portal for any incidents twice weekly. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by PQI and CLaSS leadership. The QIDP will review the behavior support plans monthly and identify any patterns and bring the information from the re-assessment to the interdisciplinary team meeting.	
W 0149 Bldg. 00	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. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to implement its policy and procedures to prevent neglect of client A regarding the prevention and investigation of his incidents of elopement behaviors. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/2/21 at 3:03 PM. The review indicated the following: 1. BDDS report dated 11/26/21 indicated, "[Client A], age and gender] who lives in a Supervised Group Living site with 5 other young men. [Diagnoses]. His targeted behaviors are: property destruction, elopement and inappropriate sexual	W 0149	1. The QIDP and/or program management will be responsible to notify the Performance and Quality Improvement (PQI) department of all incidents of client-to-client aggression as well as abuse/neglect/exploitation so that investigations can be performed for the incidents. The Director of CLaSS will be notified immediately regarding any incidents of aggression, abuse, neglect or exploitation and will notify the PQI department. Policies and procedures will be followed as written. 2. All clients have the potential to be affected by not having behaviors noted in the BSP with	01/15/2022

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	behavior. Around 11:00 am, [client A] was riding with staff and [client C] to take [client F] to work. During the ride, [client C] started talking to [client A] and [client A] ignored him because he didn't want to talk with him. [Client C] continued to annoy both [clients A and F]. [Client A] threw his water bottle at [client C]. Staff pulled over to defuse the situation. Once they reached [restaurant] [client C] tried to attack [client A] and [client A] got out of the van with [client F]. [Client C] then attacked staff and (sic) while staff was trying to get away from [client C]. [Client A] walked away. This writer, [AS (administrative staff) #1] called [police] for assistance in finding [client A] but while on the phone with the police, staff called and said they had found [client A]. [Client A] was out of sight for approximately 10-15 minutes. During the confrontation [client A] received a one-inch scratch on his left cheek and a three inch scratch on the side of his face. His right hand was also red and slightly swollen. Plan to Resolve: [Client A] was seen by the nurse and treated as needed. [Clients A and C] will not be riding in the van together. Continue to follow the HRC (human rights committee) approved behavior plan. We will continue to work with [client A] on appropriate responses to annoying behaviors of others." Investigation Summary dated 12/1/21 indicated the following: -"Program Director has established a new protocol that requires [clients A and C] to ride separately if possible. If separate trips are not possible then two staff are required for the trip so that one can be in the back with clients to monitor potential situations."		interventions in attempts to prevent the behavior being displayed. The QIDP will ensure that behaviors and interventions are noted in the BSP and include. 3. The QIDP will track the behaviors displayed monthly and as needed. Patterns identified will result in a re-assessment of the individual's needs. The interdisciplinary team will discuss and approve interventions and revise the BSP with a plan to decrease/eliminate the behavior. The behavior plans will be integrated with the work center as much as possible with respect to the environmental differences and include specific supervision. 4. The Internal Reviewer/Liaison will complete a review of the BDDS secure portal for any incidents twice weekly. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by PQI department and CLaSS leadership. The QIDP will review the behavior support plans at least monthly and identify any patterns. The QIDP will bring the results of any re-assessments to the Interdisciplinary Team.	

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	-"Incident Outcome: (selected) Evidence Does Not Support Violation of Client Rights? (selected) No." -"The staff member appears to have reacted as best he could given the situation. The outburst by [client C] was sudden and could not necessarily been predicted. The team has already taken appropriate measures to prevent further incidents. No further action is necessary at this time." The Investigation Summary dated 12/1/21 did not substantiate a violation of client A's rights regarding client C's physical aggression which resulted in client A sustaining injuries. 2. BDDS report dated 7/14/21 indicated, "Around 3:30 pm, [client C] in the house went to ask [client A] a question. This caused a peer, [client B], to be upset and start screaming. [Client B] then started to push over tables and chairs and he physically tried to attack [client C]. [Client C] then threw the fire extinguisher, microwave, and hamper, and staff redirected him to his room to call the [LS (lead staff)] to help calm down. [Client B] then went to his room to calm down. Both staff were checking on the clients when [client A] walked out the front door and eloped. One of the staff and the [QIDP (Qualified Intellectual Disabilities Professional) #1] went out to look for [client A]. The Director called the [local law enforcement] for assistance. The [QIDP #1] found [client A] walking down [highway] about an hour later and picked him up and took him back to the house. Upon arrival back at the house, [client A] was mad and yelling at staff and peers. He threw a radio, which hit [QIDP #1's] lip and busted it open. Staff redirected [client A] to his room to calm down. The other clients in			

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	the house were still agitated and Resource (agency support staff) was called. By the time Resource arrived, the situation had de-escalated and the clients were calm. The QIDP went to Urgent Care for treatment following the incident. Plan to Resolve: Staff will closely monitor [client A] and follow his BSP." The review did not indicate documentation of an investigation. 3. BDDS report dated 5/23/21 indicated, "At 4:10 PM on 5/22/2021, [client A] was on the front porch/yard with staff. Client was being quiet and walking around looking at bugs, trees, and was showing normal baseline mood and behavior. Another staff and a peer walked to the mailbox to check the mail, and the staff observed [client A] in the back/side yard as they left the front door. Upon returning from checking the mail, the staff and peer went to the backyard to get [client A] and go inside. [Client A] was not in the backyard, and the staff immediately searched the house. [Client A] was not found after a thorough search of the house and backyard. One staff immediately got in his vehicle to search the immediate area. Management was notified after he was not found in the immediate area. Management notified the campus resource team (agency support staff) and several people in multiple vehicles went out to search for [client A] and staff informed them that he likely went to a nearby store to buy candy or soda. The Director had notified the [local law enforcement], and the staff assisted the officers with information, description and likely whereabouts. At 7:10 PM, [client A] was located by a state trooper in [nearby town business address]. He was checked out by medics and			

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	cleared. Client had no physical injuries. After arriving back at the house, [client A] took a shower and ate a snack. Staff discussed the severity of the situation with [client A], but [client A] showed no understanding of the seriousness of the danger to himself and the community. [Client A] explained that he had walked to [store] to buy candy and soda. He was walking home when he was found. After bringing [client A] home, the officer gave staff a paper with information about Project Lifesaver (electronic monitoring). [Client A] went to bed at 8:15 PM and was closely monitored by staff. This is not [client A's] first incident of elopement. Staff will continue to follow the client's BSP (Behavior Support Plan) and actively supervise him. Plan to Resolve: Staff will follow the client's BSP and closely monitor the client. Staff will fill out all appropriate paperwork and notes on time." Mapquest.com was reviewed on 12/7/21 at 11:43 AM. The location client A was located in proximity to the group home was 2.6 miles on the shortest route and 3.8 miles on the longest route. Neither route was specified/known. The review did not indicate documentation of an investigation. 4. BDDS report dated 10/31/20 (this date is correct) indicated the following, "At 12:30 pm, [client A] presented normal baseline behaviors and mood, and he asked staff If he could play a hand-held video game on the back patio. Staff could monitor him through two windows, and at 2:55 pm staff saw client on the patio. Snack was served at 3:00 pm, and at 3:15 pm staff went outside to get [client A] for snack time. After not			

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	finding him in the yard, staff 1 and staff 2 searched the house to see If he was hiding, which he has done before. The staff then searched the surrounding woods on foot with no success. Staff also searched local roads and potential hiding areas, such as a local picnic awning and a cemetery. Staff then drove towards campus and a local gas station, where [client A] had previously eloped to before. Management was notified, campus Resource team was called, and the [local law enforcement] was called. [Client A] was picked up by a state trooper and taken back to the house after he was found walking along [intersection of road and interstate]. He claimed to be heading to a video game store. He showed normal baseline behaviors and mood, and appeared to have no knowledge or awareness of how dangerous of a situation he had put himself in. Plan to Resolve: All staff will monitor [client A] closely and follow his BSP and ISP (individual support plan). The police department will follow up with management if any more steps are to be taken." The review did not indicate documentation of an investigation. Client A's record was reviewed on 12/3/21 at 10:02 AM. Client A's BSP dated 9/2021 indicated the following: -"[Client A] was placed on probation in 2016 for sexually inappropriate acts.... He has a history of property destruction and elopement behaviors." -Workshop protocol "When [client A] is in a setting with other individuals present, he can be sexually			

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	inappropriate. These behaviors can cause others to become uncomfortable with [client A]. Due to this, an interactive guideline has been put in place to guide the staff in a consistent way to keep [client A] on track at [sheltered workshop]. 1. When attending [Sheltered Workshop], [client A] will follow all policies for [sheltered workshop]. 2. The staff ratio will be 1:10 while in his work room. 3. [Client A] will be supervised to the restroom by... staff. "He will be scheduled for restroom breaks upon his arrival to [sheltered workshop], after lunch and before departing [sheltered workshop]. 4. Upon [client A] having a work assignment that requires him leaving his work room, [client A] will have 1 minute to be out of line of sight. "If [client A] is not back within 1 minute, [sheltered workshop] staff will look for [client A]. 5. [Client A] will be separated from any individuals that he has threatened or has any negative verbal altercations with. He may be placed in another room for the day or staffed 1:1 if possible." Client A's BSP did not specify a detailed or specific supervision protocol for the group home regarding elopement behaviors. Client A's BSP did not identify Elopement as a targeted behavior. Client A's BSP did not indicate documentation of review or revision regarding the recommendations for Project Lifesaver or the van protocol as described in the 12/1/21 Investigation Summary. Client A's Group Home Monthly/Quarterly Behavior Summary dated 8/2021 did not indicate review, assessment or tracking of client A's elopement behavior. Group Home Meeting Minutes Binder was			

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	reviewed on 12/3/21 at 10:32 AM. The review indicated the following: -7/13/21, "Attention seeking." -6/8/21, "Bracelet?" -5/11/21, "$ (sic) talk to aunt about money." -10/13/20, "[Client A] start back at [day program] this week." The Group Home Meeting Minutes dated 7/13/21, 6/8/21, 5/11/21 and 10/13/20 did not indicate documentation of specific team review, discussion or recommendations regarding client A's elopement behavior. The binder did not indicate additional documentation of team review. Staff #1 was interviewed on 12/2/21 at 4:26 PM. Staff #1 indicated client A had elopement behaviors. Staff #1 indicated client A was assessed as needing 24-hour supervision. Staff #1 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #1 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #1 indicated there had not been a retraining or additional guidance regarding the supervision of client A's behavior. Staff #2 was interviewed on 12/2/21 at 4:38 PM. Staff #2 indicated client A had elopement behaviors. Staff #2 indicated client A was assessed as needing 24-hour supervision. Staff #2 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the			

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	group home's mail or taking the home's trash to the receptacle. Staff #2 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #3 was interviewed on 12/3/21 at 7:44 AM. Staff #3 indicated client A had elopement behaviors. Staff #3 indicated client A was assessed as needing 24-hour supervision. Staff #3 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #3 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #4 was interviewed on 12/3/21 at 7:52 AM. Staff #4 indicated client A had elopement behaviors. Staff #4 indicated client A was assessed as needing 24-hour supervision. Staff #4 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #4 indicated staff should be with client A in the outdoor areas of the home and while in the community. AS (Administrative Staff) #1 was interviewed on 12/3/21 at 11:19 AM. AS #1 indicated she was the home's administrator and acting QIDP (Qualified Intellectual Disabilities Professional) due to vacancy in the QIDP position. AS #1 indicated LS was on leave and not available for interview. AS #1 indicated the home held house meetings with administrative staff to review and discuss client programming needs. AS #1 indicated the house meetings were the agency's equivalent to an IDT meeting (Interdisciplinary Team) meeting. AS #1			

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	indicated the administrative team, or QIDP would conduct the house meeting and relay the information back to the home's staff. AS #1 indicated the house meeting/IDT reviewed client A's elopements but did not make any specific/formal recommendations to address his elopement behavior. AS #1 indicated the team had discussed utilizing noise reducing headphones as a strategy to prevent client A's elopement behaviors. AS #1 indicated the use of headphones as strategy had not been added to client A's BSP (Behavior Support Plan), staff had not been trained on the strategy and the home was in the process of purchasing the noise reducing headphones for client A. AS #1 indicated a formal re-assessment of client A's elopement behavioral needs had not been completed or implemented. AS #1 indicated the facility had an Abuse and Neglect policy and it was implemented to prevent and detect abuse, neglect and mistreatment. AS #1 indicated allegations of abuse and neglect should be thoroughly investigated within 5 business days with corrective measures developed and implemented to prevent recurrence. AS #1 indicated staff working with client A should implement his BSP and provide direct supervision to structure his leisure time activities. AS #1 indicated staff should be in the area where client A is when outside of the home. AS #1 indicated client A was assessed as needing 24-hour supervision. AS #1 indicated client A had a history of sexual inappropriate behavior with continued probation officer involvement. AS #1 indicated the facility had an elopement policy which should be implemented. AS #1 indicated staff should immediately notify the administrator/herself when/if client A eloped from the home. AS #1 indicated the agency could then send additional support staff to assist in locating			

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	client A and would also work with local law enforcement to assist in locating client A. AS #1 indicated client A's BSP did not include elopement as a formal targeted behavior or include specific preventative strategies to manage client A's elopement behavior. AS #1 indicated client A's BSP did include specific monitoring protocols for his attendance at the day program. AS #1 indicated client A's behavior management strategies at his home and his day program should be consistent. The facility's policies and procedures were reviewed on 12/6/21 at 4:15 PM. The facility's Missing Client or Elopement Policy dated 11/1/11 indicated the following: -"PROCEDURE In the event of a missing or eloping client, the following procedures must be followed: 1. Staff will report the missing client in the following ways: a. Calling out to all staff present; b. Immediately contacting the Program Supervisor. c. Contacting the Campus Resource Team (agency-based response team). 2. The Program Supervisor or Resource Team will take charge of the situation. 3. The Program Supervisor or Resource Team will direct staff to assess when and where the individual was last seen, what he/she was wearing, and what he/she was doing. The Program Supervisor or Resource Team should notify law enforcement immediately if the client is no longer within eye contact of a Damar employee." -"Group Home Services and other Bureau of Developmental Disabilities Services (BDDS) clients			

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	1. A BDDS (Bureau of Developmental Disabilities Services) Incident Report must be submitted within 24 hours of the incident by the QIDP. 2. A documented investigation of the incident including time frames and locations must be completed within 48 hours of the incident by QIDP and PQl (agency internal quality department)." The Abuse, Neglect and Exploitation of Adults dated April 2018 indicated the following: -"To ensure that every employee treats individuals receiving services with respect and dignity, and those individuals are protected from abuse, neglect and exploitation. Damar's highest priority is to ensure the safety and to protect the well-being and human rights of all clients in care." -"a. Physical abuse: a non-accidental physical injury to an adult by a person that results in or threatens serious injury. An endangered adult may also be considered physically abused if the adult is injured as a result of a caregiver's failure to take appropriate action to prevent an injury. b. Neglect: the failure of a caregiver to provide an endangered adult with adequate food, clothing, shelter, medical care or supervision." -"d. Emotional abuse: a pattern of behavior that inhibits an endangered adult's emotional development and sense of self-worth. Emotional abuse may include excessive, aggressive or unreasonable demands that place expectations on an endangered adult beyond his or her capacity. Constant criticizing, belittling, insulting, rejecting and teasing are some of the forms these verbal attacks can take." -"f. Mistreatment: treating someone badly,			

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	roughly, harshly, or inappropriately." -"7. Investigations of abuse/neglect are coordinated through or arranged by the Quality and Compliance department and will be completed within five (5) business days of the reported incident. The Quality and Compliance department is responsible for informing Damar's President/CEO, and when directed by the President/CEO, the Board of Directors of abuse incidents, reports, and/or dispositions of investigations." This federal tag relates to complaint #IN00344871. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to thoroughly investigate 4 incidents of client A's elopement behaviors. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/2/21 at 3:03 PM. The review indicated the following: 1. BDDS report dated 11/26/21 indicated, "[Client A, age and gender] who lives in a Supervised Group Living site with 5 other young men. [Diagnoses]. His targeted behaviors are: property destruction, elopement and inappropriate sexual behavior. Around 11:00 am, [client A] was riding with staff and [client C] to take [client F] to work.	W 0154	1. The QIDP and/or program management will be responsible to notify the Performance and Quality Improvement (PQI) department of all incidents of client-to-client aggression as well as abuse/neglect/exploitation so that investigations can be performed for the incidents. The Director of CLaSS will be notified immediately regarding any incidents of aggression, abuse, neglect or exploitation and will notify the PQI department. Investigations will be performed following policies and procedures. 2. All clients have the potential to be affected by not having alleged incidents of aggression,	01/15/2022

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	During the ride, [client C] started talking to [client A] and [client A] ignored him because he didn't want to talk with him. [Client C] continued to annoy both [clients A and F]. [Client A] threw his water bottle at [client C]. Staff pulled over to defuse the situation. Once they reached [restaurant] [client C] tried to attack [client A] and [client A] got out of the van with [client F]. [Client C] then attacked staff and (sic) while staff was trying to get away from [client C]. [Client A] walked away. This writer, [AS (administrative staff) #1] called [police] for assistance in finding [client A] but while on the phone with the police, staff called and said they had found [client A]. [Client A] was out of sight for approximately 10-15 minutes. During the confrontation [client A] received a one-inch scratch on his left cheek and a three inch scratch on the side of his face. His right hand was also red and slightly swollen. Plan to Resolve: [Client A] was seen by the nurse and treated as needed. [Clients A and C] will not be riding in the van together. Continue to follow the HRC (human rights committee) approved behavior plan. We will continue to work with [client A] on appropriate responses to annoying behaviors of others." Investigation Summary dated 12/1/21 indicated the following: -"Program Director has established a new protocol that requires [clients A and C] to ride separately if possible. If separate trips are not possible then two staff are required for the trip so that one can be in the back with clients to monitor potential situations." -"Incident Outcome: (selected) Evidence Does		abuse, neglect and exploitation thoroughly investigated. 3. The QIDP and/or program management will be responsible to notify the Performance and Quality Improvement (PQI) department of all alleged incidents of client-to-client aggression as well as abuse/neglect/exploitation so that investigations can be performed for the incidents. 4. The Internal Reviewer/Liaison will complete a review of the BDDS secure portal for any incidents twice weekly. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by PQI department and CLaSS leadership. The QIDP will review the behavior support plans at least monthly and identify any patterns. The QIDP will bring the results of any re-assessments to the Interdisciplinary Team.	

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	Not Support Violation of Client Rights? (selected) No." -"The staff member appears to have reacted as best he could given the situation. The outburst by [client C] was sudden and could not necessarily been predicted. The team has already taken appropriate measures to prevent further incidents. No further action is necessary at this time." The Investigation Summary dated 12/1/21 did not substantiate a violation of client A's rights regarding client C's physical aggression which resulted in client A sustaining injuries. 2. BDDS report dated 7/14/21 indicated, "Around 3:30 pm, [client C] in the house went to ask [client A] a question. This cause a peer, [client B], to be upset and start screaming. [Client B] then started to push over tables and chairs and he physically tried to attack [client C]. [Client C] then threw the fire extinguisher, microwave, and hamper, and staff redirected him to his room to call the [LS (lead staff)] to help calm down. [Client B] then went to his room to calm down. Both staff were checking on the clients when [client A] walked out the front door and eloped. One of the staff and the [QIDP (Qualified Intellectual Disabilities Professional) #1] went out to look for [client A]. The Director called the [local law enforcement] for assistance. The, [QIDP #1], found [client A] walking down [highway] about an hour later and picked him up and took him back to the house. Upon arrival back at the house, [client A] was mad and yelling at staff and peers. He threw a radio, which hit [QIDP #1's] lip and busted it open. Staff redirected [client A] to his room to calm down. The other clients in the house were still agitated and Resource (agency support staff) was (sic) called. By the			

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	time Resource arrived, the situation had de-escalated and the clients were calm. The QIDP went to Urgent Care for treatment following the incident. Plan to Resolve: Staff will closely monitor [client A] and follow his BSP." The review did not indicate documentation of an investigation. 3. BDDS report dated 5/23/21 indicated, "At 4:10 PM on 5/22/2021, [client A] was on the front porch/yard with staff. Client was being quiet and walking around looking at bugs, trees, and was showing normal baseline mood and behavior. Another staff and a peer walked to the mailbox to check the mail, and the staff observed [client A] in the back/side yard as they left the front door. Upon returning from checking the mail, the staff and peer went to the backyard to get [client A] and go inside. [Client A] was not in the backyard, and the staff immediately searched the house. [Client A] was not found after a thorough search of the house and backyard. One staff immediately got in his vehicle to search the immediate area. Management was notified after he was not found in the immediate area. Management notified the campus resource team (agency support staff) and several people in multiple vehicles went out to search for [client A] and staff informed them that he likely went to a nearby store to buy candy or soda. The Director had notified the [local law enforcement], and the staff assisted the officers with information, description and likely whereabouts. At 7:10 PM, [client A] was located by a state trooper in [nearby town business address]. He was checked out by medics and cleared. Client had no physical injuries. After			

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	arriving back at the house, [client A] took a shower and ate a snack. Staff discussed the severity of the situation with [client A], but [client A] showed no understanding of the seriousness of the danger to himself and the community. [Client A] explained that he had walked to [store] to buy candy and soda. He was walking home when he was found. After bringing [client A] home, the officer gave staff a paper with information about Project Lifesaver (electronic monitoring). [Client A] went to bed at 8:15 PM and was closely monitored by staff. This is not [client A's] first incident of elopement. Staff will continue to follow the client's BSP (Behavior Support Plan) and actively supervise him. Plan to Resolve: Staff will follow the client's BSP and closely monitor the client. Staff will fill out all appropriate paperwork and notes on time." Mapquest.com was reviewed on 12/7/21 at 11:43 AM. The location client A was located in proximity to the group home was 2.6 miles on the shortest route and 3.8 miles on the longest route. Neither route was specified/known. The review did not indicate documentation of an investigation. 4. BDDS report dated 10/31/20 (this date is correct) indicated the following, "At 12:30 pm, [client A] presented normal baseline behaviors and mood, and he asked staff If he could play a hand-held video game on the back patio. Staff could monitor him through two windows, and at 2:55 pm staff saw client on the patio. Snack was served at 3:00 pm, and at 3:15 pm staff went outside to get [client A] for snack time. After not finding him in the yard, staff 1 and staff 2			

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	searched the house to see If he was hiding, which he has done before. The staff then searched the surrounding woods on foot with no success. Staff also searched local roads and potential hiding areas, such as a local picnic awning and a cemetery. Staff then drove towards campus and a local gas station, where [client A] had previously eloped to before. Management was notified, campus Resource team was called, and the [local law enforcement] was called. [Client A] was picked up by a state trooper and taken back to the house after he was found walking along [intersection of road and interstate]. He claimed to be heading to a video game store. He showed normal baseline behaviors and mood, and appeared to have no knowledge or awareness of how dangerous of a situation he had put himself in. Plan to Resolve: All staff will monitor [client A] closely and follow his BSP and ISP (individual support plan). The police department will follow up with management if any more steps are to be taken." The review did not indicate documentation of an investigation. AS (Administrative Staff) #1 was interviewed on 12/3/21 at 11:19 AM. AS #1 indicated allegations of abuse and neglect should be thoroughly investigated within 5 business days This federal tag relates to complaint #IN00344871. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate			

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	corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to develop and implement effective corrective measures to prevent incidents of client A's elopement behaviors. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/2/21 at 3:03 PM. The review indicated the following: 1. BDDS report dated 11/26/21 indicated, "[Client A, age and gender] who lives in a Supervised Group Living site with 5 other young men. [Diagnoses]. His targeted behaviors are: property destruction, elopement and inappropriate sexual behavior. Around 11:00 am, [client A] was riding with staff and [client C] to take [client F] to work. During the ride, [client C] started talking to [client A] and [client A] ignored him because he didn't want to talk with him. [Client C] continued to annoy both [clients A and F]. [Client A] threw his water bottle at [client C]. Staff pulled over to defuse the situation. Once they reached [restaurant] [client C] tried to attack [client A] and [client A] got out of the van with [client F]. [Client C] then attacked staff and (sic) while staff was trying to get away from [client C]. [Client A] walked away. This writer, [AS (administrative staff) #1] called [police] for assistance in finding [client A] but while on the phone with the police, staff called and said they had found [client A]. [Client A was out of sight for approximately 10-15 minutes. During the confrontation [client A] received a one-inch scratch on his left cheek and a three inch scratch on the side of his face. His right hand was also red	W 0157	1. The QIDP will develop and implement effective measures to prevent incidents of abuse, neglect and exploitation. 2. All clients have the potential to be affected by not developing and implementing effective corrective measures to prevent incidents of abuse, neglect, and exploitation. 3. The QIDP and/or program management will be responsible to identify patterns of behavior that could be perceived to be abuse, neglect or exploitation. The behaviors will have effective corrective measures developed and implemented to decrease/eliminate the behaviors. 4. The Internal Reviewer/Liaison will complete a review of the BDDS secure portal for any incidents twice weekly. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by the PQI department and CLaSS leadership. The QIDP will bring the results of all re-assessments and interventions to the Interdisciplinary Team.	01/15/2022

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

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	down. [Client B] then went to his room to calm down. Both staff were checking on the clients when [client A] walked out the front door and eloped. One of the staff and the [QIDP (Qualified Intellectual Disabilities Professional) #1] went out to look for [client A]. The Director called the [local law enforcement] for assistance. The [QIDP #1] found [client A] walking down [highway] about an hour later and picked him up and took him back to the house. Upon arrival back at the house, [client A] was mad and yelling at staff and peers. He threw a radio, which hit [QIDP #1's] lip and busted it open. Staff redirected [client A] to his room to calm down. The other clients in the house were still agitated and Resource (agency support staff) was called. By the time Resource arrived, the situation had de-escalated and the clients were calm. The QIDP went to Urgent Care for treatment following the incident. Plan to Resolve: Staff will closely monitor [client A] and follow his BSP." 3. BDDS report dated 5/23/21 indicated, "At 4:10 PM on 5/22/2021, [client A] was on the front porch/yard with staff. Client was being quiet and walking around looking at bugs, trees, and was showing normal baseline mood and behavior. Another staff and a peer walked to the mailbox to check the mail, and the staff observed [client A] in the back/side yard as they left the front door. Upon returning from checking the mail, the staff and peer went to the backyard to get [client A] and go inside. [Client A] was not in the backyard, and the staff immediately searched the house. [Client A] was not found after a thorough search of the house and backyard. One staff immediately got in his vehicle to search the immediate area. Management was notified after he was not found			

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	in the immediate area. Management notified the campus resource team (agency support staff) and several people in multiple vehicles went out to search for [client A] and staff informed them that he likely went to a nearby store to buy candy or soda. The Director had notified the [local law enforcement], and the staff assisted the officers with information, description and likely whereabouts. At 7:10 PM, [client A] was located by a state trooper in [nearby town business address]. He was checked out by medics and cleared. Client had no physical injuries. After arriving back at the house, [client A] took a shower and ate a snack. Staff discussed the severity of the situation with [client A], but [client A] showed no understanding of the seriousness of the danger to himself and the community. [Client A] explained that he had walked to [store] to buy candy and soda. He was walking home when he was found. After bringing [client A] home, the officer gave staff a paper with information about Project Lifesaver (electronic monitoring). [Client A] went to bed at 8:15 PM and was closely monitored by staff. This is not [client A's] first incident of elopement. Staff will continue to follow the client's BSP (Behavior Support Plan) and actively supervise him. Plan to Resolve: Staff will follow the client's BSP and closely monitor the client. Staff will fill out all appropriate paperwork and notes on time." Mapquest.com was reviewed on 12/7/21 at 11:43 AM. The location client A was located in proximity to the group home was 2.6 miles on the shortest route and 3.8 miles on the longest route. Neither route was specified/known. 4. BDDS report dated 10/31/20 (this date is			

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	correct) indicated the following, "At 12:30 pm, [client A] presented normal baseline behaviors and mood, and he asked staff If he could play a hand-held video game on the back patio. Staff could monitor him through two windows, and at 2:55 pm staff saw client on the patio. Snack was served at 3:00 pm, and at 3:15 pm staff went outside to get [client A] for snack time. After not finding him in the yard, staff 1 and staff 2 searched the house to see If he was hiding, which he has done before. The staff then searched the surrounding woods on foot with no success. Staff also searched local roads and potential hiding areas, such as a local picnic awning and a cemetery. Staff then drove towards campus and a local gas station, where [client A] had previously eloped to before. Management was notified, campus Resource team was called, and the [local law enforcement] was called. [Client A] was picked up by a state trooper and taken back to the house after he was found walking along [intersection of road and interstate]. He claimed to be heading to a video game store. He showed normal baseline behaviors and mood, and appeared to have no knowledge or awareness of how dangerous of a situation he had put himself in. Plan to Resolve: All staff will monitor [client A] closely and follow his BSP and ISP (individual support plan). The police department will follow up with management if any more steps are to be taken." Client A's record was reviewed on 12/3/21 at 10:02 AM. Client A's BSP dated 9/2021 indicated the following: -"[Client A] was placed on probation in 2016 for sexually inappropriate acts.... He has a history of			

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	property destruction and elopement behaviors." -Workshop protocol "When [client A] is in a setting with other individuals present, he can be sexually inappropriate. These behaviors can cause others to become uncomfortable with [client A]. Due to this, an interactive guideline has been put in place to guide the staff in a consistent way to keep [client A] on track at [sheltered workshop]. 1. When attending [Sheltered Workshop], [client A] will follow all policies for [sheltered workshop]. 2. The staff ratio will be 1:10 while in his work room. 3. [Client A] will be supervised to the restroom by... staff. "He will be scheduled for restroom breaks upon his arrival to [sheltered workshop], after lunch and before departing [sheltered workshop]. 4. Upon [client A] having a work assignment that requires him leaving his work room, [client A] will have 1 minute to be out of line of sight. "If [client A] is not back within 1 minute, [sheltered workshop] staff will look for [client A]. 5. [Client A] will be separated from any individuals that he has threatened or has any negative verbal altercations with. He may be placed in another room for the day or staffed 1:1 if possible." Client A's BSP did not specify a detailed or specific supervision protocol for the group home regarding elopement behaviors. Client A's BSP did not identify Elopement as a targeted behavior. Client A's BSP did not indicate documentation of review or revision regarding the recommendations for Project Lifesaver or the van protocol as described in the 12/1/21 Investigation Summary. Client A's Group Home Monthly/Quarterly			

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	Behavior Summary dated 8/2021 did not indicate review, assessment or tracking of client A's elopement behavior. Group Home Meeting Minutes Binder was reviewed on 12/3/21 at 10:32 AM. The review indicated the following: -7/13/21, "Attention seeking." -6/8/21, "Bracelet?" -5/11/21, "$ (sic) talk to aunt about money." -10/13/20, "[Client A] start back at [day program] this week." The Group Home Meeting Minutes dated 7/13/21, 6/8/21, 5/11/21 and 10/13/20 did not indicate documentation of specific team review, discussion or recommendations regarding client A's elopement behavior. The binder did not indicate additional documentation of team review. Staff #1 was interviewed on 12/2/21 at 4:26 PM. Staff #1 indicated client A had elopement behaviors. Staff #1 indicated client A was assessed as needing 24-hour supervision. Staff #1 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #1 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #1 indicated there had not been a retraining or additional guidance regarding the supervision of client A's behavior. Staff #2 was interviewed on 12/2/21 at 4:38 PM. Staff #2 indicated client A had elopement			

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	behaviors. Staff #2 indicated client A was assessed as needing 24-hour supervision. Staff #2 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #2 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #3 was interviewed on 12/3/21 at 7:44 AM. Staff #3 indicated client A had elopement behaviors. Staff #3 indicated client A was assessed as needing 24-hour supervision. Staff #3 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #3 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #4 was interviewed on 12/3/21 at 7:52 AM. Staff #4 indicated client A had elopement behaviors. Staff #4 indicated client A was assessed as needing 24-hour supervision. Staff #4 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #4 indicated staff should be with client A in the outdoor areas of the home and while in the community. AS (Administrative Staff) #1 was interviewed on 12/3/21 at 11:19 AM. AS #1 indicated she was the home's administrator and acting QIDP (Qualified Intellectual Disabilities Professional) due to vacancy in the QIDP position. AS #1 indicated LS was on leave and not available for interview. AS			

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	#1 indicated the home held house meetings with administrative staff to review and discuss client programming needs. AS #1 indicated the house meetings were the agency's equivalent to an IDT meeting (Interdisciplinary Team) meeting. AS #1 indicated the administrative team, or QIDP would conduct the house meeting and relay the information back to the home's staff. AS #1 indicated the house meeting/IDT reviewed client A's elopement's but did not make any specific/formal recommendations to address his elopement behavior. AS #1 indicated the team had discussed utilizing noise reducing headphones as a strategy to prevent client A's elopement behaviors. AS #1 indicated the use of headphones as strategy had not been added to client A's BSP (Behavior Support Plan), staff had not been trained on the strategy and the home was in the process of purchasing the noise reducing headphones for client A. AS #1 indicated a formal re-assessment of client A's elopement behavioral needs had not been completed or implemented. AS #1 indicated staff working with client A should implement his BSP and provide direct supervision to structure his leisure time activities. AS #1 indicated staff should be in the area where client A is when outside of the home. AS #1 indicated client A was assessed as needing 24-hour supervision. AS #1 indicated client A had a history of sexual inappropriate behavior with continued probation officer involvement. AS #1 indicated the facility had an elopement policy which should be implemented. AS #1 indicated staff should immediately notify the administrator/herself when/if client A eloped from the home. AS #1 indicated the agency could then send additional support staff to assist in locating client A and would also work with local law enforcement to assist in locating client A. AS #1 indicated client			

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	A's BSP did not include elopement as a formal targeted behavior or include specific preventative strategies to manage client A's elopement behavior. AS #1 indicated client A's BSP did include specific monitoring protocols for his attendance at the day program. AS #1 indicated client A's behavior management strategies at his home and his day program should be consistent. This federal tag relates to complaint #IN00344871. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 1 of 3 sampled clients (A), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor client A's active treatment program by failing to complete a re-assessment of client A's behavior management needs regarding a pattern of elopement behavior and failing to ensure client A's BSP (Behavior Support Plan) addressed client A's identified elopement behaviors. Findings include: 1. The QIDP failed to complete a re-assessment of client A's behavior management needs regarding a pattern of elopement behavior. Please see W214. 2. The QIDP failed to to ensure client A's BSP (Behavior Support Plan) addressed client A's identified elopement behaviors. Please see W227.	W 0159	1. The QIDP will integrate, coordinate, and monitor all active treatment programs. Re-assessments of the client's needs will be completed when a pattern of incidents occur. BSPs will be created/revised because of the re-assessment results. 2. All clients could be affected by not integrating, coordinating, and monitoring active treatment programs. 3. The QIDP will integrate, coordinate and monitor all active treatment programs. Re-assessments of the client's needs will be completed as indicated. BSPs will be created/revised because of the re-assessment results. 4. The Internal Reviewer/Liaison	01/15/2022

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	This federal tag relates to complaint #IN00344871. 9-3-3(a)		will complete a review of the BDDS secure portal for any incidents twice weekly. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by the PQI department and CLaSS leadership. The QIDP will bring the results of all re-assessments and interventions to the Interdisciplinary Team. The QIDP will monitor active treatment programs at least monthly.	
W 0214 Bldg. 00	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to complete a re-assessment of client A's behavior management needs regarding a pattern of elopement behavior. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/2/21 at 3:03 PM. The review indicated the following: 1. BDDS report dated 11/26/21 indicated, "[Client A, age and gender] who lives in a Supervised Group Living site with 5 other young men. [Diagnoses]. His targeted behaviors are: property destruction, elopement and inappropriate sexual behavior. Around 11:00 am, [client A] was riding with staff and [client C] to take [client F] to work.	W 0214	1. The QIDP and/or program management will be responsible to notify PQI and of all incidents of client-to-client aggression as well as abuse/neglect/exploitation. The Director of CLaSS will be notified immediately regarding any incidents of aggression, abuse or exploitation. Behavior Support Plans will be reviewed and revised monthly, as needed, to include all behaviors of aggression, abuse, neglect and exploitation. Staff will be trained/retrained on the BSPs as indicated. 2. The Internal Reviewer/Liaison will complete a review of the BDDS secure portal for any incidents twice weekly.	01/15/2022

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	During the ride, [client C] started talking to [client A] and [client A] ignored him because he didn't want to talk with him. [Client C] continued to annoy both [clients A and F]. [Client A] threw his water bottle at [client C]. Staff pulled over to defuse the situation. Once they reached [restaurant] [client C] tried to attack [client A] and [client A] got out of the van with [client F]. [Client C] then attacked staff and (sic) while staff was trying to get away from [client C]. [Client A] walked away. This writer, [AS (administrative staff) #1] called [police] for assistance in finding [client A] but while on the phone with the police, staff called and said they had found [client A]. [Client A] was out of sight for approximately 10-15 minutes. During the confrontation [client A] received a one-inch scratch on his left cheek and a three inch scratch on the side of his face. His right hand was also red and slightly swollen. Plan to Resolve: [Client A] was seen by the nurse and treated as needed. [Clients A and C] will not be riding in the van together. Continue to follow the HRC (human rights committee) approved behavior plan. We will continue to work with [client A] on appropriate responses to annoying behaviors of others." Investigation Summary dated 12/1/21 indicated the following: -"Program Director has established a new protocol that requires [clients A and C] to ride separately if possible. If separate trips are not possible then two staff are required for the trip so that one can be in the back with clients to monitor potential situations." -"Incident Outcome: (selected) Evidence Does		3. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by PQI and CLaSS leadership. Behavior Support Plans will be reviewed and revised monthly, as needed, to include all behaviors of aggression, abuse, neglect and exploitation. 4. The Internal Reviewer/Liaison will conduct a review of all group home incidents including 1/1/2021-12/31/2021 to ensure appropriate follow up was completed.	

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	Not Support Violation of Client Rights? (selected) No." -"The staff member appears to have reacted as best he could given the situation. The outburst by [client C] was sudden and could not necessarily been predicted. The team has already taken appropriate measures to prevent further incidents. No further action is necessary at this time." 2. BDDS report dated 7/14/21 indicated, "Around 3:30 pm, [client C] in the house went to ask [client A] a question. This caused a peer, [client B], to be upset and start screaming. [Client B] then started to push over tables and chairs and he physically tried to attack [client C]. [Client C] then threw the fire extinguisher, microwave, and hamper, and staff redirected him to his room to call the [LS (lead staff)] to help calm down. [Client B] then went to his room to calm down. Both staff were checking on the clients when [client A] walked out the front door and eloped. One of the staff and the [QIDP (Qualified Intellectual Disabilities Professional) #1] went out to look for [client A]. The Director called the [local law enforcement] for assistance. The [QIDP #1] found [client A] walking down [highway] about an hour later and picked him up and took him back to the house. Upon arrival back at the house, [client A] was mad and yelling at staff and peers. He threw a radio, which hit [QIDP #1's] lip and busted it open. Staff redirected [client A] to his room to calm down. The other clients in the house were still agitated and Resource (agency support staff) was called. By the time Resource arrived, the situation had de-escalated and the clients were calm. The QIDP went to Urgent Care for treatment following the incident. Plan to Resolve:			

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	Staff will closely monitor [client A] and follow his BSP." 3. BDDS report dated 5/23/21 indicated, "At 4:10 PM on 5/22/2021, [client A] was on the front porch/yard with staff. Client was being quiet and walking around looking at bugs, trees, and was showing normal baseline mood and behavior. Another staff and a peer walked to the mailbox to check the mail, and the staff observed [client A] in the back/side yard as they left the front door. Upon returning from checking the mail, the staff and peer went to the backyard to get [client A] and go inside. [Client A] was not in the backyard, and the staff immediately searched the house. [Client A] was not found after a thorough search of the house and backyard. One staff immediately got in his vehicle to search the immediate area. Management was notified after he was not found in the immediate area. Management notified the campus resource team (agency support staff) and several people in multiple vehicles went out to search for [client A] and staff informed them that he likely went to a nearby store to buy candy or soda. The Director had notified the [local law enforcement], and the staff assisted the officers with information, description and likely whereabouts. At 7:10 PM, [client A] was located by a state trooper in [nearby town business address]. He was checked out by medics and cleared. Client had no physical injuries. After arriving back at the house, [client A] took a shower and ate a snack. Staff discussed the severity of the situation with [client A], but [client A] showed no understanding of the seriousness of the danger to himself and the community. [Client A] explained that he had walked to [store] to buy candy and soda. He was walking home when he was found. After bringing [client A] home, the officer gave staff a paper with			

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	information about Project Lifesaver (electronic monitoring). [Client A] went to bed at 8:15 PM and was closely monitored by staff. This is not [client A's] first incident of elopement. Staff will continue to follow the client's BSP (Behavior Support Plan) and actively supervise him. Plan to Resolve: Staff will follow the client's BSP and closely monitor the client. Staff will fill out all appropriate paperwork and notes on time." Mapquest.com was reviewed on 12/7/21 at 11:43 AM. The location client A was located in proximity to the group home was 2.6 miles on the shortest route and 3.8 miles on the longest route. Neither route was specified/known. 4. BDDS report dated 10/31/20 (this date is correct) indicated the following, "At 12:30 pm, [client A] presented normal baseline behaviors and mood, and he asked staff If he could play a hand-held video game on the back patio. Staff could monitor him through two windows, and at 2:55 pm staff saw client on the patio. Snack was served at 3:00 pm, and at 3:15 pm staff went outside to get [client A] for snack time. After not finding him in the yard, staff 1 and staff 2 searched the house to see If he was hiding, which he has done before. The staff then searched the surrounding woods on foot with no success. Staff also searched local roads and potential hiding areas, such as a local picnic awning and a cemetery. Staff then drove towards campus and a local gas station, where [client A] had previously eloped to before. Management was notified, campus Resource team was called, and the [local law enforcement] was called. [Client A] was picked up by a state trooper and taken back to the house after he was found walking along			

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	15G482	A. BUILDING 00 B. WING	12/08/2021

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	[intersection of road and interstate]. He claimed to be heading to a video game store. He showed normal baseline behaviors and mood, and appeared to have no knowledge or awareness of how dangerous of a situation he had put himself in. Plan to Resolve: All staff will monitor [client A] closely and follow his BSP and ISP (individual support plan). The police department will follow up with management if any more steps are to be taken." Client A's record was reviewed on 12/3/21 at 10:02 AM. Client A's BSP dated 9/2021 indicated the following: -"[Client A] was placed on probation in 2016 for sexually inappropriate acts.... He has a history of property destruction and elopement behaviors." Client A's BSP did not indicate a functional assessment of client A's elopement behaviors. Client A's Group Home Monthly/Quarterly Behavior Summary dated 8/2021 did not indicate review, assessment or tracking of client A's elopement behavior. Group Home Meeting Minutes Binder was reviewed on 12/3/21 at 10:32 AM. The review indicated the following: -7/13/21, "Attention seeking." -6/8/21, "Bracelet?" -5/11/21, "$ (sic) talk to aunt about money." -10/13/20, "[Client A] start back at [day program]			

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	this week." The Group Home Meeting Minutes dated 7/13/21, 6/8/21, 5/11/21 and 10/13/20 did not indicate documentation of specific team review, discussion or recommendations regarding the assessment of client A's elopement behaviors. AS (Administrative Staff) #1 was interviewed on 12/3/21 at 11:19 AM. AS #1 indicated she was the home's administrator and acting QIDP (Qualified Intellectual Disabilities Professional) due to vacancy in the QIDP position. AS #1 indicated LS was on leave and not available for interview. AS #1 indicated a formal re-assessment of client A's elopement behavioral needs had not been completed or implemented. This federal tag relates to complaint #IN00344871. 9-3-4(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's BSP (Behavior Support Plan) addressed client A's identified elopement behaviors. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/2/21 at 3:03 PM. The review	W 0227	1. The QIDP and/or program management will be responsible to notify PQI and of all incidents of client-to-client aggression as well as abuse/neglect/exploitation. The Director of CLaSS will be notified immediately regarding any incidents of aggression, abuse or exploitation. Behavior Support Plans will be reviewed and revised	01/15/2022

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	indicated the following: 1. BDDS report dated 11/26/21 indicated, "[Client A, age and gender] who lives in a Supervised Group Living site with 5 other young men. [Diagnoses]. His targeted behaviors are: property destruction, elopement and inappropriate sexual behavior. Around 11:00 am, [client A] was riding with staff and [client C] to take [client F] to work. During the ride, [client C] started talking to [client A] and [client A] ignored him because he didn't want to talk with him. [Client C] continued to annoy both [clients A and F]. [Client A] threw his water bottle at [client C]. Staff pulled over to defuse the situation. Once they reached [restaurant] [client C] tried to attack [client A] and [client A] got out of the van with [client F]. [Client C] then attacked staff and while staff was trying to get away from [client C]. [Client A] walked away. This writer, [AS (administrative staff) #1] called [police] for assistance in finding [client A] but while on the phone with the police, staff called and said they had found [client A]. [Client A] was out of sight for approximately 10-15 minutes. During the confrontation [client A] received a one-inch scratch on his left cheek and a three inch scratch on the side of his face. His right hand was also red and slightly swollen. Plan to Resolve: [Client A] was seen by the nurse and treated as needed. [Clients A and C] will not be riding in the van together. Continue to follow the HRC (human rights committee) approved behavior plan. We will continue to work with [client A] on appropriate responses to annoying behaviors of others." Investigation Summary dated 12/1/21 indicated the following:		monthly, as needed, to include all behaviors of aggression, abuse, neglect and exploitation. Staff will be trained/retrained on the BSPs as indicated. 2. The Internal Reviewer/Liaison will complete a review of the BDDS secure portal for any incidents twice weekly. 3. There are bi-weekly CLaSS Flash meetings for on-going reviews of all incidents by PQI and CLaSS leadership. Behavior Support Plans will be reviewed and revised monthly, as needed, to include all behaviors of aggression, abuse, neglect and exploitation. 4. The Internal Reviewer/Liaison will conduct a review of all group home incidents including 1/1/2021-12/31/2021 to ensure appropriate follow up was completed.	

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	-"Program Director has established a now protocol that requires [clients A and C] to ride separately if possible. If separate trips are not possible then two staff are required for the trip so that one can be in the back with clients to monitor potential situations." -"Incident Outcome: (selected) Evidence Does Not Support Violation of Client Rights? (selected) No." -"The staff member appears to have reacted as best he could given the situation. The outburst by [client C] was sudden and could not necessarily been predicted. The team has already taken appropriate measures to prevent further incidents. No further action is necessary at this time." 2. BDDS report dated 7/14/21 indicated, "Around 3:30 pm, [client C] in the house went to ask [client A] a question. This cause a peer, [client B], to be upset and start screaming. [Client B] then started to push over tables and chairs and he physically tried to attack [client C]. [Client C] then threw the fire extinguisher, microwave, and hamper, and staff redirected him to his room to call the [LS (lead staff)] to help calm down. [Client B] then went to his room to calm down. Both staff were checking on the clients when [client A] walked out the front door and eloped. One of the staff and the [QIDP (Qualified Intellectual Disabilities Professional) #1] went out to look for [client A]. The Director called the [local law enforcement] for assistance. The [QIDP #1] found [client A] walking down [highway] about an hour later and picked him up and took him back to the house. Upon arrival back at the house, [client A] was mad and yelling at staff and peers. He threw a radio, which hit [QIDP #1's] lip and busted it open. Staff redirected [client			

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	A] to his room to calm down. The other clients in the house were still agitated and Resource (agency support staff) was called. By the time Resource arrived, the situation had de-escalated and the clients were calm. The QIDP went to Urgent Care for treatment following the incident. Plan to Resolve: Staff will closely monitor [client A] and follow his BSP." 3. BDDS report dated 5/23/21 indicated, "At 4:10 PM on 5/22/2021, [client A] was on the front porch/yard with staff. Client was being quiet and walking around looking at bugs, trees, and was showing normal baseline mood and behavior. Another staff and a peer walked to the mailbox to check the mail, and the staff observed [client A] in the back/side yard as they left the front door. Upon returning from checking the mail, the staff and peer went to the backyard to get [client A] and go inside. [Client A] was not in the backyard, and the staff immediately searched the house. [Client A] was not found after a thorough search of the house and backyard. One staff immediately got in his vehicle to search the immediate area. Management was notified after he was not found in the immediate area. Management notified the campus resource team (agency support staff) and several people in multiple vehicles went out to search for [client A] and staff informed them that he likely went to a nearby store to buy candy or soda. The Director had notified the [local law enforcement], and the staff assisted the officers with information, description and likely whereabouts. At 7:10 PM, [client A] was located by a state trooper in [nearby town business address]. He was checked out by medics and cleared. Client had no physical injuries. After arriving back at the house, [client A] took a			

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	shower and ate a snack. Staff discussed the severity of the situation with [client A], but [client A] showed no understanding of the seriousness of the danger to himself and the community. [Client A] explained that he had walked to [store] to buy candy and soda. He was walking home when he was found. After bringing [client A] home, the officer gave staff a paper with information about Project Lifesaver (electronic monitoring). [Client A] went to bed at 8:15 PM and was closely monitored by staff. This is not [client A's] first incident of elopement. Staff will continue to follow the client's BSP (Behavior Support Plan) and actively supervise him. Plan to Resolve: Staff will follow the client's BSP and closely monitor the client. Staff will fill out all appropriate paperwork and notes on time." Mapquest.com was reviewed on 12/7/21 at 11:43 AM. The location client A was located in proximity to the group home was 2.6 miles on the shortest route and 3.8 miles on the longest route. Neither route was specified/known. 4. BDDS report dated 10/31/20 (this date is correct) indicated the following, "At 12:30 pm, [client A] presented normal baseline behaviors and mood, and he asked staff If he could play a hand-held video game on the back patio. Staff could monitor him through two windows, and at 2:55 pm staff saw client on the patio. Snack was served at 3:00 pm, and at 3:15 pm staff went outside to get [client A] for snack time. After not finding him in the yard, staff 1 and staff 2 searched the house to see If he was hiding, which he has done before. The staff then searched the surrounding woods on foot with no success. Staff also searched local roads and potential hiding			

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	areas, such as a local picnic awning and a cemetery. Staff then drove towards campus and a local gas station, where [client A] had previously eloped to before. Management was notified, campus Resource team was called, and the [local law enforcement] was called. [Client A] was picked up by a state trooper and taken back to the house after he was found walking along [intersection of road and interstate]. He claimed to be heading to a video game store. He showed normal baseline behaviors and mood, and appeared to have no knowledge or awareness of how dangerous of a situation he had put himself in. Plan to Resolve: All staff will monitor [client A] closely and follow his BSP and ISP (individual support plan). The police department will follow up with management if any more steps are to be taken." Client A's record was reviewed on 12/3/21 at 10:02 AM. Client A's BSP dated 9/2021 indicated the following: -"[Client A] was placed on probation in 2016 for sexually inappropriate acts.... He has a history of property destruction and elopement behaviors." -Workshop protocol "When [client A] is in a setting with other individuals present, he can be sexually inappropriate. These behaviors can cause others to become uncomfortable with [client A]. Due to this, an interactive guideline has been put in place to guide the staff in a consistent way to keep [client A] on track at [sheltered workshop]. 1. When attending [Sheltered Workshop], [client A] will follow all policies for [sheltered workshop]. 2. The staff ratio will be 1:10 while in his work			

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	room. 3. [Client A] will be supervised to the restroom by... staff. "He will be scheduled for restroom breaks upon his arrival to [sheltered workshop], after lunch and before departing [sheltered workshop]. 4. Upon [client A] having a work assignment that requires him leaving his work room, [client A] will have 1 minute to be out of line of sight. "If [client A] is not back within 1 minute, [sheltered workshop] staff will look for [client A]. 5. [Client A] will be separated from any individuals that he has threatened or has any negative verbal altercations with. He may be placed in another room for the day or staffed 1:1 if possible." Client A's BSP did not specify a detailed or specific supervision protocol for the group home regarding elopement behaviors. Client A's BSP did not identify Elopement as a targeted behavior. Client A's BSP did not indicate documentation of review or revision regarding the recommendations for Project Lifesaver or the van protocol as described in the 12/1/21 Investigation Summary. Client A's Group Home Monthly/Quarterly Behavior Summary dated 8/2021 did not indicate review, assessment or tracking of client A's elopement behavior. Group Home Meeting Minutes Binder was reviewed on 12/3/21 at 10:32 AM. The review indicated the following: -7/13/21, "Attention seeking." -6/8/21, "Bracelet?" -5/11/21, "$ (sic) talk to aunt about money."			

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	-10/13/20, "[Client A] start back at [day program] this week." The Group Home Meeting Minutes dated 7/13/21, 6/8/21, 5/11/21 and 10/13/20 did not indicate documentation of specific team review, discussion or recommendations regarding client A's elopement behavior. The binder did not indicate additional documentation of team review. Staff #1 was interviewed on 12/2/21 at 4:26 PM. Staff #1 indicated client A had elopement behaviors. Staff #1 indicated client A was assessed as needing 24-hour supervision. Staff #1 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #1 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #1 indicated there had not been a retraining or additional guidance regarding the supervision of client A's behavior. Staff #2 was interviewed on 12/2/21 at 4:38 PM. Staff #2 indicated client A had elopement behaviors. Staff #2 indicated client A was assessed as needing 24-hour supervision. Staff #2 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #2 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #3 was interviewed on 12/3/21 at 7:44 AM. Staff #3 indicated client A had elopement behaviors. Staff #3 indicated client A was			

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	assessed as needing 24-hour supervision. Staff #3 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #3 indicated staff should be with client A in the outdoor areas of the home and while in the community. Staff #4 was interviewed on 12/3/21 at 7:52 AM. Staff #4 indicated client A had elopement behaviors. Staff #4 indicated client A was assessed as needing 24-hour supervision. Staff #4 indicated client A should not be unsupervised while on the home's backyard patio, while completing outdoor chores such as getting the group home's mail or taking the home's trash to the receptacle. Staff #4 indicated staff should be with client A in the outdoor areas of the home and while in the community. AS (Administrative Staff) #1 was interviewed on 12/3/21 at 11:19 AM. AS #1 indicated she was the home's administrator and acting QIDP (Qualified Intellectual Disabilities Professional) due to vacancy in the QIDP position. AS #1 indicated LS was on leave and not available for interview. AS #1 indicated the home held house meetings with administrative staff to review and discuss client programming needs. AS #1 indicated the house meetings were the agency's equivalent to an IDT meeting (Interdisciplinary Team) meeting. AS #1 indicated the administrative team, or QIDP would conduct the house meeting and relay the information back to the home's staff. AS #1 indicated the house meeting/IDT reviewed client A's elopement's but did not make any specific/formal recommendations to address his elopement behavior. AS #1 indicated the team had discussed utilizing noise reducing headphones as			

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	a strategy to prevent client A's elopement behaviors. AS #1 indicated the use of headphones as strategy had not been added to client A's BSP (Behavior Support Plan), staff had not been trained on the strategy and the home was in the process of purchasing the noise reducing headphones for client A. AS #1 indicated staff working with client A should implement his BSP and provide direct supervision to structure his leisure time activities. AS #1 indicated staff should be in the area where client A is when outside of the home. AS #1 indicated client A was assessed as needing 24-hour supervision. AS #1 indicated client A had a history of sexual inappropriate behavior with continued probation officer involvement. AS #1 indicated client A's BSP did not include elopement as a formal targeted behavior or include specific preventative strategies to manage client A's elopement behavior. AS #1 indicated client A's BSP did include specific monitoring protocols for his attendance at the day program. AS #1 indicated client A's behavior management strategies at his home and his day program should be consistent. This federal tag relates to complaint #IN00344871. 9-3-4(a)			