

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G729	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 4331 MELBOURNE RD INDIANAPOLIS, IN 46228
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W 000 Bldg. 00	<p>This visit was for the post certification revisit (PCR) survey to the full recertification and state licensure survey completed on 12/31/14.</p> <p>Dates of Survey: February 19, 20 and 25, 2015.</p> <p>Facility Number: 011220 Provider Number: 15G729 AIMS Number: 200839230</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/2/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 2 of 2 clients living in the group home (clients #1 and #2), the governing body failed to exercise general policy and operating direction over the facility to ensure: __ Sufficient direct care staff were</p>	W 104	All broken furniture in the home will be removed and replaced. A checklist will be completed three times weekly by the QDDP-Designee that will verify all furniture is in working order and submitted to the Director for review. At least two staff will	03/27/2015

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>provided to supervise and care for clients #1 and #2 throughout the day to provide training and meet the clients' basic health and safety needs.</p> <p>__The recliners in the home were maintained and in good repair for clients #1 and #2 to be able to recline and/or use.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 2/19/15 between 3:15 PM and 7:15 PM. During this time period the following was observed:</p> <p>__There were three recliners and two couches in the living room of the home.</p> <p>__Client #1 was a frail thin elderly male with multiple contractures and required a wheel chair for mobility and staff assistance to meet all of his needs.</p> <p>__At 5:50 PM staff #2 transferred client #1 from his wheel chair into one of the recliners in the living room. Staff #2 placed a pillow under client #1's right side and then returned to the kitchen to begin preparing the evening meal. Client #1 immediately began pulling at the pillow and the material of the right arm rest of the recliner. The pillow fell to the floor as client #1 continued to pull on the material of the right arm rest of the recliner. Staff #2 prompted staff #1 to watch client #1 so he did not fall out of the recliner.</p>		<p>work each shift at the group home during waking hours. The QDDP-Designee will complete a monthly staffing schedule and submit it to the Director to demonstrate staff is scheduled as expected. The QDDP will monitor and approve staff time each day during the week to ensure appropriate staffing has occurred and will notify the Director of any scheduling or staffing issues. The Director will monitor staffing time each week to ensure appropriate staffing has occurred.</p>	

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	<p>During interview with staff #2 on 2/19/15 at 6 PM, staff #2: __ Indicated two of the three recliners in the home were broken and no longer reclined. __ Indicated the lever for the foot rest of the recliner client #1 was sitting in was broken and client #1 could not recline. __ Indicated the recliner client #2 was currently sitting in was the only recliner that functioned properly.</p> <p>Interview with the AD (Area Director) on 2/20/15 at 3:45 PM indicated the furniture in the home was to be maintained and in good repair at all times.</p> <p>2. The governing body failed to ensure sufficient direct care staff was provided to supervise and care for clients #1 and #2 throughout the day to meet the clients' basic health and safety needs. Please see W186.</p> <p>This deficiency was cited on 12/31/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-1(a)</p>			

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W 186 Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>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 2 of 2 clients living in the home (clients #1 and #2), the facility failed to provide sufficient direct care staff to supervise and care for the clients throughout the day to provide training and meet the clients' basic health and safety needs.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/15 between 3:15 PM and 7:15 PM. During this observation period there were two direct care staff and two clients.</p> <p>__ Client #1 was a frail thin non verbal elderly male with multiple contractures. Client #1 could no longer wear shoes because of severe contractures causing his feet to point toward the floor. Client #1 required a wheel chair for mobility and total staff assistance to meet all of his</p>	W 186	<p>At least two staff will work each shift at the group home during waking hours. The QDDP-Designee will complete a monthly staffing schedule and submit it to the Director to demonstrate staff is scheduled as expected. The QDDP will monitor and approve staff time each day during the week to ensure appropriate staffing has occurred and will notify the Director of any scheduling or staffing issues. The Director will monitor staffing time each week to ensure appropriate staffing has occurred.</p>	03/27/2015

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	<p>needs. Client #1 required staff to lift him from his chair and/or bed during transfers.</p> <p>__ Client #2 wore a helmet and a gait belt and required one staff to one client supervision and hands on assistance from the staff at all times when ambulating due to a history of drop seizures. Client #2 required staff assistance to meet all of her needs. The staff used a seat alarm beneath client #2 to alert the staff when client #2 was getting up from the recliner in the living room.</p> <p>__ Both clients #1 and #2 utilized bed alarms to alert the staff when and/or if the clients would get out of bed on their own.</p> <p>__ At 6:02 PM client #2 was in the kitchen with staff #2. Client #2 fell forward with staff #2 catching her. Staff #2 stated, "Are you ok?" Staff #2 indicated client #2 had just had a drop seizure and escorted her to the recliner to sit down.</p> <p>Review of the February, 2015 staffing hours on 2/20/15 at 1 PM indicated one staff worked alone with clients #1 and #2 from 1 AM to 3 PM on January 1, 7, 8, 14 and 15.</p> <p>During interview with staff #2 on 2/19/15 at 5 PM, staff #2:</p> <p>__ Indicated two staff were to be in the home when the clients were being bathed</p>			

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W 210	<p>and during meal time. ___ Stated, "Yeah, it's hard for just one staff to be here by their self."</p> <p>During interview with the RM (Residential Manager) on 2/20/15 at 2 PM, the RM: ___ Indicated clients #1 and #2 required total staff assistance to meet all of their needs throughout the day. ___ Indicated two staff were to be in the home during peak hours when the clients were being bathed and/or at meal time. ___ Indicated one staff worked the overnight shifts while the clients were sleeping. ___ Indicated the night shift staff got the clients up in the AM between 5 AM and 6 AM. ___ Indicated one staff worked alone the weekend shifts of January 1, 7, 8, 14 and 15 from 7 AM to 3 PM.</p> <p>This deficiency was cited on 12/31/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p>						

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Bldg. 00	<p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on observation, interview, and record review for 1 of 1 sample client (#1),</p> <p>__ The facility failed to ensure client #1 was assessed by PT/OT (Physical Therapy/Occupational Assessment) to include how the staff were to transfer client #1 in and out of his wheelchair, the recliner, a straight chair and the supports/wedges and/or cushions that were to be used to support client #1 to maintain a good position while in his chair, the recliner or in bed.</p> <p>__ The facility failed to ensure client #1's sensory needs were assessed.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/15 between 3:15 PM and 7:15 PM. During this observation period the following was observed:</p> <p>__ There were two direct care staff working in the home with clients #1 and #2.</p> <p>__ Client #1 was a frail thin elderly male with multiple contractures. Client #1 could no longer wear shoes because of severe contractures causing his feet to point toward the floor. Client #1 required a wheel chair for mobility and total staff assistance to meet all of his needs.</p> <p>__ Client #1 was non verbal and made periodic moaning and grunting noises.</p> <p>__ Throughout this observation period client #1</p>	W 210	<p>A PT/OT evaluation will be scheduled with specific instructions requested regarding how staff are to transfer him in and out of his wheelchair, the recliner, a straight chair, and the appropriate use of the supports/wedges and/or cushions used to support him in maintaining a good position while in his chair, the recliner, or in bed and while dining. Once the recommendations are received, all staff will receive training regarding the appropriate method for implementing all transfers and use of supports, wedges, cushions, and dining supports. The QDDP will then monitor staff three times weekly to insure appropriate implementation is occurring. An appointment will be scheduled with National Seating and Mobility to have client #1's wheelchair evaluated for any needed updates or repairs. All needed updates and repairs will be completed and follow up appointments scheduled as recommended for ongoing appropriate wheelchair maintenance. The QDDP Designee will complete a checklist three times weekly verifying that the wheelchair is in good repair and will submit</p>	03/27/2015

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	<p>pulled at his clothing; his sweat shirt, his sweat pants and the strings on his sweat pants. Client #1 would pull his sweat shirt over his head and then back again trying to take his sweat shirt off. Client #1's sweatshirt was stretched out of proportion and hung off of his shoulder.</p> <p>__At 4:15 PM staff #1 pushed client #1 in his wheelchair to the dining room table with client #2, staff #1 and staff #2. Staff #1 opened a new board game and attempted to put some of the pieces in client #1's hand. Staff #1 then got out another game and again tried to put some of the game pieces into client #1's hand. Client #1 did not show any interest in the games and continued to pull at his clothing.</p> <p>__At 5 PM staff #1 stated, "Don't pull on your clothes [client #1]," as staff #1 pulled client #1's sweatshirt down and tucked it into his sweat pants covering client #1's exposed ileostomy bag (a bag attached to the abdomen that covers a stoma (a surgical opening in the abdomen to contain feces moving through the intestines).</p> <p>At 5:30 PM: __Staff #1 and #2 pushed client #1 in his wheelchair to his bedroom to change his adult brief. __Staff #1 placed one arm under client #1's neck and her other arm under client #1's knees and proceeded to scoop client #1 up out of his wheelchair doing a one person lift to transfer client #1 to his bed. __Staff #2 stopped staff #1 and stated, "Whoa, wait, what are you doing? That's not how we are supposed to transfer him." __Staff #1 stopped leaving client #1 half in and half out of his wheelchair with staff #1 holding/preventing client #1 from falling out of his wheel chair. __Staff #1 and staff #2 straightened client #1 back to a sitting position into his wheelchair.</p>		<p>this report to the Director for review.</p> <p>Client #1 will be assessed by a qualified Behavior Consultant to determine how to address his sensory needs related to his frequent pulling at his clothing. Client #1's BSP will be updated to include instructions detailing what the staff are to do when client #1 is pulling at his clothing. All staff will be trained regarding this BSP update, and the QDDP-Designee will monitor the staff three times weekly to ensure they are following the BSP instructions.</p>	
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	<p>__ Staff #2 then stood in front of client #1 and stated, "This is how we do it."</p> <p>__ Staff #1 placed her arms under client #1's arm pits and lifted client #1 up out of his chair, turned him around and sat him down on his bed.</p> <p>__ Client #1's toes barely touched the floor.</p> <p>__ Staff #2 indicated she was having back problems now because of lifting client #1 so much by herself.</p> <p>__ Staff #2 laid client #1 back onto his bed.</p> <p>__ Staff #1 stated, "That's not how I do it. I do it the other way. Hey if I'm here by myself I have to do it my way."</p> <p>__ Client #1's adult brief was changed and staff #2 transferred client #1 back into his wheel chair.</p> <p>__ At 5:50 PM:</p> <p>__ Staff #2 pushed client #1 in his wheelchair back to the living room and transferred client #1 from his wheel chair into one of the recliners in the living room.</p> <p>__ Client #1 leaned to the right while sitting in the recliner.</p> <p>__ Staff #2 placed a small pillow under client #1's right side and then returned to the kitchen to begin preparing the evening meal.</p> <p>__ Client #1 immediately began pulling at the pillow and the material of the recliner trying to get out of the recliner.</p> <p>__ Client #1 finally got the pillow out and it fell to the floor.</p> <p>__ Staff #1 prompted staff #2 to sit near client #1 to keep him from falling out of the recliner.</p> <p>__ Staff #1 sat down on the couch near client #1 and maintained one hand on client #1 while holding onto his sweat pants.</p> <p>__ Staff #2 stated, "He doesn't like sitting there and probably wants back in his chair but we can't just keep him in his chair all the time."</p> <p>During this observation period:</p>			

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	<p>__ Client #1 leaned off to the right while sitting in his wheelchair.</p> <p>__ Staff #1 and #2 tried to sit client #1 up in his wheelchair and each time he would fall back to the right side.</p> <p>__ While sitting in the recliner client #1 was offered a small couch cushion for support to his right side.</p> <p>__ No supports were used to straighten client #1's posture while sitting in his wheelchair.</p> <p>__ The staff did not offer client #1 any sensory or tactile objects to hold and/or to choose from.</p> <p>Client #1's record was reviewed on 2/20/15 at 12 PM. Client #1's record indicated diagnoses of, but not limited to, Surgical anastomosis (a connection made surgically between adjacent parts of the intestine) due to a megacolon (an abnormally large colon) and a bowel obstruction resulting in an Ileostomy, Osteoporosis (porous bones causing reduced bone strength and a higher risk of fractures), Kyphoscoliosis (a combination of outward curvature (kyphosis) and lateral curvature (Scoliosis) of the spine), Cerebral Palsy (a disorder of posture, muscle tone and movement resulting from brain damage), leg muscle spasms with pain and lower extremity weakness.</p> <p>Client #1's Nutrition Review by the facility's dietician dated 10/21/14 indicated "feel that [client #1] needs a cushion and/or wedge for better positioning and to be more comfortable-bony prominence may be painful on hard wooden chair.... [Client #1] appeared gaunt with muscle wasting evident. Temporal wasting and pad between thumb and index finger indented."</p> <p>Client #1's 10/1/14 BSP (Behavior Support Plan) indicated "Avoid too much idle time, he needs a highly structured and consistent daily routine to</p>			

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	<p>keep focused and on task.... Due to his limited mobility a variety of stimulating activities should be easily available to [client #1] throughout the day.... When possible provide [client #1] with choices for meals, activities, etc. Encourage a variety of activities but only give a choice between two options at once. Too many options will likely cause confusion."</p> <p>Client #1's 9/23/14 ISP indicated "[Client #1] is reported as not being able to hear from either ear.... Does not speak. Vocalizes at times, yelling, screaming, grunting, laughs out loud and uses eye gaze to indicate his wants and desires."</p> <p>Client #1's ISP indicated "PT/OT evaluations completed on 12/01/10. [Client #1] has reached rehabilitation max potential at this time. OT has seen [client #1] to assist in positioning and safety when up in wheel chair. Recommendations; 1. Pt (patient)/staff to be given positioning schedule for when pt in wheel chair goal met (sic). 2. Pt to tolerate adaptations/modifications of current wheel chair 100% of the time. Pt compliant with right-sided padding removed left sided padding. Wheel chair recommendations noted. Foot plan in place. Positioning plan in place. Bed positioning plan in place. ROM (Range Of Motion) exercises in place."</p> <p>__Client #1's Medical Appointment form dated 6/8/14 indicated client #1 was seen by PT/OT with recommendations "for discharge secondary to patient resisting treatments.... May look into adductor wedge for his positioning and continue HEP (Home Exercise Program) - stretching."</p> <p>Client #1's Medical Appointment Form dated 9/8/14 indicated client #1 was assessed for a new tilt wheelchair and seating position. The form indicated the facility would pursue funding for client #1 to get a new wheel chair.</p>			

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	<p>Client #1's record indicated no assessment of how the staff were to transfer client #1 in and out of his wheelchair, the recliner, a straight chair and the supports/wedges and/or cushions client #1 required to maintain a good position while in his wheel chair, the recliner and/or in his bed.</p> <p>Client #1's record indicated no assessment of client #1's sensory needs and/or what stimulating activities and/or objects should be offered to client #1 in regard to client #1's constant self stimulating behavior of pulling at his clothing and items around him.</p> <p>During interview with staff #2 on 2/19/15 at 5 PM, staff #2: ___ Stated, "He is always pulling at his clothes. He likes to pull his shirt up over his head." ___ Indicated the staff has to watch client #1 to make sure he doesn't uncover his colostomy bag and pull it off as he has done in the past. ___ When asked what the staff were to do when client #1 was pulling at his clothing, staff #1 stated, "We just ask him to stop but that doesn't make a difference, he still does it."</p> <p>During interview with the RM (Residential Manager) on 2/20/15 at 2 PM, the RM: ___ Indicated client #1 frequently pulls on his clothing. ___ Indicated when client #1 would pull on his clothing the staff should ask him to stop. ___ Indicated no assessments of client #1's sensory needs. ___ Indicated client #1 was supposed to be getting a new wheel chair but they were waiting on the funding to come through. ___ Indicated the PT/OT assessments did not address specifically how client #1 was to be</p>			

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W 240 Bldg. 00	<p>transferred from one surface to another, the number of staff required to transfer client #1 safely from one seated position to another and/or the specific supports that were to be used to ensure client #1's optimal positioning and posture.</p> <p>This deficiency was cited on 12/31/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 1 sampled client (#1), the client's Individualized Support Plan (ISP)/ BSP (Behavior Support Plan) failed to include what the staff were to do when client #1 was pulling at his clothing.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/15 between 3:15 PM and 7:15 PM. During this observation period the following was observed: __ There were two direct care staff working in the home with clients #1 and #2.</p>	W 240	Client #1 will be assessed by a qualified Behavior Consultant to determine how to address his sensory needs related to his frequent pulling at his clothing. Client #1's BSP will be updated to include instructions detailing what the staff are to do when client #1 is pulling at his clothing. All staff will be trained regarding this BSP update, and the QDDP-Designee will monitor the staff three times weekly to ensure they are following the BSP instructions.	03/27/2015			

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	<p>__The facility RN was conducting observations and the RM (Residential Manager) was in and out of the home throughout the observation.</p> <p>__Client #1 was a frail thin elderly male with multiple contractures, required a wheel chair for mobility and staff assistance to meet all of his needs</p> <p>__Client #1 was non verbal and made periodic moaning and grunting noises.</p> <p>__Throughout this observation period client #1 pulled at his clothing, his sweat shirt, his sweat pants and the strings on his sweat pants. Client #1 would pull his sweat shirt over his head and then back again trying to take his sweat shirt off. Client #1's sweatshirt was stretched out of proportion and hung off of his shoulder.</p> <p>__At 4:15 PM staff #1 pushed client #1 in his wheelchair to the dining room table with client #2, staff #1 and staff #2. Staff #1 opened a new board game and attempted to put some of the pieces in client #1's hand. Staff #1 then got out another game and again tried to put some of the game pieces into client #1's hand. Client #1 did not show any interest in the games and continued to pull at his clothing.</p> <p>__At 5 PM staff #1 stated, "Don't pull on your clothes [client #1]," as staff #1 pulled client #1's sweatshirt down and tucked it into his sweat pants covering</p>			

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	<p>client #1's exposed colostomy bag (a bag attached to the abdomen that covers a stoma (a surgical opening in the abdomen to contain feces moving through the intestines).</p> <p>__At 5:30 PM the games were removed from the table and client #1 was taken to his bedroom to change his adult brief. While lying on the bed, client #1 continued to pull at his clothing.</p> <p>__At 5:50 PM staff #2 pushed client #1 in his wheel chair to the living room and transferred client #1 from his wheel chair into one of the recliners in the living room. Staff #2 placed a small pillow under client #1's right side and then returned to the kitchen to begin preparing the evening meal. Client #1 immediately began pulling at the pillow and the material of the right arm rest of the recliner as well as his sweat shirt and sweat pants.</p> <p>Client #1's record was reviewed on 2/20/15 at 12 PM. Client #1's 10/1/14 BSP and client #1's ISP dated 9/23/14 did not address client #1's self stimulating behavior of pulling at his clothing.</p> <p>During interview with staff #2 on 2/19/15 at 5 PM, staff #2: __Stated, "He is always pulling at his clothes. He likes to pull his shirt up over his head."</p>			

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W 249 Bldg. 00	<p>___ Indicated the staff has to watch client #1 to make sure he doesn't uncover his colostomy bag and pull it off as he has done in the past.</p> <p>___ When asked what the staff were to do when client #1 was pulling at his clothing, staff #1 stated, "We just ask him to stop."</p> <p>During interview with the RM (Residential Manager) on 2/20/15 at 2 PM, the RM: ___ Stated, "He (client #1) just always does that (pull at his clothing)." ___ Indicated client #1's ISP/BSP did not address what the staff were to do when client #1 was pulling on his clothing.</p> <p>This deficiency was cited on 12/31/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the</p>						

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	<p>achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 1 sampled client (#1), the facility failed to ensure the staff implemented client #1's ISP (Individual Support Plan) and offered client #1 his communication device when formal and informal training opportunities existed to assist client #1 in making his needs and wants known and to provide client #1 an opportunity to make choices of leisure time activities.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/15 between 3:15 PM and 7:15 PM. During this observation period the following was observed:</p> <p>__ There were two staff working in the home with client #1 and the facility RN was conducting observations.</p> <p>__ Client #1 was a frail thin elderly male with multiple contractures and required a wheel chair for mobility.</p> <p>__ Client #1 was non verbal and made moaning and grunting noises periodically during this observation period.</p> <p>__ Client #1 required staff assistance to meet all of his needs.</p> <p>__ Throughout this observation period client #1 pulled at his clothing pulling his sweat shirt and sweat shirt over his head</p>	W 249	<p>All staff at this home will receive training regarding the appropriate use of client #1's communication device. All staff will document on an ISP data sheet that they are offering client#1 the opportunity to use the device at least twice daily, and this documentation will be reviewed monthly by the QDDP-Designee. The QDDP-Designee will monitor staff in the home three times weekly to ensure the device is being used and report to the Director the results of this monitoring.</p>	03/27/2015
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	<p>and pulling at the strings on his sweat pants. Client #1's sweatshirt hung off of his shoulder and was stretched out of proportion from client #1 pulling on it.</p> <p>__At 4:15 PM staff #1 pushed client #1 in his wheelchair to the dining room table with client #2, staff #1 and staff #2. Staff #1 opened a new board game and attempted to put some of the pieces in client #1's hand. Staff #1 then got out another game and again tried to put some of the game pieces into client #1's hand. Client #1 did not show any interest in the games and continued to pull at his clothing. Staff #1 did not provide client #1 with his communication device to choose an activity he wanted to participate in. Staff #2 stated, "Looks like he doesn't want to play."</p> <p>__At 5:30 PM the games were removed from the table and staff #1 and #2 took client #1 to his bedroom to change his adult brief.</p> <p>__At 5:50 PM staff #2 pushed client #2 in his wheel chair to the living room and transferred client #1 from his wheel chair into one of the recliners in the living room. Staff #2 placed a small pillow under client #1's right side and then returned to the kitchen to begin preparing the evening meal. Client #1 immediately began pulling at the pillow and the material of the right arm rest of the recliner as well as his sweat shirt. The</p>			

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	<p>pillow fell to the floor while client #1 pulled harder at the material of the right arm of the recliner. Staff #2 indicated client #1 did not like sitting in the recliner and was trying to get up. Staff #1 and staff #2 did not provide client #1 with his communication device.</p> <p>__ During this observation period the television was on but client #1 did not show interest in watching it.</p> <p>__ At 6 PM staff #1 indicated client #1 enjoyed watching cartoons. The television was never turned to a cartoon station and/or client #1 was not asked what he wanted to watch on television.</p> <p>__ Throughout this observation period client #1 periodically made moaning and low grunting sounds.</p> <p>__ Throughout this observation period staff #1 and/or staff #2 did not offer client #1 his communication device.</p> <p>Client #1's record was reviewed on 2/20/15 at 12 PM.</p> <p>__ Client #1's 10/1/14 BSP (Behavior Support Plan) indicated "Avoid too much idle time, he needs a highly structured and consistent daily routine to keep focused and on task.... Due to his limited mobility a variety of stimulating activities should be easily available to [client #1] throughout the day.... When possible provide [client #1] with choices for meals, activities, etc. Encourage a variety</p>			

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	<p>of activities but only give a choice between two options at once. Too many options will likely cause confusion." __ Client #1's 9/23/14 ISP indicated "[Client #1] is reported as not being able to hear from either ear.... Does not speak. Vocalizes at times, yelling, screaming, grunting, laughs out loud and uses eye gaze to indicate his wants and desires." Client #1's ISP indicated "[Client #1] will improve his communication skills." The ISP indicated twice daily client #1 was to use a communication device to choose an activity to participate in.</p> <p>During interview with the RM (Residential Manager) on 2/20/15 at 12:30 PM, the RM: __ Indicated client #1's communication device was located on the book shelf in the living room. __ Stated the staff "should have" offered client #1 his communication device to choose an activity and/or used the device to assist client #1 in communicating his wants and needs.</p> <p>This deficiency was cited on 12/31/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p>			

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W 342 Bldg. 00	<p>483.460(c)(5)(iii) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on observation, interview and record review for 1 of 1 sample clients (#1), the facility nursing services failed to ensure all staff were trained and/or retrained in regard to client #1's dining needs and how client #1 was to be safely transferred from one surface to another.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/15 between 3:15 PM and 7:15 PM. During this observation period the following was observed: ___At 3:15 PM there was one direct care staff and the RM (Residential Manager) in the home with two clients. ___At 4 PM a second direct care staff arrived along with the facility's RN.</p>	W 342	<p>A PT/OT evaluation will be scheduled with specific instructions requested regarding how staff are to transfer him in and out of his wheelchair, the recliner, a straight chair, and the appropriate use of the supports/wedges and/or cushions used to support him in maintaining a good position while in his chair, the recliner, or in bed and while dining. Once the recommendations are received, all staff will receive training regarding the appropriate method for implementing all transfers and use of supports, wedges, cushions, and dining supports. The QDDP will then monitor staff three times weekly to insure appropriate implementation is occurring.</p>	03/27/2015

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	<p>__The RN indicated she was there to conduct a medication and a meal observation.</p> <p>__Client #1 was a non verbal frail thin elderly male with multiple contractures. Client #1 could no longer wear shoes because of his severe contractures that caused his feet to point toward the floor. Client #1 required a wheel chair for all mobility and total staff assistance to meet all of his needs and for all transfers from one surface to another.</p> <p>At 5:30 PM:</p> <p>__Staff #1 and #2 pushed client #1 in his wheelchair to his bedroom to change his adult brief.</p> <p>__Staff #1 placed one arm under client #1's neck and her other arm under client #1's knees and proceeded to scoop client #1 up out of his wheelchair doing a one person lift to transfer client #1 to his bed.</p> <p>__Staff #2 stopped staff #1 and stated, "Whoa, wait, what are you doing? That's not how we are supposed to transfer him."</p> <p>__Staff #1 stopped with client #1 half in and half out of his wheelchair with staff #1 holding/preventing client #1 from falling out of his wheel chair.</p> <p>__Staff #1 and staff #2 straightened client #1 back to a sitting position into his wheelchair.</p> <p>__Staff #2 then stood in front of client #1</p>			

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	<p>and stated, "This is how we do it." __ Staff #1 placed her arms under client #1's arm pits and lifted client #1 up out of his chair, turned him around and sat him down on his bed. __ Client #1's toes barely touched the floor. __ Staff #2 laid client #1 back onto his bed. __ Staff #1 stated, "That's not how I do it. I do it the other way." Staff #1 indicated she had been trained to care for client #1.</p> <p>At 6:45 PM: __ Client #1 was positioned at the dining room table for his evening meal. __ Staff #2 placed three large bowls of food on the table, one with mashed potatoes, one with pasta bake and another with fruit. __ Staff #1 placed large portions of the power mashed potatoes and pasta bake into a divided dish and slid the divided dish along with a large handled spoon over in front of client #1. __ Client #1 immediately picked up the spoon and took a large bite. __ Staff #2 stated, "Wait, no he (client #1) has to use the plate to plate method (placing one spoonful of food on client #1's plate at a time)." __ Staff #2 pulled client #1's plate back as staff #2 explained to staff #1 how to do the plate to plate method.</p>			

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	<p>__The facility's RN stated, "He (client #1) has a tendency to eat too fast. That's why we do the cup to cup and plate to plate method." The RN indicated all staff that worked in the home were to be trained on client #1's dining needs.</p> <p>__Staff #2 filled one of the two cups sitting next to client #1 with a pink liquid.</p> <p>__Staff #2 sat down between clients #1 and #2 while staff #1 sat on the other side of client #1.</p> <p>__After client #1 had taken several bites staff #2 stated, "You (staff #1) need to give him a drink."</p> <p>__Staff #1 picked up the full cup of juice and started to give it to client #1.</p> <p>__Staff #2 stopped staff #1 and stated, "No, you have to do the cup to cup method (pouring one swallow at a time of liquid in a cup and giving it to client #1).</p> <p>__Staff #1 was asked if she had received client specific training in regard to client #1's dining needs and the cup to cup/plate to plate method of assisting client #1. Staff #1 indicated she had been trained.</p> <p>During interview with the RM on 2/19/15 at 4 PM, the RM indicated staff #1 normally worked at the day program with client #1 and was filling in at the home. The RM indicated all staff were to be trained on client #1's plans and medical needs.</p>			

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W 436 Bldg. 00	<p>This deficiency was cited on 12/31/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview for 1 of 2 clients with adaptive equipment (#1), the facility failed to ensure:</p> <p>__ Client #1's wheel chair was maintained and in good repair.</p> <p>__ Client #1 was offered and/or provided elbow protectors.</p> <p>__ Client #1's knee pads were provided to the client and the knee pads were positioned correctly while the client was wearing them.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 2/19/15 between 3:15 PM</p>	W 436	<p>An appointment will be scheduled with National Seating and Mobility to have client #1's wheelchair evaluated for any needed updates or repairs. All needed updates and repairs will be completed and follow up appointments scheduled as recommended for ongoing appropriate wheelchair maintenance. The QDDP Designee will complete a checklist three times weekly verifying that the wheelchair is in good repair and will submit this report to the Director for review. All staff at the home will receive training regarding the appropriate use of Client</p>	03/27/2015
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	<p>and 7:15 PM.</p> <p>__ Client #1 was a frail thin elderly male with multiple contractures and required a wheel chair for mobility and staff assistance to meet all of his needs.</p> <p>__ At 3:15 PM client #1 was not wearing any knee pads and/or elbow pads.</p> <p>__ At 3:30 PM staff #1 was asked if client #1 was supposed to be wearing knee pads. Staff #1 physically felt client #1's knees and stated, "I guess he doesn't have them on. She (the night shift staff) must have forgotten to put them on him this morning." Staff #1 indicated she had arrived at work at 8 AM and client #1 was not provided his knee pads until 3:30 PM.</p> <p>__ Client #1 had several pairs of knee pads on his night stand.</p> <p>__ Throughout this observation period client #1's knee pads were above and/or below client #1's knees and not positioned on or between client #1's knees.</p> <p>__ The staff and the facility RN would reposition client #1's knee pads when asked if the pads were positioned correctly.</p> <p>__ Client #1's inner knees were red and callused where client #1's knees rubbed together due to the client's contractures.</p> <p>__ Throughout the observation period the staff did not offer client #1 his elbow pads and/or place the elbow pads on</p>		<p>#1's elbow protectors and knee pads. The QDDP-Designee will monitor the staff three times weekly to ensure they are implementing the use of the elbow protector and knee pads appropriately and will submit the results of this monitoring to the Director for review.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G729	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/25/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 4331 MELBOURNE RD INDIANAPOLIS, IN 46228
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	<p>client #1.</p> <p>Client #1's seat cushion of his wheelchair was worn and frayed and the arm rests were wrapped with a material similar to duct tape. The wrapping on the arm rests was torn and frayed and revealed the padding of the armrests. Rust was noted on a portion of the metal frame of the chair and the head rest was loose and not supportive of client #1's head.</p> <p>Client #1's record was reviewed on 2/20/15 at 12 PM.</p> <p>__ Client #1's IDT (Interdisciplinary Team) Case Conference note dated 11/10/14 indicated "9/2/14 staff noted 'Knotty areas on right arm and elbow.' They have resolved but continue to try and get him to wear elbow pads. Keep armrest wrapped...."</p> <p>During interview with the RM (Residential Manager) on 2/20/15 at 12:30 PM, the RM:</p> <p>__ Indicated client #1 picked at the arms of his wheel chair causing the wrapping to fray.</p> <p>__ Indicated she (the RM) had purchased more material to wrap client #1's armrests of his wheelchair and stated, "But with the weather and everything, I haven't been able to get it done."</p> <p>__ Stated, "I've come in here and cleaned</p>			
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	<p>his chair myself and then a few minutes later it looks like I hadn't even touched it."</p> <p>__ Indicated client #1 needed a new seat cushion.</p> <p>__ Indicated the facility was still waiting on the funding to come through to get client #1 a new wheelchair.</p> <p>During interview with the facility's RN on 2/19/15 at 6 PM, the RN:</p> <p>__ Indicated the staff were to prompt client #1 to wear his elbow pads and stated, "But he doesn't like to wear them."</p> <p>__ Indicated the staff were to ensure client #1's knee pads were correctly positioned throughout the day and stated, "He (client #1) pulls them down or up and doesn't leave them in place."</p> <p>This deficiency was cited on 12/31/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-7(a)</p>			