

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2016
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May 16, 17, 18, 19, 20, 2016.</p> <p>Facility number: 003799 Provider number: 15G705 AIM number: 200447350</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 5/24/16.</p>	W 0000		
W 0268 Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure 1 of 2 sampled clients (client #1) was addressed by direct care staff in a positive manner.</p> <p>Findings include: Client #1 was observed on 5/17/16 during the group home observation period from 5:56 A.M. until 8:00 A.M.</p>	W 0268	All staff received training on the Staff and Client Interaction Policy as well as the Client Rights and Responsibilities Policy. This training focused on positive and respectful language to use with all clients. The staff were administered post-tests to ensure their understanding of positive, respectful communication. Staff will be monitored by the management staff to ensure that their	06/19/2016

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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W 0382 Bldg. 00	<p>At 6:09 A.M., direct care staff #5 was interacting with client #1 when she walked away from him and stated, "He's (client #1) a fat guy!"</p> <p>Director of Residential Services #1 was interviewed on 5/19/16 at 10:50 A.M. Director of Residential Services #1 stated, "Staff (direct care staff) should not talk that way about our residents (clients)."</p> <p>9-3-5(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1 was observed during the group home observation period on 5/17/16 from 5:56 A.M. until 8:00 A.M. At 7:00 A.M., direct care staff #1 was preparing medications to administer to client #1. At 7:01 A.M., direct care staff #1 had</p>	W 0382	<p>training was effective. The house manager and QDDP will complete observations of staff interactions three times on first shift, three times on second shift, and three times on third shift to ensure that policies are followed and that positive and respectful communication is being utilized. Monthly spot checks will be completed thereafter. These observations will be documented on a staff observation form and turned into the director to monitor for compliance.</p> <p>All staff have received additional training on the proper storage of medications. This training included securing the medications in the locked cabinet prior to leaving the medication area. The QIDP, Residential Manager or nurse will complete spot checks for one month to ensure that the medication storage policy is being followed. These unannounced spot checks will be completed three times on first shift, three times on second shift, three times on third shift. Thereafter, weekly spot checks will be completed.</p>	06/19/2016	

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	<p>client #1's medications on the medication room table when she left the medication room to get a bottle of prune juice. The open medications were left on the table making them accessible to client #1 who was in the medication room. At 7:08 A.M., direct care staff #1 again left the medication room while leaving client #1's medications out on the counter making them accessible to client #1 who remained in the room.</p> <p>Director of Residential Services #1 was interviewed on 5/19/16 at 10:50 A.M. Director of Residential Services #1 stated, "Medications are to be locked when they aren't being administered."</p> <p>9-3-6(a)</p>		<p>Observations will be documented on a Medication Administration Tracking form and turned into the director monthly so compliance can be monitored.</p>		