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
	15G764		05/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

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W 0000 Bldg. 00	This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00199638. Complaint #IN00199638: Substantiated; Federal and state deficiencies related to the allegation(s) are cited at W104 and W148. Dates of survey: May 17, 18, 20 and 23, 2016. Facility number: 012371 Provider number: 15G764 AIM number: 200986870 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/31/16.	W 0000		

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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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based upon observation and interview for 4 of 4 sampled clients (clients A, B, C and D) and for 3 additional clients (clients E, F and G), the governing body failed to exercise operating direction over the facility to maintain the home in good condition and failed to ensure client B did not use personal funds to pay library fines. Findings include: 1. Observations were completed at the group home on 5/17/16 from 4:55 PM until 6:31 PM, and on 5/18/16 from 6:42 AM until 7:32 AM in the home in which clients A, B, C, D, E, F and G resided. The front door was missing 2 panels of decorative frames exposing the unpainted door underneath. The door knocker had an unknown resident's name engraved in the brass. The shower in the bathroom off the main hallway had soiled caulking along the tub enclosure and missing and loose tiles in the shower. There was a missing floor tile in the threshold to the medication administration room. There was a patched area on the wall in the medication room that had a peeling piece	W 0104	All staff including management staffwere retrained on ensuring that client personal funds are not used topay library fines. Client B was reimbursed the $5.00 on 5/20/16.Monthly financials are completed and reviewed by the Client FinancialSpecialist monthly. The Client Financial Specialist will audit asample monthly to ensure client monies are used appropriately. TheClient Financial Specialist will then report to the ResidentialDirector for compliance. A brand new front door has been ordered andwill be installed by 6/22/16. The blinds in clients A and G's bedroomwere installed. The tiles in the shower in the bathroom off the mainhallway are being replaced and the caulking in the shower will berepaired. The floor tile in the medication room will be replaced. Themedication room wallpaper (in that area) will be replaced. The jobswill be completed by 6/22/16. The cabinet in the restroom off of themedication room was fixed and was re-painted. The management staff will completeCQA's (environmental checks of all areas of the home) weekly for 3months and turn them into the Residential Director for compliance.These will ensure	06/22/2016

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	of wallpaper 2 and 1/2 by 2 and 1/2 feet. The restroom off the medication administration/laundry room had a warped cabinet under the sink with peeling paint. Clients A and G had a sheet hanging over their window in place of a blind or curtain. Client A was interviewed on 5/18/16 at 7:32 AM and indicated the previous window coverings had been destroyed by a client who no longer lived there. The house manager (HM) was interviewed on 5/19/16 at 7:30 AM and indicated he had noted the loose tile in the restroom and had submitted a work order for it. The facility's CQA (Compliance Quality Assurance) Environmental Probes since 1/16 were reviewed on 5/18/16 at 2:45 PM. The forms indicated on 1/29/16 "Tiles fall/water damage to walls" in the bathroom. A probe dated 2/29/16 indicated "Tiles down/water damage" in the bathroom. A probe dated 3/31/16 indicated "Tile/water damage" in the bathroom. A probe dated 4/29/16 indicated "Tiles falling down/water damage to wall" in the bathroom. The RD, group home nurse and Qualified Intellectual Disabilities Professional		areas are clean and dusted, furniture/windows andappliances are in working condition, and all aspects of the house arebeing maintained. The Residential Director will complete a CQA monthly for 3 months and turn into the Vice President for 3 months toensure compliance. The CQA's will then be completed monthly bymanagement and turned into the Residential Director and VicePresident to ensure compliance and all actions needing attention inthe home are addressed appropriately.	

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	(QIDP) were interviewed on 5/20/16 at 2:09 PM. The RD indicated there was a system in place to ensure the home was maintained, but at times maintenance issues were not addressed. The RD indicated the bathroom maintenance issues were now on a work order as was the missing blind in client A and G's room. 2. Client B's financial records were reviewed on 5/18/16 at 2:28 PM. Client B's ledger for 2/26 indicated on 2/9/16, client B had paid a library fine of $5.00. The RD was interviewed on 5/20/16 at 2:15 PM and indicated the group home was responsible for paying client B's library fines and he was going to be reimbursed for the expense. This federal tag relates to complaint #IN00199638. 9-3-1(a)			

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W 0148 Bldg. 00	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based upon record review and interview, the facility failed for 2 of 2 sampled clients (clients B and D) to notify the guardian of medical appointments as requested by the guardian. Findings include: 1. Client B's record was reviewed on 5/18/16 at 4:58 PM. A Family Communication Request signed and dated 10/28/15 by client B's guardian indicated the guardian wanted to be notified of "All regularly scheduled medical appointments," and "Changes that require guardian approval only (medications, interventions, restrictions)...Monthly financial information...." A note written at the side of the financial information section indicated "Having problems in this area (sic) not given on time in past...." A Psychotropic Medication Review dated 4/4/16 indicated client B's Depakote had	W 0148	The QIDP and all management staff wereretrained on notifying guardians of medical appointments as requestedby the guardian. Management staff will review for all clients theFamily Communication Request to ensure that management is notifyingguardians as requested. The guardian for client B was given the nameof the new PCP. The QIDP for client B and D was retrained onnotifying families/guardians of medication changes and medicalappointments as requested. The QIDP will also send (email perguardian request) financial statements to guardians as requested onthe 1st of every month. The QIDP will include in theemail the Residential Director to ensure compliance every month.	06/22/2016

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	been discontinued (date not indicated) by his neurologist "due to low blood levels and no seizures reported." A note attached to the form indicated "Sent to guardian 4/5/16." There was no evidence of client B's guardian's signature on the form. A Clinical Summary of client B's visit to his neurologist dated 2/17/16 failed to indicate interventions, but did indicate a request for laboratory tests for client B. Group Home Health Issues/Nursing Notes dated 2/24/16 indicated "[Neurologist's] office called and would like to discontinue his Depakote. Blood levels are not therapeutic at this time and no seizures have been reported. Will discontinue medication as ordered." There was no evidence in the record client B's guardian had been notified of the discontinued medication. A Benchmark HS (Human Services) Medical Appointment Form dated 1/27/16 indicated he had seen his primary care physician for a cough, and an annual physical was completed on 10/13/15. Client B's guardian was interviewed on 5/18/16 at 9:16 AM. When asked if there was good communication with her by staff at the group home, client B's guardian indicated she had not been told of the discontinuation of Depakote client B received and she would have liked to			

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	have been notified as client B had taken the medication for years. When asked about client B's financial status, she indicated she had difficulty with receiving financial statements as requested in the past. She indicated she was told by client B's primary care physician's office the doctor was no longer practicing at that location and client B was to find another provider. She indicated she had not been informed client B's primary care physician was leaving practice or if a new primary care physician for client B had been obtained. The Residential Director (RD), QIDP (Qualified Intellectual Disabilities Professional) and nurse were interviewed on 5/20/16 at 2:09 PM. The QIDP indicated she had notified client B's guardian of the change to client B's medications and would note the date the forms for consent were sent to guardians/family members. She indicated she was now ensuring the financial forms were sent by the first of the month. The QIDP indicated there was now a new primary care physician that would be providing medical care for client B. 2. Client D's record was reviewed on 5/18/16 at 3:10 PM and indicated client D had a physical examination on 5/12/16. A Family Communication Request dated			

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	4/28/16 indicated client D's guardian wanted to be made aware of "All regularly scheduled medical appointments." She indicated she has not been told of client D's appointment until it after it had taken place. Client D's guardian was interviewed on 5/20/16 at 3:55 PM and indicated she had not been made aware of client D's visit to the doctor and had indicated on a form that she wanted to be made aware of client D's medical appointments. The QIDP indicated on 5/23/16 at 3:13 PM she had not documented when she had notified client D's guardian of his medical appointment, but had weekly communication with her. This federal tag relates to complaint #IN00199638. 9-3-2(a)			
W 0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS			

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Bldg. 00	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 4 sampled clients (client C) from neglect. Findings include: The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and internal incident reports were reviewed on 5/18/16 at 2:05 PM. A report dated 8/25/15 indicated Benchmark staff received a report from the police "that a day service staff member and three consumers (clients C, H and I) were in the [park name] parking lot sitting in a van with a staff member who was sitting in the driver seat and appeared to be asleep. The police arrived at 12:27 PM and knocked in the window of the staffs (sic) van. The BHS (Benchmark Human Services) staff responded saying that she was not feeling well and had laid back in her seat but she was okay. The police were approached by a community member who was at the park who informed the officer that the van had been at the parked (sic) at that spot since 11:00 AM. The staff person denied that time frame and indicated they had arrived at the park at 11:40 AM. The	W 0149	The Investigation was immediatelyinitiated. The staff was terminated for neglect. All Day ServicesStaff were retrained on the Benchmark Human Service Abuse and NeglectPolicy. The Day Service Management Staff initiated sport checkscompleted by management personnel in order to randomly monitor theactivity of both the staff and clients served. These spot checks aresubmitted to the Assistant Day Services Director for review. Thesechecks will continue as an ongoing practice to prevent furtherincidents and improve services.	06/22/2016

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	police notified Benchmark (sic) and the Day Service Program Coordinator went to the park immediately to transport [client #7] and the other two consumers back to the day programming facility. An investigation was immediately initiated and the staff member [staff #6] was interviewed. During the interview, [staff #6] admitted that as the clients were finishing their lunch, she began to feel ill and that she walked to her van and laid her head down on her hood. She stated that once the clients were done eating, they got into her van and she laid her head down in her car. [Staff #6] did not admit to sleeping in the car, however, she admitted that she did not call her supervisor to get assistance with the clients...." The report indicated staff #6 had been terminated and that client C "appeared unaffected by the incident." The investigation into the incident on 8/25/15 dated 8/27/15 was reviewed on 5/18/16 at 2:02 PM and indicated "For allegations or suspicions of abuse, neglect or exploitation, the allegation has been substantiated." The Residential Director was interviewed on 5/18/16 at 2:45 PM and indicated staff #6 had been terminated as a result of the incident.			

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	The facility's policy Group Home Abuse and Neglect dated 11/11/14 was reviewed on 5/18/16 at 2:02 PM 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. 9-3-2(a)			