STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G799		03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	10633 S AMERICA RD LA FONTAINE, IN 46940

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W 000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00164034. Complaint #IN00164034: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W122, W149, W157, W193, W240, and W249. Dates of Survey: 2/24, 2/25, 2/26, 2/27, 3/2, 3/3, and 3/4/2015. Provider Number: 15G799 Facility Number: 0012562 AIM Number: 201017540 Surveyor: Susan Eakright, QIDP The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/16/15 by Ruth Shackelford, QIDP.	W 000		
W 104	483.410(a)(1)			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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Bldg. 00	GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 clients (clients A, B, C, and D) who lived in the group home, the governing body failed to exercise operating direction over the facility to complete maintenance and repairs. Findings include: During observations on 2/24/15 from 6:25am until 9:00am and on 2/24/15 from 3:10pm until 5:00pm at the group home, clients A, B, C, and D walked throughout the group home and accessed each room. The following was observed with the RM/QIDP (Residential Manager/Qualified Intellectual Disabilities Professional), BC (Behavior Consultant), Group Home Staff (GHS) #1, GHS #2, and GHS #3: -On 2/24/15 at 6:35am, GHS #1 indicated the kitchen cabinet next to the hallway had a hole through the wood cabinet which was one foot wide by three and one half inches long (1' x 3 1/2"). The hole exposed the inside contents of the cabinet storage area. -On 2/24/15 at 6:35am, GHS #1 indicated the dining room table wood finish was	W 104	**W 104** Governing Body (Standard): Maintenance and Repairs **Corrective action for resident(s) found to have been affected** The broken kitchen cabinet will be repaired. The worn dining room table will be removed from the home, and a new table will be purchased. The worn sofa will be removed from the home, and a new one will be purchased. The stained carpet will be professionally cleaned. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Repairs made, worn items removed from home, and new items purchased to replace them. In addition, a maintenance checklist will be added to the home to keep track of needed maintenance items and repairs. **How corrective actions will be monitored to ensure no recurrence** The Manager is in charge of ensuring that maintenance in the home is kept	04/03/2015

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	worn. -On 2/24/15 at 7:40am, clients A, B, C, and D sat at the dining room table to eat breakfast and the wood grain on the table was exposed. -During both observation periods clients A, B, C, and D sat on two of two living room sofas. Each time a client sat down the client's body sank downward into the sofa. On 2/24/15 at 4:10pm, the BC retrieved cleaning wipes from a locked closet and began to wipe down both living room sofas. At 4:10pm, the BC stated the sofas were "worn and had tears" in the vinyl covering on the arm rests. The BC stated the sofa's "wooden supports were broken" to prevent sinking into the cushions when clients sat on the sofas. -On 2/24/15 at 6:55am, client A's bedroom carpet had stains on the carpeted areas around his bed. At 6:55am, client A indicated he had spilled and dumped his urinal and spilled food from his bed while he was on bedrest during the past month because of a fractured back and broken ankle. Client A indicated the staff cleaned it up at the time but the fluids had stained the carpet in his bedroom.		up to date. The Director supervises the Manager. They meet regularly, along with other members of the ESN group home team. Meeting agendas will include a standing item on maintenance, which will be reviewed at each meeting.	

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	On 2/24/15 at 4:25pm, the facility's maintenance items to be repaired and/or replaced were requested from the RM. There was none available for review. An interview with the Site Director (SD) was conducted on 2/26/15 at 12:45pm. At 12:45pm, the SD indicated client A, B, C, and D's group home had identified maintenance needs and needed repairs. The SD indicated the dining room table, kitchen cabinet, sofas, and client A's bedroom carpet maintenance/repairs to the group home had not been completed and there were no maintenance records. 9-3-1(a)			
W 122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (client A). The facility failed to implement their policy and procedures to ensure staff supervision of client A after his known behaviors and failed to implement effective corrective action. Findings include:	W 122	**W 122** Client Protections (Condition): Pica and Suicide attempt were not prevented by Client A.**Corrective action for resident(s) found to have been affected** In order to address self-destructive behaviors, especially pica and suicide attempts, supervision procedures will be added to client A's BSP that describe close supervision across environments (e.g., home, day program, etc.). These procedures will include	04/03/2015

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	Please refer to W149. The facility neglected for 1 of 1 sample client (client A) who had known behaviors of PICA (eating inedible objects) and Suicide attempts to supervise client A based on his identified behavioral needs and neglected to implement effective corrective action for 4 of 4 incidents for client A. Please refer to W157. The facility failed for 4 of 4 incidents of client behaviors of PICA (eating inedible objects) and Suicide attempt to implement effective corrective actions to address client A's continued behavioral incidents. This federal tag relates to complaint #IN00164034. 9-3-2(a)		instructions to staff on how to identify when Client A's behavior is escalated and how to respond to that escalated behavior with tighter supervision. Additionally, there will be instructions to staff on how to respond if Client A. attempts to leave supervision (often referred to as elopement). This will include a procedure for ensuring that a staff person remains on foot with Client A. as well as how to block and/or restrain as needed to prevent him from leaving supervision due to the dangerous nature of the behavior. **How facility will identify other residents potentially affected & what measures taken** These particular behaviors are not exhibited in Client A.'s housemates. The measures described here are only relevant to Client A.**Measures or systemic changes facility put in place to ensure no recurrence** New BSP procedures on supervision will be added to the BSP. These procedures will be trained across staff members. **How corrective actions will be monitored to ensure no recurrence** The Behavior Clinician (BC) is responsible for BSP interventions. The Manager supervises staff members and ensures their training needs are met. The BC and Manager work together to ensure that BSP interventions are trained to competency. The Director supervises both and meets with	

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			them regularly. The Director will ensure that BSP interventions are in place and trained across staff members.	
W 149 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 observation, record review, and interview, for 1 of 1 sample client (client A) who had known behaviors of PICA (eating inedible objects) and Suicide attempts, the facility neglected to supervise client A based on his identified behavioral needs and neglected to implement effective corrective action for 4 of 4 incidents for client A. Findings include: On 2/24/15 from 6:25am until 9:00am, observations were conducted at the group home. One staff was with four clients who were awake and walking throughout the group home. From 6:25am until 7:17am, Group Home Staff (GHS) #1 was alone with clients A, B, C, and D. At 7:17am, GHS #3 arrived at the group home. From 7:17am until 7:30am, GHS #1 and GHS #3 supervised clients A, B, C, and D. At 7:30am, GHS #2 arrived at the group home. From 7:30am until 7:40am, GHS #1, GHS #2, and GHS #3 supervised clients A, B, C, and D. Three	W 149	**W 149** Staff treatment of clients (Standard): Pica and Suicide attempt were not prevented by Client A.**Corrective action for resident(s) found to have been affected** In order to address self-destructive behaviors, especially pica and suicide attempts, supervision procedures will be added to client A's BSP that describe close supervision across environments (e.g., home, day program, etc.). These procedures will include instructions to staff on how to identify when Client A's behavior is escalated and how to respond to that escalated behavior with tighter supervision. Additionally, there will be instructions to staff on how to respond if Client A. attempts to leave supervision (often referred to as elopement). This will include a procedure for ensuring that a staff person remains on foot with Client A. as well as how to block and/or restrain as needed to prevent him from leaving supervision due to the dangerous nature of the behavior. **How facility will identify other**	04/03/2015

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	staff and four clients were at the group home. Client A did not have one on one staff available to supervise him. Client A wore a white hard plastic back brace covering client A's body from his arm pits to below his waist. On 2/25/15 from 12:15pm until 12:50pm, client A was at the facility owned day service site with no staff at his table, staff were across the large room, and staff turned their back on client A from across the room. From 12:15pm until 12:50pm, chemicals and a sharp item were out on the table where client A sat watching two large toy trains making circles on their train tracks atop of a piece of ply wood on top of a table. Client A indicated the trains belong to him and indicated the chemical and sharp items were his maintenance supplies to keep his trains running smoothly. On top of the table with the toy trains were loose wheels, a collectible car, small plastic trees, and loose wires on the table. All items were within the reach of client A. Client A stated he "did try to kill" himself by jumping off the bridge. Client A pointed to his injuries of a broken back, broken right knee, and broken left foot. Client A indicated he remained in pain. Client A indicated his trains relax him and he performs all of the maintenance on the trains. Client A indicated he did not want		**residents potentially affected & what measures taken** These particular behaviors are not exhibited in Client A.'s housemates. The measures described here are only relevant to Client A.**Measures or systemic changes facility put in place to ensure no recurrence** New BSP procedures on supervision will be added to the BSP. These procedures will be trained across staff members. **How corrective actions will be monitored to ensure no recurrence** The Behavior Clinician (BC) is responsible for BSP interventions. The Manager supervises staff members and ensures their training needs are met. The BC and Manager work together to ensure that BSP interventions are trained to competency. The Director supervises both and meets with them regularly. The Director will ensure that BSP interventions are in place and trained across staff members.	

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	to kill himself anymore and stated his "mind was in a good place." On 2/24/15 at 1:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed for client A. -A 11/27/14 BDDS report for an incident on 11/26/14 at 6:00pm, indicated client A "was upset talking about a prior incident. [Client A] ran out the front door of the group home and eloped. Staff got into a vehicle and followed [client A]. [Client A] slowed down, staff were driving next to him, talking to him in an attempt to calm him down. [Client A] seemed to be calming down when they were crossing over a bridge and [client A] jumped off the bridge. Staff called 9-1-1 and EMS (took the client) to the ER (Emergency Room)." The report indicated client A was transferred from the local hospital to a second hospital because of his injuries. Client A "appears to have fractures of the right knee, back, and left foot." No corrective actions were available for review. -A 12/2/14 Follow Up BDDS report for the 11/26/14 incident indicated "there were two staff supervising at the time of the incident."			

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	-A 11/26/14 BDDS report for an incident on 11/25/14 at 8:30pm, indicated client A "became upset because he looked at his reinforcement binder and saw that it was marked that he did not complete something he was supposed to complete to earn his reinforcement. [Client A] started to throw things around in his bedroom. [Client A] calmed down after staff talked to him. Then while staff were unloading groceries [client A] notified staff that he ate a tire off his collectible car that was in his bedroom." Client A was taken to the ER for assessment. The report indicated client A "was placed under suicide watch" at the group home. No corrective action was available for review. -A 12/2/14 Follow Up BDDS report for client A's 11/25/14 incident indicated "The X-Rays have revealed that the individual swallowed a car tire from one of his collectible cars and the individual had an endoscopy today 12/2/14" at the hospital to remove the object and check his stomach. -A 7/13/14 BDDS report for an incident on 7/13/14 at 9:45am indicated client A "confided to a staff member that he had put a wire in his nose and could not retrieve it. The wire was not visible to staff." The report indicated staff called			

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	the home manager and "during the call, [client A] was able to remove the wire which was a thin flexible wire approximately 2 1/2 in. (two and one half inches) long." The report indicated client A was taken to the ER (Emergency Room), was not injured, and did not meet the criteria for admission to the inpatient behavior unit. No corrective action was available for review. -A 5/26/14 BDDS report for an incident on 5/25/14 at 5:00pm indicated client A "came out of his room and told staff that he had swallowed 4 (four) AA (double A) batteries from his TV and DVD remotes and he kicked his train track." The report indicated client A was taken to the ER (Emergency Room) and staff were instructed to monitor client A's bowel movements for 72 hours for "up to 14 days." The report indicated client A "is currently being supervised at a 1:1 (one on one) ratio and items that are small enough to swallow have been removed from his room." The report indicated client A "felt like he was not worth anything and that he was upset about a conversation he and a peer had regarding [client A] passing gas." No corrective action was available for review. Client A's record was reviewed on			

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	2/25/15 at 1:10pm. Client A's record indicated medical appointments and follow up medical appointments for 12/30/13, 12/31/13, 1/1/14, and 1/13/14 after client A swallowed a battery from his remote control. -Client A's 12/30/13 "Medical Appointment Form" indicated "swallowed a battery...ingested a cylinder battery in stomach" signed by physician. -Client A's 12/31/13 "Medical Appointment Form" indicated "swallowed foreign body - battery...have abdomen...(recommended) X-Rays." -Client A's 1/1/14 "Medical Appointment Form" indicated "X-Ray" completed. -Client A's 1/2/14 hospital "Patient Visit Information" indicated "see your doctor on 1/2/14 for repeat X-ray. Watch for the battery in your stool...." Client A's record was reviewed on 2/25/15 at 1:10pm. Client A's 12/15/14 Hospital "Discharge Summary" from hospital #3 was reviewed. The summary indicated client A was admitted to hospital #3 on 12/15/14 and discharged from the hospital on 12/31/14 to the group home. Client A's 12/1/14 "Case Conference" documented by the Agency Registered Nurse (RN) and indicated regarding the 11/27/14 incident when client A "eloped...and suicide attempt... [Client A] was upset and eloped. Two			

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	staff followed alongside of [client A] in the van, talking to him and trying to calm him. [Client A] appeared to be calming down and then unexpectedly started running and jumped over a creek bridge. Staff immediately called 9-1-1. [Client A] was taken to [name of local hospital] by ambulance and then transferred to [name of hospital #2] after results of the X-Ray presented fractures. [Client A] had surgery on his (right) knee and (left) foot on 11/28/14. He is scheduled to have surgery on his back on 12/3/14...The team discussed the issue of his recovery. The surgeon stated that [client A] would not be able to put weight on either leg for 8 weeks and would require a wheelchair...[signed by the RN]." Client A's 1/2015 "Health Care Coordination Review" completed by the Agency RN indicated client A "was discharged from [name of hospital #3] on 12/31/14. [Client A] has a hard shell back brace to be worn at all times...a boot on left foot which is to worn at all times...non weight bearing and up in wheel chair only, transfers per (by) Hoyer Lift (sic)." The Health Care Review indicated client A "had surgery (for his injuries of a broken left foot, right knee, and fractured back) at [name of hospital #2] then transferred to [name of hospital #3] rehab. (rehabilitation hospital) until 12/31/14 for repairs of right knee, repair of fractured L			

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	(left) ankle, and repair of (fractured) back [signed by the Agency RN]." Client A's record was reviewed on 2/25/15 at 1:10pm. Client A was admitted on 11/6/13. Client A's 12/31/14 ISP (Individual Support Plan) and 11/6/13 BSP (Behavior Support Plan) updated on 2/24/15 indicated client A should be supervised by the facility staff. Client A's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Elopement, Property destruction, SIB (Self Injurious Behavior), Inappropriate Social Behaviors, and "Suicidal Gestures: Wrapping things around his neck in an attempt to choke himself, swallowing inedible items, making cuts on his body or any other self-inflicted act that threatens his own physical safety. If any actual attempts to harm himself are made, staff must try to intervene to block the attempt while verbally redirecting him...." Client A's BSP indicated he was to have "close" supervision by the facility staff and no specific guidelines for close supervision were available for review. On 2/26/15 at 11:00am, the Residential Manager (RM) and the Behavior Consultant (BC) indicated client A was admitted on 11/6/13 and swallowed batteries from his remote, put a wire up			

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	his nose, and jumped off a bridge during the previous year at the group home. The RM and BC indicated client A was to have been supervised by the facility staff. The BC indicated batteries are now kept locked, battery packs were used currently in the group home, and clients were supervised when changing batteries. The BC indicated client A had the identified behaviors of Suicidal attempts and PICA defined under suicidal gestures in client A's BSP and this behavior was identified before 12/30/13. On 2/26/15 at 12:45pm, an interview with the Site Director (SD) was conducted. The SD indicated the facility staff supervise client A based on his identified need. The SD indicated client A was alone inside client A's bedroom and took the batteries out of his remote control and consumed them. The SD indicated staff could not have predicted client A was going to jump off a bridge. The SD indicated client A was on one on one supervision before the incident because of the incident on 11/25/14 when client A consumed four double A batteries. The SD indicated staff were following in the vehicle to keep up with client A during his elopement on 11/26/14 before he jumped off the bridge. On 3/3/15 at 2:44pm, an interview with			

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	the SD was conducted. The SD stated client A "requires a supervision level of 24 hours, seven days per week, with a staff to client ratio of 1:1 during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients. During instances where 1:1 staff is required, the staff member responsible to supervise [client A] will not also be responsible for supervising anyone else. [Client A] will be assigned his own staff member to monitor him at a 1:1 ratio. Proximity to [client A] is not determined by factors such as arm's length or line of sight because these measures fail on a routine basis even when the situation is not unsafe...when someone turns a corner or walks into another room. Instead, [client A's] assigned staff members are directed to be in close enough proximity to provide safety. The staff members must be aware of [client A's] location at all times. This wording is specifically designed to provide adequate supervision without getting tied up in semantics such as how long is the staff person's arm. Staff are trained and understand that closer supervision is needed when a person is upset or escalated. This wording allows for that, which also relaxes the restriction of very close supervision when it is not required for safety." The SD stated client A "has never had a behavior incident at the day			

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	program. Although it is possible he could do something new, that is not likely if he is not upset or escalated. Again, the training and awareness of escalated behavior covers this." On 2/24/15 at 1:15pm, the 12/5/12 facility's policy on "Abuse and Neglect" was reviewed and indicated "Purpose. To educate and inform staff of the definition, define reporting requirements and stress that AWS (former name of facility) will not tolerate abuse, neglect or exploitation of any kind...Description, AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse." The policy indicated abuse, neglect, and/or mistreatment was "not tolerated" by the agency. On 2/24/15 at 1:15pm, a record review was completed of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...." This federal tag relates to complaint #IN00164034. 9-3-2(a)			

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W 157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 4 of 4 incidents of client behaviors of PICA (eating inedible objects) and Suicide attempt behaviors, the facility failed to implement effective corrective to address client A's continued maladaptive behavioral incidents. Findings include: On 2/24/15 at 1:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed for client A. -A 11/27/14 BDDS report for an incident on 11/26/14 at 6:00pm, indicated client A "was upset talking about a prior incident. [Client A] ran out the front door of the group home and eloped. Staff got into a vehicle and followed [client A]. [Client A] slowed down, staff were driving next to him, talking to him in an attempt to calm him down. [Client A] seemed to be calming down when they were crossing over a bridge and [client A] jumped off the bridge. Staff called 9-1-1 and EMS took the client to the ER (Emergency Room)." The report indicated client A was transferred from the local hospital to a second hospital because of his injuries.	W 157	**W 157**Staff Treatment of Clients (Standard): Pica and Suicide attempt were not prevented by Client A.**Corrective action for resident(s) found to have been affected** In order to address self-destructive behaviors, especially pica and suicide attempts, supervision procedures will be added to client A's BSP that describe close supervision across environments (e.g., home, day program, etc.). These procedures will include instructions to staff on how to identify when Client A's behavior is escalated and how to respond to that escalated behavior with tighter supervision. Additionally, there will be instructions to staff on how to respond if Client A. attempts to leave supervision (often referred to as elopement). This will include a procedure for ensuring that a staff person remains on foot with Client A. as well as how to block and/or restrain as needed to prevent him from leaving supervision due to the dangerous nature of the behavior. **How facility will identify other residents potentially affected & what measures taken** These particular behaviors are not exhibited in Client A.'s housemates. The measures described here are only relevant to Client A.**Measures or**	04/03/2015

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	Client A "appears to have fractures of the right knee, back, and left foot." No corrective actions were available for review. -A 12/2/14 Follow Up BDDS report for the 11/26/14 incident indicated "there were two staff supervising at the time of the incident." -A 11/26/14 BDDS report for an incident on 11/25/14 at 8:30pm, indicated client A "became upset because he looked at his reinforcement binder and saw that it was marked that he did not complete something he was suppose to complete to earn his reinforcement. [Client A] started to throw things around in his bedroom. [Client A] calmed down after staff talked to him. Then while staff were unloading groceries [client A] notified staff that he ate a tire off his collectible car that was in his bedroom." Client A was taken to the ER for assessment. The report indicated client A "was placed under suicide watch" at the group home. No corrective action was available for review. -A 12/2/14 Follow Up BDDS report for client A's 11/25/14 incident indicated "The X-Rays have revealed that the individual swallowed a car tire from one of his collectible cars and the individual had an endoscopy today 12/2/14" at the		**systemic changes facility put in place to ensure no recurrence** New BSP procedures on supervision will be added to the BSP. These procedures will be trained across staff members. **How corrective actions will be monitored to ensure no recurrence** The Behavior Clinician (BC) is responsible for BSP interventions. The Manager supervises staff members and ensures their training needs are met. The BC and Manager work together to ensure that BSP interventions are trained to competency. The Director supervises both and meets with them regularly. The Director will ensure that BSP interventions are in place and trained across staff members.	

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	hospital to remove the object and check his stomach. -A 7/13/14 BDDS report for an incident on 7/13/14 at 9:45am indicated client A "confided to a staff member that he had put a wire in his nose and could not retrieve it. The wire was not visible to staff." The report indicated staff called the home manager and "during the call, [client A] was able to remove the wire which was a thin flexible wire approximately 2 1/2 in. (two and one half inches) long." The report indicated client A was taken to the ER (Emergency Room), was not injured, and did not meet the criteria for admission to the inpatient behavior unit. No corrective action was available for review. -A 5/26/14 BDDS report for an incident on 5/25/14 at 5:00pm indicated client A "came out of his room and told staff that he had swallowed 4 (four) AA (double A) batteries from his TV and DVD remotes and he kicked his train track." The report indicated client A was taken to the ER (Emergency Room) and staff were instructed to monitor client A's bowel movements for 72 hours for "up to 14 days." The report indicated client A "is currently being supervised at a 1:1 (one on one) ratio and items that are small enough to swallow have been			

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	removed from his room." The report indicated client A "felt like he was not worth anything and that he was upset about a conversation he and a peer had regarding [client A] passing gas." No corrective action was available for review. On 2/26/15 at 11:00am, the Residential Manager (RM) and the Behavior Consultant (BC) indicated client A was admitted on 11/6/13 and swallowed batteries from his remote, put a wire up his nose, and jumped off a bridge during the previous year at the group home. The RM and BC indicated client A was to have been supervised by the facility staff. The BC indicated batteries are now kept locked, battery packs were used currently in the group home, and clients were supervised when changing batteries. The BC indicated client A had the identified behaviors of Suicidal attempts and PICA defined under suicidal gestures in client A's BSP and this behavior was identified before 12/30/13. The BC and RM both indicated no further information was available for review. The BC indicated she was unsure if the corrective actions taken were effective. On 2/26/15 at 12:45pm, an interview with the Site Director (SD) was conducted. The SD indicated the facility			

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	staff supervise client A based on his identified need. The SD indicated client A was alone inside client A's bedroom and took the batteries out of his remote control and consumed them. The SD indicated staff could not have predicted client A was going to jump off a bridge. The SD indicated the facility now used battery packs which were larger than loose batteries and could not be swallowed. The SD indicated client A was on one on one supervision before the incident because of the incident on 11/25/14 when client A consumed four double A batteries. The SD indicated staff were following in the vehicle to keep up with client A during his elopement on 11/26/14 before he jumped off the bridge. This federal tag relates to complaint #IN00164034. 9-3-2(a)			
W 186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential			

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	living unit. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 1 additional client (client D), the facility failed to provide sufficient staff at the group home to supervise clients and to implement client A, B, C, and D's Individual Support Plans (ISPs) and Behavior Support Plans (BSPs) and provide staff supervision. Findings include: On 2/24/15 from 6:25am until 9:00am, observations were conducted at the group home. From 6:25am until 7:17am, Group Home Staff (GHS) #1 was the only staff with clients A, B, C, and D. At 6:55am, client A indicated there had been one staff on duty for the overnight shift for weeks. At 6:55am, client A stated "the other staff are always late." At 6:55am, client B stated one staff "was always here, never more staff." At 6:55am, client C stated "We are always short staffed here. We make do." At 7:10am, client D indicated staff were late to work more than on time. At 7:17am, GHS #3 arrived at the group home. From 7:17am until 7:30am, GHS #1 and GHS #3 supervised clients A, B, C, and D. At 7:30am, GHS #2 arrived at the group home. From 7:30am until 7:40am, GHS #1, GHS #2, and GHS #3 supervised	W 186	**W 186**Direct Care Staff (Standard): Not enough staff members to supervise.**Corrective action for resident(s) found to have been affected** New employee recruitment efforts have been implemented, and there already are new staff members in training. Recruitment efforts include new posting on door at day program and employee referral bonus program in which current employees can receive cash incentive for referring a new employee. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in place to ensure no recurrence** New recruitment efforts have been implemented. In addition, a new sign in sheet with clock will be placed at the group home to more closely monitor staff members. This will be monitored with manager sign-off and will include disciplinary action for late arriving staff members. As an additional measure, managers will schedule random checks across shifts to ensure compliance. **How corrective actions will be monitored to ensure no recurrence** Managers supervise and train Direct Support Professional (DSP) staff	04/03/2015

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	clients A, B, C, and D. Three staff and four clients were at the group home. Client A did not have one on one staff available to supervise him. Confidential interview (CI) #1 stated the facility had one staff scheduled with clients A, B, C, and D on a "regular basis." CI #1 stated "rarely" were there two staff on duty during the overnight period. CI #2 stated CI #2 had "major concerns about the lack of enough staff to supervise" clients A, B, C, and D. Client A's record was reviewed on 2/25/15 at 1:10pm. Client A's 12/31/14 ISP (Individual Support Plan) and 11/6/13 BSP (Behavior Support Plan) updated on 2/24/15 indicated client A should be supervised by the facility staff. Client A's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Elopement, Property destruction, SIB (Self Injurious Behavior), Inappropriate Social Behaviors, and "Suicidal Gestures: Wrapping things around his neck in an attempt to choke himself, swallowing inedible items, making cuts on his body or any other self-inflicted act that threatens his own physical safety. If any actual attempts to harm himself are made,		members. Their role also includes scheduling and disciplinary action for staff who fail to be at work on time. The managers are supervised by the director who meets with them regularly. Staff sign in will be monitored by the director when meeting with managers.	

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	staff must try to intervene to block the attempt while verbally redirecting him...." Client A's 12/31/14 "Supervision Level Summary" indicated client A "requires a supervision level of 24 hours, seven days per week, with a staff to client ratio of 1:1 (one staff to one client) during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients." On 2/25/15 at 1:40pm, client B's record was reviewed. Client B's 4/21/14 ISP (Individual Support Plan) and 4/17/14 BSP indicated client B needed staff supervision twenty-four hours a day, seven days a week. Client B's ISP and BSP indicated targeted behaviors of Verbal Aggression, Physical Aggression, Public Masturbation, Rumination, Property Destruction, and Inappropriate Sexual Behavior. Client B's 4/17/14 "Supervision Level Summary" indicated client B "requires a supervision level of 24 hours, seven days per week, with a minimum staff to client ratio of 3 staff to 4 clients during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients." On 2/26/15 at 11:00am, client C's record was reviewed. Client C's 4/21/14 ISP and 10/2014 BSP both indicated client C needed staff supervision twenty-four hours a day, seven days a week. Client			

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	C's record indicated a targeted behavior of Isolation Behavior. Client C's 4/18/14 "Supervision Level Summary" indicated client C "requires a supervision level of 24 hours, seven days per week with a minimum staff to client ratio of 3 staff to 4 clients during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients." On 2/26/15 at 11:00am, the Residential Manager (RM) and the Behavior Consultant (BC) indicated client A had swallowed batteries from his remote, put a wire up his nose, and jumped off a bridge during the previous year at the group home. The RM and BC indicated client A was to have been supervised by the facility staff when awake. The RM indicated three to four staff were to be scheduled on day shift and evening shift and two staff for the overnight shift. The RM indicated the group home was experiencing a shortage of staff at this time and was in the process of recruiting more staff. On 3/3/15 at 2:44pm, an interview with the SD was conducted. The SD stated client A "requires a supervision level of 24 hours, seven days per week, with a staff to client ratio of 1:1 during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients. During			

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	instances where 1:1 staff is required, the staff member responsible to supervise [client A] will not also be responsible for supervising anyone else. [Client A] will be assigned his own staff member to monitor him at a 1:1 ratio. Proximity to [client A] is not determined by factors such as arm's length or line of sight because these measures fail on a routine basis even when the situation is not unsafe...when someone turns a corner or walks into another room. Instead, [client A's] assigned staff members are directed to be in close enough proximity to provide safety. The staff members must be aware of [client A's] location at all times. This wording is specifically designed to provide adequate supervision without getting tied up in semantics such as how long is the staff person's arm. Staff are trained and understand that closer supervision is needed when a person is upset or escalated. This wording allows for that, which also relaxes the restriction of very close supervision when it is not required for safety." The SD indicated the facility did not have enough staff working on 2/24/15 during the morning observation period. 9-3-3(a)			

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W 193 Bldg. 00	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. Based on observation, record review, and interview, for 1 of 3 sampled clients (client A) who had known behaviors of PICA (eating inedible objects), elopement, and Suicide attempt, the facility failed to ensure staff were able to demonstrate skills and consistently implement supervision techniques for client A's inappropriate behaviors. Findings include: On 2/24/15 from 6:25am until 9:00am, observations were conducted at the group home. From 6:25am until 7:17am, Group Home Staff (GHS) #1 was alone with clients A, B, C, and D. At 7:17am, GHS #3 arrived at the group home. From 7:17am until 7:30am, GHS #1 and GHS #3 supervised clients A, B, C, and D. At 7:30am, GHS #2 arrived at the group home. From 7:30am until 7:40am, GHS #1, GHS #2, and GHS #3 supervised clients A, B, C, and D. Three staff and four clients were at the group home. Client A did not have one on one staff available to supervise him. On 2/24/15 at 1:15pm, the facility's	W 193	**W 193**Staff Training Program (Standard): Supervision procedures**Corrective action for resident(s) found to have been affected** In order to address self-destructive behaviors, especially pica and suicide attempts, supervision procedures will be added to client A's BSP that describe close supervision across environments (e.g., home, day program, etc.). These procedures will include instructions to staff on how to identify when Client A's behavior is escalated and how to respond to that escalated behavior with tighter supervision. Additionally, there will be instructions to staff on how to respond if Client A. attempts to leave supervision (often referred to as elopement). This will include a procedure for ensuring that a staff person remains on foot with Client A. as well as how to block and/or restrain as needed to prevent him from leaving supervision due to the dangerous nature of the behavior. **How facility will identify other residents potentially affected & what measures taken** These particular behaviors are not exhibited in Client A.'s housemates. The measures described here are only	04/03/2015

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	BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed for client A. -A 11/27/14 BDDS report for an incident on 11/26/14 at 6:00pm, indicated client A "was upset talking about a prior incident. [Client A] ran out the front door of the group home and eloped. Staff got into a vehicle and followed [client A]. [Client A] slowed down, staff were driving next to him, talking to him in an attempt to calm him down. [Client A] seemed to be calming down when they were crossing over a bridge and [client A] jumped off the bridge. Staff called 9-1-1 and EMS to the ER (Emergency Room)." The report indicated client A was transferred from the local hospital to a second hospital because of his injuries. Client A "appears to have fractures of the right knee, back, and left foot." -A 12/2/14 Follow Up BDDS report for the 11/26/14 incident indicated "there were two staff supervising at the time of the incident." -A 11/26/14 BDDS report for an incident on 11/25/14 at 8:30pm, indicated client A "became upset because he looked at his reinforcement binder and saw that it was marked that he did not complete something he was supposed to complete		relevant to Client A.**Measures or systemic changes facility put in place to ensure no recurrence** New BSP procedures on supervision will be added to the BSP. These procedures will be trained across staff members. **How corrective actions will be monitored to ensure no recurrence** The Behavior Clinician (BC) is responsible for BSP interventions. The Manager supervises staff members and ensures their training needs are met. The BC and Manager work together to ensure that BSP interventions are trained to competency. The Director supervises both and meets with them regularly. The Director will ensure that BSP interventions are in place and trained across staff members.	

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	to earn his reinforcement. [Client A] started to throw things around in his bedroom. [Client A] calmed down after staff talked to him. Then while staff were unloading groceries [client A] notified staff that he ate a tire off his collectible car that was in his bedroom." Client A was taken to the ER for assessment. The report indicated client A "was placed under suicide watch" at the group home. -A 12/2/14 Follow Up BDDS report for client A's 11/25/14 incident indicated "The X-Rays have revealed that the individual swallowed a car tire from one of his collectible cars and the individual had an endoscopy today 12/2/14" at the hospital to remove the object and check his stomach. -A 7/13/14 BDDS report for an incident on 7/13/14 at 9:45am indicated client A "confided to a staff member that he had put a wire in his nose and could not retrieve it. The wire was not visible to staff." The report indicated staff called the home manager and "during the call, [client A] was able to remove the wire which was a thin flexible wire approximately 2 1/2 in. (two and one half inches) long." The report indicated client A was taken to the ER (Emergency Room), was not injured, and did not meet			

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	the criteria for admission to the inpatient behavior unit. -A 5/26/14 BDDS report for an incident on 5/25/14 at 5:00pm indicated client A "came out of his room and told staff that he had swallowed 4 (four) AA (double A) batteries from his TV and DVD remotes and he kicked his train track." The report indicated client A was taken to the ER (Emergency Room) and staff were instructed to monitor client A's bowel movements for 72 hours for "up to 14 days." The report indicated client A "is currently being supervised at a 1:1 (one on one) ratio and items that are small enough to swallow have been removed from his room." The report indicated client A "felt like he was not worth anything and that he was upset about a conversation he and a peer had regarding [client A] passing gas." Client A's record was reviewed on 2/25/15 at 1:10pm. Client A's record indicated medical appointments and follow up medical appointments for 12/30/13, 12/31/13, 1/1/14, and 1/13/14 after client A swallowed a battery from his remote control. -Client A's 12/30/13 "Medical Appointment Form" indicated "swallowed a battery...ingested a cylinder battery in stomach" signed by physician.			

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	Client A's record was reviewed on 2/25/15 at 1:10pm. Client A's 12/31/14 ISP (Individual Support Plan) and 11/6/13 BSP (Behavior Support Plan) updated on 2/24/15 indicated client A should be supervised by the facility staff. Client A's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Elopement, Property destruction, SIB (Self Injurious Behavior), Inappropriate Social Behaviors, and "Suicidal Gestures: Wrapping things around his neck in an attempt to choke himself, swallowing inedible items, making cuts on his body or any other self-inflicted act that threatens his own physical safety. If any actual attempts to harm himself are made, staff must try to intervene to block the attempt while verbally redirecting him...." Client A's BSP indicated he was to have "close" supervision by the facility staff and no specific trainings for client A's plans were available for review. On 2/26/15 at 11:00am, the Residential Manager (RM) and the Behavior Consultant (BC) indicated client A was admitted on 11/6/13 and swallowed batteries from his remote, put a wire up his nose, and jumped off a bridge during the previous year at the group home. The RM and BC indicated client A was to			

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	have been supervised by the facility staff. The BC indicated client A had the identified behaviors of Suicidal attempts and PICA defined under suicidal gestures in client A's BSP and this behavior was identified before 12/30/13. The BC and the RM indicated there was no staff training specific to client A's ISP and BSP available for review. On 2/26/15 at 12:45pm, an interview with the Site Director (SD) was conducted. The SD indicated the facility staff supervise client A based on his identified need. The SD indicated staff could not have predicted client A was going to jump off a bridge. The SD indicated client A was on one on one supervision before the incident because of the incident on 11/25/14 after client A had consumed four double A batteries. On 3/3/15 at 2:44pm, an interview with the SD was conducted. The SD stated client A "requires a supervision level of 24 hours, seven days per week, with a staff to client ratio of 1:1 during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients. During instances where 1:1 staff is required, the staff member responsible to supervise [client A] will not also be responsible for supervising anyone else. [Client A] will be assigned his own staff member to			

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	monitor him at a 1:1 ratio. Proximity to [client A] is not determined by factors such as arm's length or line of sight because these measures fail on a routine basis even when the situation is not unsafe...when someone turns a corner or walks into another room. Instead, [client A's] assigned staff members are directed to be in close enough proximity to provide safety. The staff members must be aware of [client A's] location at all times. This wording is specifically designed to provide adequate supervision without getting tied up in semantics such as how long is the staff person's arm. Staff are trained and understand that closer supervision is needed when a person is upset or escalated. This wording allows for that, which also relaxes the restriction of very close supervision when it is not required for safety." The SD stated client A "has never had a behavior incident at the day program. Although it is possible he could do something new, that is not likely if he is not upset or escalated. Again, the training and awareness of escalated behavior covers this." The SD indicated staff were trained and no dates for the completed staff trainings were available for review. This federal tag relates to complaint #IN00164034.			

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	9-3-3(a)			
W 225 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) who attended facility owned day services, the facility failed to assess clients A, B, and C's vocational abilities related to their individual work history, work skills, and work interests. Findings include: On 2/25/15 from 12:15pm until 12:50pm, clients A, B, and C were observed at the facility owned day services. From 12:15pm until 12:50pm, client A sat at a table with his collectible trains and was operating the controls to make them move on the tracks. Clients B and C played Wii and walked throughout the large day service room. At 12:50pm, clients B and C left for bowling in the community. At 12:50pm, client A played bingo with the staff. On 2/25/15 at 1:10pm, client A's record was reviewed. Client A's 1/5/15 FA	W 225	**W 225**Individual Program Plan (Standard): Vocational Assessments**Corrective action for resident(s) found to have been affected** A representative of Vocational Rehabilitation (VR) will conduct assessments for each resident of the home. In addition, a community employment assessment will be added to annual meeting form. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in place to ensure no recurrence** VR assessments will be conducted and an annual community employment assessment will be added to the annual meeting form. **How corrective actions will be monitored to ensure no recurrence** The manager is responsible to schedule the VR assessments. The whole Interdisciplinary Team (IDT) will participate in each resident's	04/03/2015

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	(Functional Assessment) did not include his work history and/or work interests. On 2/25/15 at 1:40pm, client B's record was reviewed. Client B's 4/21/14 ISP and 4/22/14 FA did not include his work history and/or work interests. On 2/26/15 at 11:00am, client C's record was reviewed. Client C's 4/21/14 ISP and 4/16/14 FA did not include his work history and/or work interests. On 3/3/15 at 2:44pm, an interview with the SD/QIDP (Site Director/Qualified Intellectual Disabilities Professional) was conducted. The SD/QIDP indicated clients A, B, and C were prompted and offered activities during day services. The SD/QIDP indicated clients A, B, and C's vocational assessments did not include a work history, work skills, and/or their work interests. 9-3-4(a)		annual meeting and will assist the manager and/or Qualified Intellectual Disability Professional (QIDP) when completing the annual community employment assessment. The director supervises the other members of the IDT and will ensure compliance with this new change to the format of the annual meeting.	
W 240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review, and interview, for 1 of 3 sampled clients	W 240	**W 240** Individual Program Plan	04/03/2015

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	(client A) who had known behaviors of PICA (eating inedible objects) and Suicide attempt behaviors, the facility failed to develop specific guidelines to define client A's supervision level at the group home. Findings include: On 2/24/15 from 6:25am until 9:00am, observations were conducted at the group home. From 6:25am until 7:17am, Group Home Staff (GHS) #1 was alone with clients A, B, C, and D. At 7:17am, GHS #3 arrived at the group home. From 7:17am until 7:30am, GHS #1 and GHS #3 supervised clients A, B, C, and D. At 7:30am, GHS #2 arrived at the group home. From 7:30am until 7:40am, GHS #1, GHS #2, and GHS #3 supervised clients A, B, C, and D. Three staff and four clients were at the group home. Client A did not have one on one staff available to supervise him. On 2/25/15 from 12:15pm until 12:50pm, client A was at the facility owned day service site with no staff at his table, staff were across the large room, and staff turned their back on client A from across the room. From 12:15pm until 12:50pm, chemicals and a sharp item were out on the table where client A sat watching two large toy trains making circles on their		(Standard): Supervision Procedures**Corrective action for resident(s) found to have been affected** In order to address self-destructive behaviors, especially pica and suicide attempts, supervision procedures will be added to client A's BSP that describe close supervision across environments (e.g., home, day program, etc.). These procedures will include instructions to staff on how to identify when Client A's behavior is escalated and how to respond to that escalated behavior with tighter supervision. Additionally, there will be instructions to staff on how to respond if Client A. attempts to leave supervision (often referred to as elopement). This will include a procedure for ensuring that a staff person remains on foot with Client A. as well as how to block and/or restrain as needed to prevent him from leaving supervision due to the dangerous nature of the behavior. **How facility will identify other residents potentially affected & what measures taken** These particular behaviors are not exhibited in Client A.'s housemates. The measures described here are only relevant to Client A.**Measures or systemic changes facility put in place to ensure no recurrence** New BSP procedures on supervision will be added to the BSP. These procedures will be trained across staff members.	

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	train tracks atop of a piece of ply wood on top of a table. Client A indicated the trains belong to him and indicated the chemical and sharp items were his maintenance supplies to keep his trains running smoothly. On top of the table with the toy trains were loose wheels, a collectible car, small plastic trees, and loose wires on the table. All items were within the reach of client A. Client A stated he "did try to kill" himself by jumping off the bridge. Client A pointed to his injuries of a broken back, broken right knee, and broken left foot. Client A indicated he remained in pain. Client A indicated his trains relax him and he performs all of the maintenance on the trains. Client A indicated he did not want to kill himself anymore and stated his "mind was in a good place." The staff walked across the room to client A at the table. The staff indicated the facility did not have MSDS (Material Safety Data Sheets) which would indicate what to do if the client (or any other client in the room) ingested or misused the items. The following items were on client A's table without staff supervision: -A container of "MTHE" 2 oz. liquid smoke fluid. -A tube of Super glue. -A bottle of train oil liquid with a worn label. Client A identified it.		**How corrective actions will be monitored to ensure no recurrence** The Behavior Clinician (BC) is responsible for BSP interventions. The Manager supervises staff members and ensures their training needs are met. The BC and Manager work together to ensure that BSP interventions are trained to competency. The Director supervises both and meets with them regularly. The Director will ensure that BSP interventions are in place and trained across staff members.	

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	-A 5.5 oz. gratis grease, client A indicated it was for the train gears. -A Sodar " TIX FlU " liquid which client A indicated it was to fix train wires. -A Grease with "PTFE 1/2 fl. Oz. tube" client A indicated it was for gears. -A Metal pointed Allen wrench 6 " long. -A container of "PTOT Smoke 7.0 Fl. Oz. MTN" for train smoke. -A container of "Scenic Cement 16oz." spray and a bottle to refill the other bottle. Client A indicated it was to spray on the train grass to keep it attached to the board on the table. On 2/24/15 at 1:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed for client A. -A 11/27/14 BDDS report for an incident on 11/26/14 at 6:00pm, indicated client A "was upset talking about a prior incident. [Client A] ran out the front door of the group home and eloped. Staff got into a vehicle and followed [client A]. [Client A] slowed down, staff were driving next to him, talking to him in an attempt to calm him down. [Client A] seemed to be calming down when they were crossing over a bridge and [client A] jumped off the bridge. Staff called 9-1-1 and EMS to the ER (Emergency Room)." The			

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	report indicated client A was transferred from the local hospital to a second hospital because of his injuries. Client A "appears to have fractures of the right knee, back, and left foot." -A 12/2/14 Follow Up BDDS report for the 11/26/14 incident indicated "there were two staff supervising at the time of the incident." -A 11/26/14 BDDS report for an incident on 11/25/14 at 8:30pm, indicated client A "became upset because he looked at his reinforcement binder and saw that it was marked that he did not complete something he was supposed to complete to earn his reinforcement. [Client A] started to throw things around in his bedroom. [Client A] calmed down after staff talked to him. Then while staff were unloading groceries [client A] notified staff that he ate a tire off his collectible car that was in his bedroom." Client A was taken to the ER for assessment. The report indicated client A "was placed under suicide watch" at the group home. -A 12/2/14 Follow Up BDDS report for client A's 11/25/14 incident indicated "The X-Rays have revealed that the individual swallowed a car tire from one of his collectible cars and the individual			

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	had an endoscopy today 12/2/14" at the hospital to remove the object and check his stomach. -A 7/13/14 BDDS report for an incident on 7/13/14 at 9:45am indicated client A "confided to a staff member that he had put a wire in his nose and could not retrieve it. The wire was not visible to staff." The report indicated staff called the home manager and "during the call, [client A] was able to remove the wire which was a thin flexible wire approximately 2 1/2 in. (two and one half inches) long." The report indicated client A was taken to the ER (Emergency Room), was not injured, and did not meet the criteria for admission to the inpatient behavior unit. -A 5/26/14 BDDS report for an incident on 5/25/14 at 5:00pm indicated client A "came out of his room and told staff that he had swallowed 4 (four) AA (double A) batteries from his TV and DVD remotes and he kicked his train track." The report indicated client A was taken to the ER (Emergency Room) and staff were instructed to monitor client A's bowel movements for 72 hours for "up to 14 days." The report indicated client A "is currently being supervised at a 1:1 (one on one) ratio and items that are small enough to swallow have been			

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	15G799		03/04/2015

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	removed from his room." The report indicated client A "felt like he was not worth anything and that he was upset about a conversation he and a peer had regarding [client A] passing gas." Client A's record was reviewed on 2/25/15 at 1:10pm. Client A's record indicated medical appointments and follow up medical appointments for 12/30/13, 12/31/13, 1/1/14, and 1/13/14 after client A swallowed a battery from his remote control. -Client A's 12/30/13 "Medical Appointment Form" indicated "swallowed a battery...ingested a cylinder battery in stomach" signed by physician. Client A's record was reviewed on 2/25/15 at 1:10pm. Client A was admitted on 11/6/13. Client A's 12/31/14 ISP (Individual Support Plan) and 11/6/13 BSP (Behavior Support Plan) updated on 2/24/15 indicated client A should be supervised by the facility staff. Client A's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression, Elopement, Property destruction, SIB (Self Injurious Behavior), Inappropriate Social Behaviors, and "Suicidal Gestures: Wrapping things around his neck in an attempt to choke himself, swallowing inedible items, making cuts on his body			

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	or any other self-inflicted act that threatens his own physical safety. If any actual attempts to harm himself are made, staff must try to intervene to block the attempt while verbally redirecting him...." Client A's BSP indicated he was to have "close" supervision by the facility staff and no specific guidelines for close supervision were available for review. On 2/26/15 at 11:00am, the Residential Manager (RM) and the Behavior Consultant (BC) indicated client A was admitted on 11/6/13 and swallowed batteries from his remote, put a wire up his nose, and jumped off a bridge during the previous year at the group home. The RM and BC indicated client A was to have been supervised by the facility staff. The BC indicated client A had the identified behaviors of Suicidal attempts and PICA defined under suicidal gestures in client A's BSP and this behavior was identified before 12/30/13. The BC and the RM indicated client A's ISP and BSP did not contain specific guidelines for his supervision level. The BC indicated no further information was available for review. On 2/26/15 at 12:45pm, an interview with the Site Director (SD) was conducted. The SD indicated the facility staff supervise client A based on his			

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	identified need. The SD indicated staff could not have predicted client A was going to jump off a bridge. The SD indicated client A was on one on one supervision before the incident because of the incident on 11/25/14 after client A consumed four double A batteries. On 3/3/15 at 2:44pm, an interview with the SD was conducted. The SD stated client A "requires a supervision level of 24 hours, seven days per week, with a staff to client ratio of 1:1 during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients. During instances where 1:1 staff is required, the staff member responsible to supervise [client A] will not also be responsible for supervising anyone else. [Client A] will be assigned his own staff member to monitor him at a 1:1 ratio. Proximity to [client A] is not determined by factors such as arm's length or line of sight because these measures fail on a routine basis even when the situation is not unsafe...when someone turns a corner or walks into another room. Instead, [client A's] assigned staff members are directed to be in close enough proximity to provide safety. The staff members must be aware of [client A's] location at all times. This wording is specifically designed to provide adequate supervision without getting tied up in semantics such			

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	as how long is the staff person's arm. Staff are trained and understand that closer supervision is needed when a person is upset or escalated. This wording allows for that, which also relaxes the restriction of very close supervision when it is not required for safety." The SD stated client A "has never had a behavior incident at the day program. Although it is possible he could do something new, that is not likely if he is not upset or escalated. Again, the training and awareness of escalated behavior covers this." This federal tag relates to complaint #IN00164034. 9-3-4(a)			
W 249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview, and record review, for 3 of 3 sampled clients (clients A, B, and C) and for 1 additional client (client D), the facility failed to ensure client A, B, C, and D's BSPs	W 249	**W 249**Program Implementation (Standard): Locked Chemicals**Corrective action for resident(s) found to have been affected** All chemicals will be	04/03/2015

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	(Behavior Support Plans) were implemented to secure locked chemicals when not in direct staff supervision for clients A, B, C, and D and failed to provide staff supervision for client A for his known maladaptive behaviors. Findings include: 1. On 2/24/15 from 6:25am until 9:00am, observations were conducted at the group home. From 6:25am until 7:17am, Group Home Staff (GHS) #1 was alone with clients A, B, C, and D. At 6:35am, clients A, B, C, and D walked throughout the group home including the kitchen. At 6:35am, a 32 fluid ounce bottle of Lysol Multi Surface cleaner was unsecured and stored under the kitchen sink. At 6:35am, GHS #1 indicated the Lysol cleaner should have been stored in the secured closet. GHS #1 indicated clients A, B, C, and D had the identified need for chemicals and cleaners to be secured. Client A's record was reviewed on 2/26/15 at 1:10pm. Client A's 11/6/13 ISP (Individual Support Plan) and 11/6/13 BSP (Behavior Support Plan) indicated client A should be supervised by the facility staff. Client A's BSP indicated targeted behaviors of Physical Aggression, Verbal Aggression,		locked per existing restriction. Staff members will be retrained on proper implementation of the chemical restriction. Train chemicals cited in the survey will be locked up, and supervision procedures will address close supervision when Client A. uses his trains, including the use of chemicals for this purpose. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in place to ensure no recurrence** All chemicals will be locked, and staff members will be retrained on this restriction. Train chemicals will be added to the list of restricted chemicals. Supervision procedures will be added to the BSP for Client A. to ensure safety. **How corrective actions will be monitored to ensure no recurrence** The Behavior Clinician (BC) is responsible for BSP interventions. The Manager supervises staff members and ensures their training needs are met. The BC and Manager work together to ensure that BSP interventions are trained to competency. The Director supervises both and meets with them regularly. The Director will ensure that BSP interventions are in place and trained across staff members.	

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	Elopement, Property destruction, SIB (Self Injurious Behavior), Inappropriate Social Behaviors, and "Suicidal Gestures: Wrapping things around his neck in an attempt to choke himself, swallowing inedible items, making cuts on his body or any other self-inflicted act that threatens his own physical safety. If any actual attempts to harm himself are made, staff must try to intervene to block the attempt while verbally redirecting him...." Client A's BSP indicated he needed sharps and chemicals secured at "all times" for his safety. On 2/25/15 at 1:40pm, client B's record was reviewed. Client B's 4/21/14 ISP (Individual Support Plan) and 4/17/14 BSP indicated client B needed staff supervision regarding locked chemicals. Client B's record indicated client B lived in the group home and required staff supervision to teach him regarding locked items. Client B's record indicated he required a living environment with security to ensure safety. On 2/26/15 at 11:00am, an interview with the Behavior Consultant (BC) and the Residential Manager (RM) was conducted. The BC stated facility staff should have ensured that "all" chemicals were kept secured and locked when not directly supervised by the facility staff.			

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	The BC indicated the unsecured chemicals should not have been left out under the kitchen sink by the group home staff. The RM indicated clients A, B, C, and D had the identified need for locked chemicals to ensure their safety. 2. On 2/24/15 from 6:25am until 9:00am, observations were conducted at the group home. From 6:25am until 7:17am, Group Home Staff (GHS) #1 was alone with clients A, B, C, and D. At 7:17am, GHS #3 arrived at the group home. From 7:17am until 7:30am, GHS #1 and GHS #3 supervised clients A, B, C, and D. At 7:30am, GHS #2 arrived at the group home. From 7:30am until 7:40am, GHS #1, GHS #2, and GHS #3 supervised clients A, B, C, and D. Three staff and four clients were at the group home. Client A did not have one on one staff available to supervise him. On 2/25/15 from 12:15pm until 12:50pm, client A was at the facility owned day service site with no staff at his table. Staff were across the large room and had their backs turned away from client A. From 12:15pm until 12:50pm, chemicals and a sharp item were out on the table where client A sat watching two large toy trains making circles on their train tracks atop of a piece of ply wood on top of a table. Client A indicated the trains			

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	belong to him and indicated the chemical and sharp items were his maintenance supplies to keep his trains running smoothly. On top of the table with the toy trains were loose wheels, a collectible car, small plastic trees, and loose wires on the table. All items were within the reach of client A. Client A stated he "did try to kill" himself by jumping off the bridge. Client A pointed to his injuries of a broken back, broken right knee, and broken left foot. Client A indicated he remained in pain. Client A indicated his trains relax him and he performs all of the maintenance on the trains. Client A indicated he did not want to kill himself anymore and stated his "mind was in a good place." The staff walked from across the room to client A who was seated at the table with the trains. The staff indicated the facility did not have MSDS (Material Safety Data Sheets) which would indicate what to do if the client (or any other client in the room) ingested or misused the items. The following items were on client A's table without staff supervision: -A container of "MTHE" 2 oz. liquid smoke fluid. -A tube of Super glue. -A bottle of train oil liquid with a worn label. Client A identified it. -A 5.5 oz. gratis grease, client A			

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	indicated it was for the train gears. -A Sodar " TIX FlU " liquid which client A indicated it was to fix train wires. -A Grease with "PTFE 1/2 fl. Oz. tube" client A indicated it was for gears. -A Metal pointed Allen wrench 6 " long. -A container of "PTOT Smoke 7.0 Fl. Oz. MTN" for train smoke. -A container of "Scenic Cement 16oz." spray and a bottle to refill the other bottle. Client A indicated it was to spray on the train grass to keep it attached to the board on the table. On 2/24/15 at 1:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed for client A. -A 11/27/14 BDDS report for an incident on 11/26/14 at 6:00pm, indicated client A "was upset talking about a prior incident. [Client A] ran out the front door of the group home and eloped. Staff got into a vehicle and followed [client A]. [Client A] slowed down, staff were driving next to him, talking to him in an attempt to calm him down. [Client A] seemed to be calming down when they were crossing over a bridge and [client A] jumped off the bridge. Staff called 9-1-1 and EMS to the ER (Emergency Room)." The report indicated client A was transferred			

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	from the local hospital to a second hospital because of his injuries "appears to have fractures of the right knee, back, and left foot." -A 12/2/14 Follow Up BDDS report for the 11/26/14 incident indicated "there were two staff supervising at the time of the incident." -A 11/26/14 BDDS report for an incident on 11/25/14 at 8:30pm, indicated client A "became upset because he looked at his reinforcement binder and saw that it was marked that he did not complete something he was supposed to complete to earn his reinforcement. [Client A] started to throw things around in his bedroom. [Client A] calmed down after staff talked to him. Then while staff were unloading groceries [client A] notified staff that he ate a tire off his collectible car that was in his bedroom." Client A was taken to the ER for assessment. The report indicated client A "was placed under suicide watch" at the group home. -A 12/2/14 Follow Up BDDS report for client A's 11/25/14 incident indicated "The X-Rays have revealed that the individual swallowed a car tire from one of his collectible cars and the individual had an endoscopy today 12/2/14" at the			

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	actual attempts to harm himself are made, staff must try to intervene to block the attempt while verbally redirecting him...." Client A's BSP indicated he was to have "close" supervision by the facility staff and no guidelines for close supervision were available for review. Client A's BSP indicated "...[Client A's] trains and collectible cars will be stored at Day Services and he will be allowed to use these items while maintaining close supervision at Day Services only. Staff should maintain a 1:1 supervision level with [client A] and ensure that [client A] does not have access to small items or that items are blocked if [client A] tries to harm himself with such objects." Client A's 1/5/15 "Individual Support Plan Assessment" indicated "Sharps and Chemical restrictions...Cars and trains at day service with supervision." On 2/26/15 at 11:00am, the Residential Manager (RM) and the Behavior Consultant (BC) indicated client A was admitted on 11/6/13 and swallowed batteries from his remote, put a wire up his nose, and jumped off a bridge during the previous year at the group home. The RM and BC indicated client A was to have been supervised by the facility staff. On 3/3/15 at 2:44pm, an interview with the SD was conducted. The SD stated			

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	client A "requires a supervision level of 24 hours, seven days per week, with a staff to client ratio of 1:1 during normally awake hours. Overnight ratio is minimally 2 staff to 4 clients. During instances where 1:1 staff is required, the staff member responsible to supervise [client A] will not also be responsible for supervising anyone else. [Client A] will be assigned his own staff member to monitor him at a 1:1 ratio. Proximity to [client A] is not determined by factors such as arm's length or line of sight because these measures fail on a routine basis even when the situation is not unsafe...when someone turns a corner or walks into another room. Instead, [client A's] assigned staff members are directed to be in close enough proximity to provide safety. The staff members must be aware of [client A's] location at all times. This wording is specifically designed to provide adequate supervision without getting tied up in semantics such as how long is the staff person's arm. Staff are trained and understand that closer supervision is needed when a person is upset or escalated. This wording allows for that, which also relaxes the restriction of very close supervision when it is not required for safety." The SD stated client A "has never had a behavior incident at the day program. Although it is possible he			

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NAME OF PROVIDER OR SUPPLIER: BENCHMARK HUMAN SERVICES

STREET ADDRESS, CITY, STATE, ZIP CODE: 10633 S AMERICA RD, LA FONTAINE, IN 46940

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	could do something new, that is not likely if he is not upset or escalated. Again, the training and awareness of escalated behavior covers this." This federal tag relates to complaint #IN00164034. 9-3-4(a)			
W 327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on interview and record review, for 2 of 3 sampled clients (clients A and B), the facility failed to complete client B's yearly Mantoux (tuberculin skin test) and/or screening and the facility failed to ensure client A's yearly Mantoux skin test was read in millimeters. Findings include: On 2/25/15 at 1:10pm, client A's record was reviewed. Client A was readmitted to the facility on 12/31/14 from the hospital. Client A's hospital stay was from 11/26/14 through 12/31/14. Client	W 327	**W 327**Physician Services (Standard): TB Testing**Corrective action for resident(s) found to have been affected** All clients will have a TB test that is read in millimeters as required by regulation TB testing will be added to the annual physical form to ensure that this requirement is met on an annual basis. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in**	04/03/2015

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	A's record indicated a 1/27/15 Mantoux skin test read a "neg." and not in millimeters. On 2/25/15 at 1:40pm, client B's record was reviewed an no yearly Mantoux/Tuberculin skin test and/or a tuberculosis screening was available for review. On 2/26/15 at 11:00am, an interview with the RN (Registered Nurse) was conducted. The RN indicated clients living in the group home should receive a yearly Mantoux/Tuberculin skin test and/or a tuberculosis screening. The RN indicated no further information was available for review. 9-3-6(a)		**place to ensure no recurrence** All residents of the home will have their TB test read in millimeters. TB testing will be added to the annual physical form. **How corrective actions will be monitored to ensure no recurrence** The nurse is responsible for health care coordination at the group home. This includes communication with the residents' primary care physician (PCP). The nurse will ensure that TB testing takes place and will add annual TB testing to the physical form. The director supervises the nurse and meets with her regularly. The director will monitor that this regulatory requirement takes place and is read in millimeters as required.	
W 331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 3 sampled clients (client A), the facility's nursing services failed to develop protocols specific to client A to monitor and to manage his pain and failed to ensure client A's pain medication was available for his use at the group home.	W 331	**W 331**Nursing Services (Standard): Client A's Pain Management**Corrective action for resident(s) found to have been affected** Pain management procedure will be put in place by nurse. This includes a multipoint pain scale assessment, with nurse notified for Narcan. All DSP Staff will receive training on how to implement the	04/03/2015

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	Findings include: On 2/24/15 at 6:50am, client A, wearing a back brace, walked out of his bedroom using his walker, walked up to GHS (Group Home Staff) #1, and requested pain medication. At 6:55am, GHS #1 stated client A could have had a PRN (as needed) pain pill, "when [client A] asks we give it." At 6:55am, client A stated he had broken his back, his left ankle, and his right knee "when I jumped off a bridge" on 11/26/14. At 7:10am, GHS #1 told client A he did not have pain medication available for use. GHS #1 stated the facility "should have had" client A's pain medication. GHS #1 stated client A's last dose of as needed pain medication was given "on 2/22/15." On 2/24/15 at 9:00am, client A indicated he remained in pain and had not received pain medication. On 2/25/15 at 12:15pm, client A indicated he did not receive pain medication on 2/23/15 or 2/24/15 when he had requested it. Client A indicated he received his pain medication on the afternoon of 2/24/15. Client A stated he was "constantly in pain" from his injuries after jumping off a bridge. On 2/25/15 at 2:00pm, an interview with the agency Registered Nurse (RN) was		pain management protocol. **How facility will identify other residents potentially affected & what measures taken** This pain management protocol is only relevant to Client A.**Measures or systemic changes facility put in place to ensure no recurrence** Pain management procedure and staff training will ensure that Client A.'s pain is appropriately managed. **How corrective actions will be monitored to ensure no recurrence** The nurse is responsible for health care coordination at the group home. This includes developing and implementing medical procedures. The nurse will train DSP staff on how the pain management procedure is implemented. The director supervises the nurse and meets with her regularly. The director will monitor that the pain management procedure is being implemented by staff who have been trained to do so.	

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	conducted. The RN indicated client A had physician's orders for as needed pain medications and should have received the pain medication any time he requested it. The RN indicated client A was recently released from bedrest recovering from a fractured back, left foot, and knee after jumping off a bridge The RN indicated the facility followed Core A/Core B Living in the Community policy and procedure for medication administration. The RN indicated client A's pain medication should have been available on hand for use. The RN indicated the facility staff had purchased client A's pain medication and locked the medication in a different location at the group home. The RN indicated the staff did not leave a note or communicate the location of client A's as needed pain medication to ensure it was available for his use. Client A's record was reviewed on 2/25/15 at 1:10pm. Client A's 12/21/14 ISP (Individual Support Plan) did not identify client A having the potential for pain. Client A's 1/2015 nursing review did not address client A's pain and use of pain medication. Client A's diagnoses were updated on the 1/2015 "Health Care Coordination Review" to indicate "Skeletal: was discharged from [name of hospital] on 12/31/14, has a hard shell			

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	back brace to be worn at all times except when showering or in bed; a boot on left foot which is to worn at all times except when showering; restrictions for no bending, twisting, and lifting restriction of 5 lb. (pounds) for upper body only...from injuries sustained on 11/26/14...Elopement, SIB (Self Injurious Behavior), and suicide attempt...[signed by the RN]." Client A's 12/31/14 Physician's Order and 2/2015 MAR (Medication Administration Record) both indicated "Acetaminophen 325mg (milligrams) tablet, give 1 tablet orally every 4 hours as needed for mild pain...." Client A's 2/2015 MAR indicated he received the pain medication every four hours and the last dose on 2/22/15 at 10pm. Client A's MAR indicated he next received the PRN medication on 2/25/15. No information was available for review to determine if client A's pain medication was effective and no information was available for review to determine if the pain medication was effective to control client A's pain. No guidelines or protocols for client A's pain were available for review. On 2/24/15 at 2:15pm, the RN provided an undated "Pain Assessment Policy - [Client A]." The Plan indicated "The following practice should be used when assessing and administering pain			

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	medications for [client A]. [Client A] should rate his pain level 1 - 10, with 10 being the worst pain ever. If after he rates his pain on a range of 1 - 3, give Tylenol as directed and reassess after 30 minutes. If after 30 minutes, pain level should be rated again. If pain has not been relieved, give Ibuprofen as ordered. If pain level is rated at 4 -6, give Ibuprofen as ordered. Reassess pain level after 30 minutes. If pain is not relieved, give Narcan as ordered. If pain level is rated above 6, call nurse before giving Narcan as ordered. Reassess pain level again after 30 minutes." The agency RN stated the facility had "nothing" in place to address client A's pain until 2/24/15 after the surveyor requested it for review. 9-3-6(a)			
W 368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review, and interview, for 4 of 4 clients (clients A, B, C, and D) living in the group home, the facility failed to administer medications without error and as prescribed by the clients' personal physician. Findings include:	W 368	**W 368**Drug Administration (Standard): Medication Errors**Corrective action for resident(s) found to have been affected** The nurse developed a new procedure to minimize confusion during medication pass. For each time of medication administration (e.g., 8am), all medication cards will	04/03/2015

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	1. On 2/24/15 at 1:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 9/2014 through 2/24/15 were reviewed and indicated the following for client A, B, C, and D's medication errors. For client A. -A 1/28/15 BDDS report for an incident on 1/24/15 at 8:00am indicated "It was discovered that [client A] was only given 1 capsule of Lovaza 1gm (gram) during the 8am med (medication) pass on 1/24/15. The order is written for 4 capsules once a day" for Cholesterol. -A 1/4/15 BDDS report for an incident on 1/1/15 at 8pm, indicated client A "has an order for Gabapentin (for nerve pain) 300mg (milligrams), take 2 capsules by mouth two times daily. On 1/1/15 and 1/2/15 at 8pm [client A] only received one capsule instead of two." -A 1/4/15 BDDS report for an incident on 1/3/15 at 8am indicated client A "has an order for Lovaza 1gm (gram) capsule, give 4 capsules (4 grams) orally once a day. [Client A] only reviewed 3 capsules of Lovaza instead of 4." On 2/25/15 at 1:10pm, client A's 12/31/14 "Physician's Order" indicated		have a hole punched and will be connected with a wire loop. All staff will be trained on this new procedure. **How facility will identify other residents potentially affected & what measures taken**All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in place to ensure no recurrence** New medication administration procedure was developed and will be trained across DSP staff members. **How corrective actions will be monitored to ensure no recurrence** The nurse is responsible for health care coordination at the group home. This includes developing and implementing medical procedures. The nurse will train DSP staff on how the new medication administration procedure is implemented. Each month, the nurse will prepare the medication according to this procedure, and a manager will double check that it is correct prior to placing the medication cards in the home. The director supervises the nurse and meets with her regularly. The director will monitor that the new medication administration procedure is being implemented by staff who have been trained to do so.	

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	Gabapentin 300mg, give 2 capsules (600mg) orally 2 times a day...Lovaza 1gm capsule, give 4 capsules (4gm) orally once a day." For client B: -A 2/5/15 BDDS report for an incident on 2/3/15 at 8:00pm indicated client B "did not receive three of his medications: Zantac (for heartburn), Simvastatin (for high cholesterol), and Topiramate (for behaviors) because they were located in the PRN (as needed) side of the medication cart by accident." -A 1/7/15 BDDS report for an incident on 1/7/15 at 8:00am indicated client B "has an order for Byetta (for Insulin Dependent Diabetes Mellitus) Pen 5mcg/dose, Inject 5mcg sub-q twice daily before meals." Client B's physician sent an order for 10mcg/dose to the pharmacy and that was the pen received from the pharmacy. The report indicated the staff "noticed the discrepancy," the physician notified, the physician said the pharmacy "wrote the wrong dose," and the indicated the order should be for 5mcg. The BDDS report indicated the 5mcg dose was not on hand at the group home on 1/7/15 at 8:00am. -A 12/28/14 BDDS report for an incident on 12/23/14 at 8:00pm indicated client B			

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	"missed his Valium (for behaviors) 2mg at 8pm on 12/23/14. The order reads as Valium 2mg tablets. Give one tab two times daily." -A 11/25/14 BDDS report for an incident on 11/24/14 at 8:00am indicated client B "was not given his Valium 2mg" on 1/24/15. -A 10/7/14 BDDS report for an incident on 10/1/14 at 8:00pm indicated client B "has an order for Cogentin (for side effects of psych medications) 2mg, give twice daily. On October 1, 2, 3, 4, and 5, 2014 [client B] was given a roommates Cogentin 1mg during 8pm doses. So for 5 days straight [client B] only received 3mg of Cogentin a day." -A 9/28/14 BDDS report for an incident on 9/28/14 at 8:00am indicated "On 9/28/14 at 8am medication pass the staff member did not give [client B] his morning dose of Clozapine" for behaviors. On 2/25/15 at 1:40pm, client B's 12/24/14 "Physician's Order" and 2/2015 MAR both indicated "Valium 2mg, give one tab two times daily, Byetta 5mcg/dose pen, inject 5mcg 2 times a day before meals, Zantac 150mg tablet, give 1 tablet orally daily at bedtime for			

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	Esophageal Reflux, Topiramate 200mg tablet, give 1 tablet orally 2 times a day, Simvastatin 20mg tablet, give 1 tablet orally at bedtime, Cogentin 2mg, give 1 tablet orally 2 times a day for side effects, Clozapine 100mg, give 1 tablet orally daily at noon." For client C: -A 1/7/15 BDDS report for an incident on 1/7/15 at 8:00am indicated client C "has an order for Sulfameth/Trimethorprim (Antibiotic) 800/160mg tab. Take 1 tablet twice daily for 10 days. He started taking it on 12/29/14 at 8:00pm. His last dose should have been on 1/8/15 at 8pm. There is one extra tab in his pill bottle at this time. It is believed that he has missed a dose." -A 10/15/14 BDDS report for an incident on 10/12/14 at 8:00am indicated client C "was given 100mg of Clozapine (for behaviors). [Client C] should have been given 200mg of Clozapine during his morning medication pass." On 2/26/15 at 11:00am, client C's record was reviewed. Client C's 12/24/14 "Physician's Order" and 2/2015 MAR both indicated "Clozapine 100mg, give 2 tablets in the AM (morning)." For client D:			

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	-A 1/5/15 BDDS report for an incident on 1/2/15 at 8:00am indicated client D "has an order for Clonazepam (for behaviors) 1mg, give one tab two times daily. On 1/2/15 it appears that [client D] received 2 tabs at 8am and 1 tab at 8pm, receiving 1 extra mg of Clonazepam that day." -A 11/22/14 BDDS report for an incident on 11/19/14 at 8:00am indicated "staff missed giving [client D] his 8am dose of Benztropine (for side effects) on 11/19/14, 11/20/14, and 11/21/14. It is not completely clear whether or not [client D] missed the medication or not." On 2/26/15 at 11:30am, client D's record was reviewed. Client D's 12/24/14 "Physician's Order" and 2/2015 MAR both indicated "Clonazepam 1mg, give 1 tab orally 2 times a day (and) Benztropine 1mg tablet, give 1 tablet orally 2 times a day." On 2/25/15 at 12:15pm, an interview with the agency nurse was conducted. The agency nurse indicated staff should administer medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders.			

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	On 2/25/15 at 12:15pm, a review of the facility's 11/30/12 Medication Administration Policy and Procedure was conducted. The policy and procedure indicated staff should administer client medications according to physician's orders. 2. On 2/24/15 at 6:50am, client A, wearing a back brace, walked out of his bedroom using his walker, walked up to GHS (Group Home Staff) #1, and requested pain medication. At 6:55am, GHS #1 stated client A could have had a PRN (as needed) pain pill, "when [client A] asks we give it." At 6:55am, client A stated he had broken his back, his left ankle, and his right knee "when I jumped off a bridge" on 11/26/14. At 7:10am, GHS #1 told client A he did not have pain medication available for use. GHS #1 stated the facility "should have had" client A's pain medication. GHS #1 stated client A's last dose of as needed pain medication was given "on 2/22/15." On 2/24/15 at 9:00am, client A indicated he remained in pain and had not received pain medication. On 2/25/15 at 12:15pm, client A indicated he did not receive pain medications on 2/23/15 or 2/24/15 when he had requested it. Client A indicated			

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	he received his pain medication on the afternoon of 2/24/15. Client A stated he was "constantly in pain" from his injuries after jumping off a bridge. On 2/25/15 at 2:00pm, an interview with the agency Registered Nurse (RN) was conducted. The RN indicated client A had physician's orders for as needed pain medications and should have received the pain medication any time he requested it. The RN indicated client A was recently released from bedrest recovering from a fractured back, left foot, and knee after jumping off a bridge The RN indicated the facility followed Core A/Core B Living in the Community policy and procedure for medication administration. The RN indicated client A's pain medication should have been available on hand for use. The RN indicated the facility staff had purchased client A's pain medication and locked the medication in a different location at the group home. The RN indicated the staff did not leave a note or communicate the location of client A's as needed pain medication to ensure it was available for his use. Client A's record was reviewed on 2/25/15 at 1:10pm. Client A's 12/31/14 Physician's Order and 2/2015 MAR (Medication Administration Record) both			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	10633 S AMERICA RD LA FONTAINE, IN 46940

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	indicated "Acetaminophen 325mg (milligrams) tablet, give 1 tablet orally every 4 hours as needed for mild pain...." Client A's 2/2015 MAR indicated he received the pain medication every four hours and the last dose on 2/22/15 at 10pm. Client A's MAR indicated he next received the PRN medication on 2/25/15. 9-3-6(a)			
W 440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 clients (clients A, B, C, and D) living in the group home, the facility failed to conduct quarterly evacuation drills for the 11:00pm-7am and the 7am-3pm shifts of personnel. Findings include: On 2/24/15 at 12:36pm, a review of the facility's evacuation drills from 2/2014 through 2/2015 was conducted. The review indicated the facility had failed to conduct evacuation drills for clients A, B, C, and D after 7/8/14 at 8:15am through 2/24/15 shift of personnel. The review indicated the facility had failed to conduct evacuation drills for clients A, B, C, and D after 6/14/14 at 6:55am to	W 440	**W 440**Evacuation Drills (Standard): Fire Drills**Corrective action for resident(s) found to have been affected** Evacuation drills will be completed across shifts as required. A drill schedule will be placed in the home. In addition, all drills will be placed on the home calendar. Finally, DSP staff members will receive training on how to follow schedule. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in place to ensure no recurrence** Evacuation drills to take place and drill schedule placed in home.	04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G799		03/04/2015

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	11/12/14 at 3:00am shift of personnel. On 2/24/15 at 12:40pm, an interview with the Residential Manager (RM) was conducted. The RM indicated no additional evacuation drills were available for review. 9-3-7(a)		Scheduled drills will be placed on the home calendar. Staff will be trained to follow the schedule. **How corrective actions will be monitored to ensure no recurrence** The manager is responsible for ensuring that drills take place. This includes placing the schedule in the home and transferring the dates and times to the home calendar. In addition, the manager will follow-up after a drill is scheduled to ensure that it took place as scheduled. The manager is supervised by the director. They meet regularly. The director will monitor implementation of the drill schedule to ensure that this does not recur.	