

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G721	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/05/2016
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 6835 W CR 950 N SCIPIO, IN 47273
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W 0000  Bldg. 00	<p>This visit was for the annual recertification and state licensure survey.</p> <p>Survey Dates: May 4 and 5, 2016.</p> <p>Facility Number: 004492 Provider Number: 15G721 AIM Number: 200512660</p> <p>These federal deficiencies reflect findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/11/16.</p>	W 0000		
W 0140  Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), and 2 additional clients (#3 and #4), the facility failed to assure an accurate and complete accounting of the clients' personal cash on hand and bank accounts.</p> <p>Findings include:</p> <p>An audit was conducted on 5/05/16 at 8:14 AM with the facility's Qualified</p>	W 0140	The Residential Manager and Client Financial Specialist will receive a record of training indicating the process for establishing and maintaining a system that assures that a full and complete accounting of clients' personal funds are available within the home. The Benchmark Client Financial Specialist will then work with the Residential Manager to ensure this system is maintained appropriately and will give a	06/04/2016

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><b>Intellectual Disabilities</b> Professional/QIDP of clients #1, #2, #3, and #4's cash on hand (cash kept at the facility for clients' personal use). Client #1's cash on hand/COH amount was \$72.23. Client #2's cash on hand was \$71.11. Client #3's cash on hand was \$29.68. Client #4's cash on hand was \$59.53.</p> <p>The facility had a "Finance Book" used for record keeping of clients' money on "Cash on Hand Ledger" sheets and "Client Banking Activity Log" sheets. A review (5/05/16 8:14 AM) of the "Finance Book" indicated no Ledger/Log sheets for the month of May 2016. There was no accounting of the above listed amounts of clients' money. The most recent paperwork at the facility for review was for the month of February 2016: Client #1's COH Ledger sheet dated 2/29/16 indicated he had \$56.90. Client #2's COH Ledger sheet dated 2/29/16 indicated he had \$16.57. Client #3's COH Ledger sheet dated 2/29/16 indicated she had \$0.00. Client #4's COH Ledger sheet dated 2/29/16 indicated he had \$37.43.</p> <p>A review of clients' paperwork/receipts was conducted with the Client Financial Specialist/CFS on 5/05/2016 at 2:25 PM.</p>		monthly summary report of each client's financial activity to the Director to verify compliance.		

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	<p>The CFS offered March receipts and banking activity for review for clients #1, #2, #3, and #4. The CFS had no documentation from April 2016 for review. The CFS was interviewed on 5/05/16 at 2:43 PM and indicated the Manager (staff #2) of the facility should have had May 2016 documentation of client funds (Cash on Hand Ledgers and Client Banking Activity Logs) in the Finance Book. The interview also indicated it was an agency policy not to have an excess of \$50.00 in client COH accounts unless personal shopping was planned soon.</p> <p>Interview with the QIDP on 5/05/16 at 4:00 PM indicated the agency was implementing a new system of managing the clients' funds under direction of the Client Financial Specialist. The interview indicated Manager staff #2 may have been confused regarding responsibilities associated with the new system which led to the absence of documentation in the clients' Finance Book.</p> <p>9-3-2(a)</p>			

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W 0440  Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>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 #1, #2, #3, and #4) living in the group home, the facility failed to conduct quarterly evacuation drills for all personnel shifts.</p> <p>Findings include:</p> <p>On 5/05/2016 at 10:21 am, a review of the facility's evacuation drills from 5/04/2015 through 5/02/2016 was conducted. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, and #4 during the 3rd quarter of 2015 (October, November, December), for the sleepshift (12:00 AM to 6:00 AM) of personnel. The review also indicated the facility had failed to conduct an evacuation drill for the clients during the third quarter of 2015 (July, August, September) for the afternoon/evening shift of personnel (4:00 PM to 12:00 AM).</p> <p>On 5/05/16 at 10:30am, an interview with the Qualified Intellectual Disabilities Professional/QIDP indicated no additional evacuation drills were available for review.</p> <p>9-3-7(a)</p>	W 0440	The Residential Manager and QDDP will receive documented training regarding the requirement to follow the evacuation drill schedule that includes quarterly evacuation drills for each shift. The Residential Manager and QDDP will then ensure compliance with the evacuation drill schedule by monitoring that the scheduled drills are completed and documented, and will send the results to the Director to verify that they are completed.	06/04/2016	

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

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FORM APPROVED

OMB NO. 0938-0391

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