

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2015
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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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W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00180669.</p> <p>Complaint #IN00180669: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W104, W122, W149, and W193.</p> <p>Unrelated deficiency cited.</p> <p>Dates of Survey: 10/20, 10/21, 10/26, 10/29, and 10/30/2015.</p> <p>Provider Number: 15G799 Facility Number: 0012562 AIM Number: 201017540</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/9/15.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p>			

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>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and D) and 1 additional client (client C), the governing body failed to exercise operating direction over the facility to ensure the Condition of Participation: Client Protections was met for client A. The governing body failed to exercise operating direction over the facility to ensure the facility had sufficient numbers of competent staff to supervise clients A, B, C, and D. The governing body failed to implement their policy to ensure facility staff supervised client A based on his identified behavioral needs. The governing body failed to exercise operating direction over the facility to ensure staff were sufficiently trained to implement interventions to address client A's behaviors.</p> <p>Findings include:</p> <p>Please refer to W122. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 of 3 sampled clients (client A). The governing body failed to ensure the facility implemented their policy and procedures to ensure staff supervision of client A to protect client A from his known behaviors.</p>	W 0104	Please refer to W122, W149, W186 and W193	11/29/2015

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	<p>Please refer to W149. The governing body failed 1 of 1 sampled client (client A) who had known behaviors of Elopement (AWOL-Absent Without Leave), property destruction, and Suicide attempts, to ensure the facility supervised client A based on his identified behavioral needs.</p> <p>Please refer to W186. The governing body failed 3 of 3 sampled clients (clients A, B, and D) and 1 additional client (client C), to ensure the facility provided 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 identified needs.</p> <p>Please refer to W193. The governing body failed 1 of 3 sampled clients (client A) who had known behaviors of elopement, property destruction, and Suicide attempts, to ensure the facility staff were able to demonstrate skills and consistently implemented supervision techniques for client A's inappropriate behaviors.</p> <p>This federal tag relates to complaint #IN00180669.</p> <p>9-3-1(a)</p>			

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W 0122 Bldg. 00	<p>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 to protect client A from his known behaviors.</p> <p>Findings include:</p> <p>Please refer to W149. For 1 of 1 sampled client (client A) who had known behaviors of Elopement (AWOL-Absent Without Leave), property destruction, and Suicide attempts, the facility neglected to supervise client A based on his identified behavioral needs.</p> <p>This federal tag relates to complaint #IN00180669.</p> <p>9-3-2(a)</p>	W 0122	Please refer to W149, W186 and W193	11/29/2015

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W 0149 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 observation, record review, and interview, for 1 of 1 sampled client (client A) who had known behaviors of Elopement (AWOL - Absent Without Leave), property destruction, and Suicide attempts, the facility neglected to supervise client A based on his identified behavioral needs.</p> <p>Findings include:</p> <p>On 10/20/15 from 7:00am until 9:15am, observations were conducted at the group home. At 7:00am, the Assistant Group Home Manager (AGHM) was outside the group home cleaning out the facility van. At 7:00am, GHS #1 was alone with four clients (clients A, B, C, and D). At 7:00am, GHS #1 and the AGHM both indicated GHS #1 had arrived to the group home at 7:00am. AGHM stated he had "sent [GHS #4] to [name of another Group Home] at 6:15am." AGHM stated "one (1) staff was on duty with four clients." At 7:30am, the AGHM indicated the group home staffing was to have been two (2) staff for the overnight period and "three to four (3-4) staff" for the day shift of personnel to supervise clients A, B, C, and D. The AGHM</p>	W 0149	<p>The support team including the Program Coordinator, Assistant Group Home Manager, QIDP, Behavior Analyst, Regional Director, BDDS Service Coordinator and the guardian for client A met and made changes to improve the likelihood of success for the Behavior Support Plan of client A. All staff were trained on the changes to the plan and the guardian and Human Rights Committee approved the changes. The previous plan indicated that staff should follow client A if he left the home and redirect him back. The staff followed the plan which was in place at the time of the incident. The new plan includes strategies to prevent client A from leaving the premises. The incidents are being monitored by the BC to ensure that the training has been effective and that staff are implementing the plan. All staff have been retrained on the plans for all of the clients in the home and are being monitored through review of internal behavior data sheets, staff meetings and debriefings as needed. There was an adequate amount of staff working in the home on the night of the elopement with client A. Benchmark Human Resources is working to fill positions</p>	11/29/2015

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	<p>stated the group home had been "short staffed for over two months" and "only one staff" was scheduled "on a regular basis" for the overnight period. During the observation period client A did not have one on one staff supervision. At 7:30am, during the observation period the AGHM stated client A's behaviors of property destruction caused the following maintenance needs:</p> <ul style="list-style-type: none"> -One of four (1 of 4) front windows were broken and had duct tape covering the shattered glass. -One of six (1 of 6) living room windows were broken and had duct tape covering the shattered glass. -Two of four (2 of 4) dining room windows were broken and had duct tape covering the shattered glass. -The back patio porch light fixture was missing with exposed bare wires. <p>At 7:30am, the AGHM stated the shattered glass and missing patio porch light were the result of client A "having behaviors." The AGHM stated client A had "picked up a metal patio chair and threw it through the windows" during a behavioral incident.</p> <p>On 10/20/15 at 8:10am, an interview with client A was conducted. Client A stated he left the group home during the night "after I got upset" about other people. Client A stated he "had some problems</p>		<p>within the home and the managers have been instructed that they must maintain appropriate staffing patters at all times and this is being monitored through the Benchmark electronic time entry.</p>	

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	<p>running, but I'm getting better every day" when asked if he had elopement behaviors. Client A indicated he spent the night in a field near the group home on 8/18/15.</p> <p>On 10/20/15 at 9:35am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed for client A.</p> <p>-An 8/19/15 BDDS report for an incident on 8/18/15 at 10:40pm indicated client A "became upset based on an incident that happened the day before. [Client A] ran for the door and two staff ran behind him. Staff lost sight of [client A] when he ran into the field and wooded area at 10:40pm. Staff called police immediately as [client A] has a history of elopement. Staff got into a vehicle and began to look for [client A] with headlights and flashlights. Police and staff set a perimeter around the field in which [client A] was believed to be in and staff and officers walked the field several times looking for [client A] and calling his name. At 5:05am, [client A] walked out of the field/wooded (sic) area and walked to the Residential Director's vehicle. He was easily redirected into the vehicle and agreed to return to the group home." The report indicated client A had a "1" (inch) superficial scratch on his left</p>			

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	<p>shoulder, two 2" superficial scratches and two 4" deeper scratches on the left lower leg, a 1/4" scratch on the left side of his foot, and a 1/2" scratch on the left side of his face." The report indicated "The IDT (Interdisciplinary Team) debriefed and reviewed the incident. [Client A's] supervision level is being increased to eyesight during times of agitation to reduce the risk of [client A] running outside and providing additional guidance to staff related to Mandt (interventions to prevent elopement and physical aggression) blocking if needed in the future."</p> <p>On 10/20/15 at 11:35am, an interview with the Regional Residential Director (RRD) was conducted. The RRD provided a 9/21/15 at 4:30pm, "Behavior Data Sheet" which indicated client A was "upset," refused supper, "stormed" while walking to his bedroom, and "slammed" the door. The report indicated GHS #5 "went to check" on client A, client A refused supper, and indicated client A was "calm" inside his bedroom. GHS #5 indicated "I walked out and then went into the kitchen, not even five minutes later [client A] comes storming out and said I'm done with this, put me on watch. I don't care anymore and then stormed to his room and slammed the door. We heard him throwing and banging stuff</p>			

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	<p>around...[client A] came swinging and running after [GHS #6]. [GHS #5] told [client A] to calm down and just relax and [client A] said I wanna (sic) go to a state hospital. I can't stand being in this f----- house with people that don't care about me. So then [client A] was still going after [GHS #6], so [client B] got up and said [client A] better leave staff alone, and [clients A and B] started going at it and [client A] was throwing stuff all at the house and in the house. [GHS #5 and GHS #6] got [clients C and D] out ASAP (As Soon As Possible) (sic) and to the drive way to keep them safe. [Client B] finally came out and [client A] went to the back yard and he started throwing chairs and everything at the windows and was yelling and screaming and threatened staff and clients. [Name of AGHM] was called and came in."</p> <p>On 10/20/15 at 1140am, an interview with the RRD and Behavior Consultant (BC) was conducted. The RRD indicated the facility followed the BDDS reporting guidelines for abuse, neglect, and/or mistreatment. The RRD and BC both stated client A's behaviors on 9/21/15 caused the property destruction at the group home. The RRD indicated client A had a history of AWOL behaviors, property destruction, and suicide threats with attempts. The RRD indicated client</p>			

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	A's last suicide attempt was when client A left the facility AWOL on 11/26/14 when staff failed to implement his plans correctly, client A's behaviors had escalated, client A walked down the road during an elopement from the group home, and "jumped off" a bridge. The RRD indicated client A suffered a "fractured back" and leg injuries from his previous suicide attempt. The RRD indicated during client A's elopement on 8/18/15 staff did not implement client A's plan to prevent his escalating behaviors and elopement. The RRD stated the staff neglected to "implement" client A's plans "correctly." The RRD stated after the incident "we revised" client A's plan to ensure staff "prevented" client A from leaving (elopement) from the group home during his escalating behaviors. The RRD and BC both stated they as professional staff became the administrative oversight of the facility "just before this incident." The RRD stated "that's why" the behavior on 9/21/15 occurred. The RRD stated "we can replace" and repair the property destruction inside and damage within the fenced in patio areas of the group home. The RRD stated client A "was not able to leave" the group home to hurt himself on 9/21/15. The RRD and BC indicated the wording to client A's plan was changed to ensure staff understood and implemented			

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	<p>client A's plan correctly. The RRD stated client A was "missing" from the group home on 8/18/15 for "approximately six (6) hours" during client A's elopement. The RRD indicated the facility staff neglected to supervise client A "correctly" on 8/18/15. The RRD indicated the facility had been "short" staffed "for the past several months." The RRD indicated two staff should be on duty at the group home for the overnight hours.</p> <p>On 10/30/15 at 2:00pm, an interview with the RRD was conducted. The RRD indicated the identified broken windows and exposed wires have been repaired and replaced. The RRD indicated the facility staff neglected to implement client A's plan correctly on 8/18/15 which resulted in client A's elopement.</p> <p>Client A's record was reviewed on 10/20/15 at 10:45am. Client A's 12/1/14 "Case Conference" documented by the Agency Registered Nurse (RN) indicated regarding the 11/27/14 incident when client A "eloped...suicide attempt... [Client A] was upset and eloped. Two 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</p>			

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	<p>(sic)." 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." 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 (left) ankle, and repair of (fractured) back [signed by the Agency RN]."</p> <p>Client A's record indicated he was admitted on 11/6/13. Client A's 12/31/14 ISP (Individual Support Plan) and 11/6/13 BSP (Behavior Support Plan) revised on 8/28/15 indicated client A should be supervised by the facility staff. Client A's record indicated he was not safe alone in the community. 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,</p>			

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	<p>staff must try to intervene to block the attempt while verbally redirecting him."</p> <p>Client A's record and BSP indicated an undated "addendum #2" which indicated 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</p>			

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	<p>relaxes the restriction of very close supervision when it is not required for safety."</p> <p>Client A's revised 8/28/2015 BSP "addendum #2" indicated "Supervision should increase to eyesight supervision when [client A] is escalated, making threats to harm himself, being very negative, making suicidal threats/comments, dwelling on something that has happened that has made him upset, cursing, threatening comments, raised voice. Eyesight supervision is defined as having [client A] in eyesight at all times during waking hours except when using the restroom, showering, or changing his clothes...." Client A's revised BSP indicated additional interventions for staff to "block the doorways" should client A attempt to leave the group home during elopement behaviors.</p> <p>On 10/20/15 at 10:45am, the 11/11/14 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 Benchmark will not tolerate abuse, neglect or exploitation of any kind...Description, Benchmark does not tolerate abuse in any form by any person; this includes physical abuse,</p>			

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W 0186 Bldg. 00	<p>verbal abuse, psychological abuse or sexual abuse." The policy indicated abuse, neglect, and/or mistreatment was "not tolerated" by the agency.</p> <p>On 10/20/15 at 10:45am, 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...."</p> <p>This federal tag relates to complaint #IN00180669.</p> <p>9-3-2(a)</p> <p>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.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and D) and 1 additional client (client C), the facility failed to</p>	W 0186	There was an adequate amount of staff working in the home on the night of the elopement with client A. Benchmark Human Resources is working to fill open	11/29/2015

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	<p>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 identified needs.</p> <p>Findings include:</p> <p>On 10/20/15 from 7:00am until 9:15am, observations were conducted at the group home. At 7:00am, the Assistant Group Home Manager (AGHM) was outside the group home cleaning out the facility van. At 7:00am, GHS #1 was alone with four clients (clients A, B, C, and D). At 7:00am, GHS #1 and the AGHM both indicated GHS #1 had arrived to the group home at 7:00am. AGHM stated he had "sent [GHS #4] to [name of another Group Home] at 6:15am." AGHM stated "one (1) staff was on duty with clients" A, B, C, and D. At 7:30am, the AGHM indicated the group home staffing was to have been two (2) staff for the overnight period and "three to four (3-4) staff" for the day shift of personnel to supervise clients A, B, C, and D. The AGHM stated the group home had been "short staffed for over two months" and "only one staff" was scheduled "on a regular basis" for the overnight period. During the observation period client A did not have one on one staff supervision.</p>		<p>positions within the home and the managers have been instructed that they must maintain appropriate staffing patters at all times. All staff have also been trained on the attendance requirements and expectations of fulfilling their scheduled shifts. Benchmark provides on call staff to the home to ensure that if there is a shortage, hours will be filled by professional staff is a direct care staff cannot be scheduled. This is being monitored through the Benchmark electronic time entry.</p>	

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	<p>On 10/20/15 at 1140am, an interview with the RRD (Regional Residential Director) and Behavior Consultant (BC) was conducted. The RRD and BC both stated the facility "required" two staff for the overnight period and three to four staff on duty during the daytime hours. The RRD indicated the facility had been "short" staffed "for the past several months." The RRD indicated two staff should be on duty at the group home for the overnight hours and were not on 10/20/15. The RRD indicated client A's supervision level was increased and decreased based on his behavioral needs. The RRD indicated clients A, B, C, and D's identified needs include staff on duty to supervise the clients.</p> <p>Client A's record was reviewed on 10/20/15 at 10:45am. 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) revised on 8/28/15 indicated client A should be supervised by the facility staff. Client A's record indicated he was not safe alone in the community. 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</p>			

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	<p>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."</p> <p>Client A's record and BSP indicated an undated "addendum #2" which indicated 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</p>			

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	<p>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."</p> <p>On 10/20/15 at 9:15am, client B's record was reviewed. Client B's 10/23/15 ISP and 10/2015 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, Elopement, and Inappropriate Social Behaviors. Client B's 10/2015 "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."</p> <p>On 10/30/15 at 1:30pm, client C's record was reviewed. Client C's 4/2015 ISP (Individual Support Plan) and 4/17/14 BSP indicated client C needed staff supervision twenty-four hours a day, seven days a week. Client C's ISP and BSP indicated targeted behaviors of Verbal Aggression, Physical Aggression,</p>			

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W 0193 Bldg. 00	<p>Public Masturbation, Ruminaton, Property Destruction, and Inappropriate Sexual Behavior. Client C's 4/17/14 "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."</p> <p>On 10/20/15 at 10:00am, client D's record was reviewed. Client D's 4/9/15 ISP and 10/2014 BSP both indicated client D needed staff supervision twenty-four hours a day, seven days a week. Client D's record indicated a targeted behavior of Isolation Behavior. Client D's 4/18/14 "Supervision Level Summary" indicated client D "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."</p> <p>9-3-3(a)</p> <p>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.</p>			

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	<p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client A) who had known behaviors of elopement, property destruction, and Suicide attempts, the facility failed to ensure staff were able to demonstrate skills and consistently implement supervision techniques for client A's inappropriate behaviors.</p> <p>Findings include:</p> <p>On 10/20/15 from 7:00am until 9:15am, observations were conducted at the group home. At 7:00am, the Assistant Group Home Manager (AGHM) was outside the group home cleaning out the facility van. At 7:00am, GHS #1 was alone with four clients (clients A, B, C, and D). At 7:00am, GHS #1 and the AGHM both indicated GHS #1 had arrived to the group home at 7:00am. AGHM stated he had "sent [GHS #4] to [name of another Group Home] at 6:15am." AGHM stated "one (1) staff was on duty with four clients." At 7:30am, the AGHM indicated the group home staffing was to have been two (2) staff for the overnight period and "three to four (3-4) staff" for the day shift of personnel to supervise clients A, B, C, and D. At 7:30am, during the observation period the AGHM stated client A's behaviors of property destruction caused the following</p>	W 0193	The support team including the Program Coordinator, Assistant Group Home Manager, QIDP, Behavior Analyst, Regional Director, BDDS Service Coordinator and the guardian for client A met and made changes to improve the likelihood of success for the Behavior Support Plan of client A. All staff were trained on the changes to the plan and the guardian and Human Rights Committee approved the changes. The previous plan indicated that staff should follow client A if he left the home and redirect him back. The staff followed the plan which was in place at the time of the incident. The new plan includes strategies to prevent client A from leaving the premises. The incidents are being monitored by the BC to ensure that the training has been effective and that staff are implementing the plan. All staff have been retrained on the plans for all of the clients in the home and are being monitored through review of internal behavior data sheets, staff meetings and debriefings as needed.	11/29/2015			

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	<p>maintenance needs:</p> <ul style="list-style-type: none"> -One of four (1 of 4) front windows were broken and had duct tape covering the shattered glass. -One of six (1 of 6) living room windows were broken and had duct tape covering the shattered glass. -Two of four (2 of 4) dining room windows were broken and had duct tape covering the shattered glass. -The back patio porch light fixture was missing with exposed bare wires. <p>At 7:30am, the AGHM stated the shattered glass and missing patio porch light were the result of client A "having behaviors." The AGHM stated client A had "picked up a metal patio chair and threw it through the windows" during a behavioral incident.</p> <p>On 10/20/15 at 8:10am, an interview with client A was conducted. Client A stated he left the group home during the night "after I got upset" about other people. Client A stated he "had some problems running, but I'm getting better every day" when asked if he had elopement behaviors. Client A indicated he spent the night in a field near the group home on 8/18/15.</p> <p>On 10/20/15 at 9:35am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and</p>			

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	<p>investigations were reviewed for client A.</p> <p>-An 8/19/15 BDDS report for an incident on 8/18/15 at 10:40pm indicated client A "became upset based on an incident that happened the day before. [Client A] ran for the door and two staff ran behind him. Staff lost sight of [client A] when he ran into the field and wooded area at 10:40pm. Staff called police immediately as [client A] has a history of elopement. Staff got into a vehicle and began to look for [client A] with headlights and flashlights. Police and staff set a perimeter around the field in which [client A] was believed to be in and staff and officers walked the field several times looking for [client A] and calling his name. At 5:05am, [client A] walked out of the field/wooded (sic) area and walked to the Residential Director's vehicle. He was easily redirected into the vehicle and agreed to return to the group home." The report indicated client A had a "1" (inch) superficial scratch on his left shoulder, two 2" superficial scratches and two 4" deeper scratches on the left lower leg, a 1/4" scratch on the left side of his foot, and a 1/2" scratch on the left side of his face." The report indicated "The IDT (Interdisciplinary Team) debriefed and reviewed the incident. [Client A's] supervision level is being increased to eyesight during times of agitation to</p>			

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	<p>reduce the risk of [client A] running outside and providing additional guidance to staff related to Mandt (interventions to prevent elopement and physical aggression) blocking if needed in the future."</p> <p>On 10/20/15 at 11:35am, an interview with the Regional Residential Director (RRD) was conducted. The RRD provided a 9/21/15 at 4:30pm, "Behavior Data Sheet" which indicated client A was "upset," refused supper, "stormed" while walking to his bedroom, and "slammed" the door. The report indicated GHS #5 "went to check" on client A, client A refused supper, and indicated client A was "calm" inside his bedroom. GHS #5 indicated "I walked out and then went into the kitchen, not even five minutes later [client A] comes storming out and said I'm done with this, put me on watch. I don't care anymore and then stormed to his room and slammed the door. We heard him throwing and banging stuff around...[client A] came swinging and running after [GHS #6]. [GHS #5] told [client A] to calm down and just relax and [client A] said I wanna (sic) go to a state hospital. I can't stand being in this f----- house with people that don't care about me. So then [client A] was still going after [GHS #6], so [client B] got up and said [client A] better leave staff</p>			

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	<p>alone, and [clients A and B] started going at it and [client A] was throwing stuff all at the house and in the house. [GHS #5 and GHS #6] got [clients C and D] out ASAP (As Soon As Possible) (sic) and to the drive way to keep them safe. [Client B] finally came out and [client A] went to the back yard and he started throwing chairs and everything at the windows and was yelling and screaming and threatened staff and clients. [Name of AGHM] was called and came in."</p> <p>On 10/20/15 at 1140am, an interview with the RRD and Behavior Consultant (BC) was conducted. The RRD and BC both stated client A's behaviors on 9/21/15 caused the property destruction at the group home. The RRD indicated client A had a history of AWOL behaviors, property destruction, and suicide threats with attempts. The RRD indicated client A's last suicide attempt was when client A left the facility AWOL on 11/26/14 when staff failed to implement his plans correctly, client A's behaviors had escalated, client A walked down the road during an elopement from the group home, and "jumped off" a bridge. The RRD indicated client A suffered a "fractured back" and leg injuries from his previous suicide attempt. The RRD indicated during client A's elopement on 8/18/15 staff did</p>			

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	<p>not implement client A's plan to prevent his escalating behaviors and elopement. The RRD stated the staff failed to "implement" client A's plans "correctly." The RRD stated after the incident "we revised" client A's plan to ensure staff "prevented" client A from leaving (elopement) from the group home during his escalating behaviors. The RRD and BC both stated they as professional staff became the administrative oversight of the facility "just before this incident." The RRD stated "that's why" the behavior on 9/21/15 occurred. The RRD stated "we can replace" and repair the property destruction inside and damage within the fenced in patio areas of the group home. The RRD stated client A "was not able to leave" the group home to hurt himself on 9/21/15. The RRD and BC indicated the wording to client A's plan was changed to ensure staff understood and implemented client A's plan correctly. The RRD stated client A was "missing" from the group home on 8/18/15 for "approximately six (6) hours" during client A's elopement. The RRD indicated the facility staff failed to supervise client A "correctly" on 8/18/15. The RRD indicated the facility had been "short" staffed "for the past several months." The RRD indicated two staff should be on duty at the group home for the overnight hours.</p>			

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	<p>On 10/30/15 at 2:00pm, an interview with the RRD was conducted. The RRD indicated the identified broken windows and exposed wires have been repaired and replaced. The RRD indicated the facility staff failed to implement client A's plan correctly on 8/18/15 which resulted in client A's elopement.</p> <p>Client A's record was reviewed on 10/20/15 at 10:45am. Client A's 12/31/14 ISP (Individual Support Plan) and 11/6/13 BSP (Behavior Support Plan) revised on 8/28/15 indicated client A should be supervised by the facility staff. Client A's record indicated he was not safe alone in the community. 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."</p> <p>Client A's record and BSP indicated an undated "addendum #2" which indicated client A "requires a supervision level of</p>			

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	<p>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."</p> <p>Client A's revised 8/28/2015 BSP "addendum #2" indicated "Supervision</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G799	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2015
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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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	<p>should increase to eyesight supervision when [client A] is escalated, making threats to harm himself, being very negative, making suicidal threats/comments, dwelling on something that has happened that has made him upset, cursing, threatening comments, raised voice. Eyesight supervision is defined as having [client A] in eyesight at all times during waking hours except when using the restroom, showering, or changing his clothes...." Client A's revised BSP indicated additional interventions for staff to "block the doorways" should client A attempt to leave the group home during elopement behaviors.</p> <p>This federal tag relates to complaint #IN00180669.</p> <p>9-3-3(a)</p>			