

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G796	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/06/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 6856 WHEELLOCK RD FORT WAYNE, IN 46835
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W 000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: April 29, 30, May 1, 4 and 6, 2015.</p> <p>Facility number: 012549 Provider number: 15G796 AIM number: 201019420</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based upon record review and interview, the facility failed to obtain a legally sanctioned representative for 2 of 4 sampled clients (clients #2 and #4) assessed as being in need of assistance to assure their protection of rights as a citizen of the United States.</p>	W 125	A volunteer guardian has been identified for client #2 and #4. There is no family available to fulfill this role. A referral is being made to an attorney, Solomon Lowenstein so that he may begin to gather the needed information to prepare for filing. It is assumed that the judge will	06/05/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Findings include:</p> <p>1. Client #2's record was reviewed on 5/1/15 at 10:05 AM. A Behavior Support Plan (BSP) for dated 11/1/14 indicated diagnoses of Disruptive Behavior NOS (not otherwise specified), Auditory Hallucinations and target behaviors of food stealing and physical aggression. The plan included the use of physical redirection and psychotropic medications, Zyprexa Zydys (anti-psychotic) 15 mg (milligrams) twice daily, Cogentin (side effects) 1 mg twice daily and Buspar (anxiety) 10 mg twice daily to address her behavior and the possible side effects of taking the medication. Client #2's comprehensive functional assessment (CFA) dated 10/8/14 indicated she was unable to understand the reason for her prescribed medication and was unable to provide consent for her BSP. A signature page for client #2's BSP indicated client #2's typed name and was dated 10/8/14. The facility's Human Rights Committee (HRC) signed approval for the BSP on 10/20/14.</p> <p>2. Client #4's record was reviewed on 5/1/15 at 1:50 PM. A BSP dated 9/1/14 indicated client #4 had a diagnosis of autistic disorder. A target behavior of verbal outburst ("yells, screams, jumps</p>		<p>assign a guardian ad litem to represent client numbered 2 and 4 during the proceeding and to assist the clients while competency is determined. Once that is established we will be dependent upon the court for the timeline for completion. All other assessments for this home have been reviewed to ensure no other clients are effected. The Director will monitor compliance and will complete all needed paperwork for referral by June 5, 2015.</p>	

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	<p>and hits the floor with his hands"). The plan included the use of Divalproex SOD (sodium) (mood stabilizer) 1500 mg and Risperidone 2 mg (bi-polar). The plan indicated client #4 did not have a legal guardian and had been referred to a guardianship services agency. The facility's HRC signed approval for client #4's BSP on 9/15/14. There was no evidence of informed consent for client #4's BSP. A CFA dated 8/20/14 indicated client #4 was unable to provide consent for his BSP.</p> <p>A copy of an e-mail to the guardianship services program dated 8/14/14 was reviewed on 5/1/15 at 10:38 AM and indicated clients #2 and #4 were still in need of guardianship services.</p> <p>The Residential Director was interviewed on 5/1/15 at 2:20 PM and indicated clients #2 and #4 were in need of a guardian to assist them in making decisions, and had been referred for assistance in obtaining a guardian at a guardianship services agency. The RD stated, "I'll keep trying with our resources."</p> <p>9-3-2(a)</p>			

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W 149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility neglected to implement their policy and procedures to protect 1 of 3 sampled clients (client #3), and 1 additional client (client #5) from neglect and seclusion.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 4/29/15 at 3:20 PM. A BDDS report dated 8/12/14 indicated staff #6 reported to the Residential Director (RD), Residential Manager (RM) and QIDP (Qualified Intellectual Disabilities Professional) that during a behavioral incident involving client #5 on 8/3/14, client #5 was directed to his room in the basement and the door at the top of the steps to the basement was closed and staff #7 placed a chair in the front of the door preventing exit by client #5. The chair was removed by staff #6 and client #5 was in his room</p>	W 149	<p>W149</p> <p>Staff number 7 and 8 were terminated and staff number 6 received disciplinary action and was retrained immediately on the requirement to report incidents of abuse and neglect. All staff received retraining on Abuse and Neglect Policy. Competency based training was completed and turned into the Director for compliance. Abuse and Neglect monthly trainings will be completed at house meetings for the next 3 months with competency based outcomes. The staff person who committed the medication error was immediately retrained on the Medication Administration Policy prior to administering medications to clients. All staff received retraining on the Medication Administration Policy. All staff were also retained on ensuring there are no distractions during times of medication administration. The nurse and management also will continue monitor weekly medication passes to ensure ongoing compliance. These</p>	06/05/2015

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	<p>and not near the door at the time of the chair being placed against the door.</p> <p>A conclusion to the investigation of the incident dated 8/14/14 indicated a witness to the incident (staff #8) indicated staff #7 had placed a chair against the door in front of the door "2-3 times prior when working with the staff accused of placing the chair in front of the door (staff #7)..." Staff #7 denied placing the chair in front of the door. The conclusion indicated based upon witness statements, the allegation was substantiated and staff #7 and #8 were terminated. Staff #6 was retrained on reporting requirements and all staff were retrained on client #5's behavior support plan.</p> <p>The Residential Director (RD) was interviewed on 4/29/15 at 3:20 PM. The RD indicated the incident on 8/3/14 and reported on 8/12/14 had been substantiated for staff #7 placing a chair which would have prevented egress by client #5 from the basement after he had been directed to go to his room during a behavioral incident. She indicated the staff responsible for placing the chair at the door had been terminated. She indicated the staff who reported the incident (staff #6) had been retrained on the requirement to report incidents of</p>		<p>observations are documented and turned into the Director for compliance.</p>	

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	<p>abuse and neglect immediately.</p> <p>2. Client #3's record was reviewed on 5/1/15 at 9:35 AM. Hospital discharge instructions dated 10/17/14 indicated client #3 had been seen in the emergency room for poisoning by medication or other substance.</p> <p>The RD was interviewed on 5/1/15 at 10:35 AM and indicated client #3 had been given another client's medications on 10/17/14.</p> <p>A BDDS report dated 10/17/14 and reported 10/18/14 was reviewed on 5/6/15 at 9:30 AM and indicated "As staff was preparing [client #3's] medications, two other peers at the home began to argue. This distracted the staff person and she punched out another client's medications and administered them to [client #3]. [Client #3] received the following medications that were not his: Abilify 30 mg (milligrams), Divalproex 500 mg, and Seroquel 400 mg. The staff immediately called the manager, nurse and residential director. The decision was made to send [client #3] to the Emergency Room (ER) to be evaluated. [Client #3] did not show or voice any adverse reactions...."</p> <p>Corrective action indicated the physician at the ER indicated he was not concerned</p>			

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	<p>about the medications as they were either the same or in the same class as his prescribed medication. The report indicated staff was retrained on medication administration policy and procedures and staff were instructed to ensure that when one staff was administering medications other staff were to intervene in client behaviors.</p> <p>The facility's policy Group Home Abuse and Neglect dated 11/11/14 was reviewed on 5/6/15 at 11:50 AM and indicated "Benchmark Human Services (BHS) does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse...Physical abuse is any action that could lead to bodily harm, including corporal punishment, like spanking or hitting and pinching...Psychological abuse includes doing or saying anything that would humiliate an individual, like teasing or making fun. It includes threats of punishment or deprivation as well as threats or intimidation...Neglect includes the failure to provide appropriate care, food, medical care or supervision...." The policy indicated incidents of abuse and neglect should be reported immediately to a supervisor and the BHS Residential Director.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2015

FORM APPROVED

OMB NO. 0938-0391

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	9-3-2(a)				