STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G794	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	9110 N CR 700 W SCIPIO, IN 47273

(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	This visit was for an extended annual recertification and state licensure survey. Survey dates: May 14, 15, 20, 21, 22 and 26, 2015 Facility number: 012529 Provider number: 15G794 AIM number: 201017530 These deficiencies also reflect state findings in accordance with 460 IAC 9.	W 0000		
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 on observation and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the governing body failed to exercise operating direction over the facility by failing to ensure 1) the walls in the common areas were free of scuffs, stains, marks and discoloration and a chair in the living room was in good condition, 2) the staff sanitized the hand washed dishes after dinner and 3) the Qualified Intellectual Disabilities Professional (QIDP) integrated,	W 0104	**W 104** Governing Body: Scuffed walls, sanitizing hand-washed dishes, and QIDP role. **Corrective action for resident(s) found to have been affected** The walls of the home will be painted. Most dishes in the home are cleaned in the dishwasher. When dishes are hand-washed, Steramine Sanitize Tablets will be used (tablets to be purchased and material safety data sheets – MSDS - appropriately	06/25/2015

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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	coordinated and monitored the clients' program plans. Findings include: 1) Observations were conducted at the group home on 5/14/15 from 3:29 PM to 5:48 PM and 5/20/15 from 6:39 AM to 9:03 AM. During the observations, the walls in the common areas of the group home (kitchen, living room, dining room and hallways) were marked, stained, scuffed and discolored. A chair in the living room had peeling upholstery. There was writing on the chair in the areas where the upholstery was missing. The floor in front of the chair was covered with pieces of the upholstery that had fallen off. This affected clients #1, #2, #3 and #4. On 5/14/15 at 5:01 PM, the Program Manager (PM) stated, regarding the chair, "it definitely needs to go, looks terrible." On 5/20/15 at 11:19 AM, the Program Coordinator (PC) indicated the chair needed to be replaced. The PC indicated the chair was usually covered up but he noted last month that it needed to be replaced. On 5/20/15 at 11:21 AM, the PC indicated the common areas of the group home needed to be repainted.		filed). The facility Behavior Clinician (BC), who has an MS in Clinical Psychology and over 30 years' experience with people with ID, will assume the role of QIDP. He is active on the team, including participating in all meetings, and he spends significant time in both the home and day program. A procedure will be put in place to document his time monitoring plans. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in place to ensure no recurrence** Walls painted, sanitizing tablets for hand-washed dishes, and the BC will assume QIDP role. **How corrective actions will be monitored to ensure no recurrence** The manager is responsible for ensuring home upkeep and keeping supplies on hand. That includes both painting and maintaining supply of sanitizing tablets. The BC will be responsible for monitoring programs as the QIDP. Both the manager and BC report to the director, and they meet regularly.	

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	2) An observation was conducted at the group home on 5/14/15 from 3:29 PM to 5:48 PM. At 5:32 PM while clients #1, #2, #3 and #4 ate their dinner, staff #8 hand washed pots and pans used in the preparation of the food. Staff #8 did not use a bleach water solution after washing the dishes to sanitize the pots and pans. Staff #8 hand washed the pots and pans and placed them onto a drying rack. This affected clients #1, #2, #3 and #4. On 5/20/15 at 11:22 AM, the PC indicated there was no procedure in place to sanitize the hand washed dishes. The PC indicated all the dishes needed to be washed in the dishwasher. On 5/20/15 at 11:22 AM, the nurse indicated there was no procedure in place to sanitize the hand washed dishes. The nurse indicated the staff was trained in Core A and B to use hot, soapy water to wash and hot water to rinse the dishes. The nurse indicated there was no information given to the staff to sanitize the dishes using a bleach water solution. 3) Please refer to W159. For 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility's governing body failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the			

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	clients' program plans. 9-3-1(a)			
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review for 6 of 46 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its policies and procedures to prevent client to client abuse. The facility failed to implement its policies and procedures to prevent Pica (ingesting non-nutritive substances). The facility failed to ensure the results of an investigation were submitted to the administrator within 5 working days. The facility failed to conduct an investigation into client to client abuse. Findings include: 1) Please refer to W149. For 6 of 46 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility neglected to implement its policies and procedures to prevent client to client abuse and Pica (ingesting	W 0122	**W 122** Client Protections (Condition): Preventing client-to-client abuse and pica, completing investigation within five working days, and conducting investigation of peer abuse.**Corrective action for resident(s) found to have been affected** In order to prevent client-to-client abuse, a competency-based training will be conducted across staff that outlines the issue and the requirement to prevent it. Similarly, a competency-based training will be conducted across staff members on preventing pica. The manager will receive training by the director on the requirement by both policy and regulation to conduct investigations for all peer incidents and that they must be completed within five working days of the incident. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or**	06/25/2015

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	non-nutritive substances), submit the results of an investigation to the administrator within 5 working days and conduct an investigation of client to client abuse. 2) Please refer to W154. For 1 of 46 incident/investigative reports reviewed affecting clients #3 and #4, the facility failed to conduct an investigation of client to client abuse. 3) Please refer to W156. For 1 of 46 incident/investigative reports reviewed affecting client #1, the facility failed to report the results of an investigation to the administrator within 5 working days. 9-3-2(a)		**systemic changes facility put in place to ensure no recurrence** Competency-based training for prevention of both peer-to-peer abuse and pica and manager training on investigation requirements. In addition, a tracking form will be put in place to ensure that all incidents that require investigations are properly investigated. **How corrective actions will be monitored to ensure no recurrence** The BC and managers train staff members with the BC taking the lead on behavior-related training. The director is responsible to train the manager. They all are supervised by the director who will ensure that these trainings occur.	
W 0124 Bldg. 00	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Based on record review and interview for 1 of 2 clients in the sample (#4), the facility failed to offer client #4 and her guardian information regarding acceptable alternatives to taking her	W 0124	**W 124** Protection of Client Rights: One client in the home had repeated medication refusals. **Corrective action for resident(s) found to have been affected** In order to provide	06/25/2015

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	medication including providing information of the attendant risks of any recommended treatments or interventions and of her right to refuse treatment, training or services. Findings include: On 5/20/15 at 1:47 PM, a review of client #4's Health Care Coordination (HCC) notes was conducted. The HCC notes indicated client #4 refused to take her medications on the following dates: On 5/19/15 at 6:00 PM and 8:00 PM. On 5/18/15 at 8:00 AM and 2:00 PM. On 5/17/15 at 8:00 PM. On 5/13/15 at 8:00 AM. On 5/12/15 at 2:00 PM and 8:00 PM. On 3/5/15 at 8:00 AM and 12:00 PM. On 1/12/15 at 8:00 PM. On 1/4/15 refused meds all day. On 12/5/14 staff report 8:00 PM and 10:00 PM. On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's most recent Comprehensive Functional Assessment was conducted on 10/1/14. The Decision Making/Critical Skills Assessment section indicated, "Understands the reason for his/her prescribed medication- Seldom." The assessment did not address medication refusals. There was no documentation client #4's refusals to take her medications was reassessed since 10/1/14. There was no documentation in client #4's record indicating the facility offered information about acceptable alternatives to her treatment. There was no documentation the client's preferences about alternatives was elicited and considered in deciding on the course of treatment.		adequate information to the client and her guardian, the Behavior Clinician will generate a list of risks and benefits of taking psychotropic medication. Whenever the client refuses, the staff members should use the entire window of time to get the medication administered. If that fails, staff will call the on-call manager. Usually refusals occur when the client is agitated/escalated, so it is not considered a positive to address the issue with her at that time. Within a week, the manager who took the call will review with the list with the client, sign and date the list, then fax/email to the guardian. **How facility will identify other residents potentially affected & what measures taken** Housemates do not have similar pattern of medication refusal, so it only applies to the one client. **Measures or systemic changes facility put in place to ensure no recurrence** Risk/benefit list generated, reviewed with client, and faxed/emailed to guardian. **How corrective actions will be monitored to ensure no recurrence** The BC will generate the list, which will be distributed to all managers who participate in the on-call rotation. Those managers will review, as needed, with the client when she is calm within one week of the incident. The director supervises both the BC and the managers and will	

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	Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had the following targeted behaviors: physical aggression (defined as punching, biting, kicking or hitting another person with the potential to cause harm to that person or attempting to do so), elopement (defined as leaving a designated area without notifying her staff and walking out of their line of sight at a distance where staff is unable to safely supervise her), self-injurious behavior (defined as making threats to harm herself by banging her head or any other self-inflicted act that threatens her own physical safety), Pica (defined as eating, chewing, or placing inedible objects into her mouth) and inappropriate sexual behavior (defined as taking/tearing her clothing off and threatening to accuse staff of raping her, attempting to or touching her genitals and attempting to wipe any secretions on staff and/or attempting to touch or grope staff or others in a sexual way). The BSP indicated, "...She had a history of refusing to participate in scheduled activities and her medications, often stating 'It is my right to refuse.' In order to maximize consistency and structure within [client #4's] environment, the following criteria have been established: The daily schedule consists of those activities that are routine, such as medication times, hygiene, home maintenance, work or day program (if applicable), meals, and scheduled recreation activities. Other tasks or choices of activities are not considered part of the daily schedule and should not count against her. [Client #4] should be given 1 prompt, for each task in the schedule. This should not be a threat, but simply a reminder that she needs to participate if she wants to earn his (sic) soda at the end of the day." The BSP did not include a targeted behavior of refusing to take her medications. Client #4's Individual Support Plan (ISP), dated		ensure that these actions take place.	

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	10/1/14, indicated client #4 had a training objective to take her medications at their prescribed time. The ISP indicated, in part, "[Client #4] requires staff's assistance with medication administration and is not able to complete this task safely, as she will attempt to overdose herself, she often refuses to take her medications and will say things like 'I ma (sic) not taking my seizure meds so that I can have lots of seizures and die,' staff are to continue to offer the medications until the allotted time limit." On 5/21/15 at 11:09 AM, the Program Coordinator (PC) stated client #4's medication refusals were "usually due to behavior." The PC stated there was "not necessarily a plan." The PC indicated client #4's medication refusals were a recent issue. The PC stated "she may need one (a plan)." The PC stated, "there's a pattern of refusals." On 5/21/15 at 1:05 PM, the Behavior Clinician (BC) indicated client #4 used to have an informal plan the nurse implemented with her for taking her medications. The BC indicated the nurse was not implementing the plan anymore. The BC indicated client #4 taking her medications was part of her reward system. The BC indicated client #4 was expected to follow her routine including taking her medications. The BC stated he "could add (medication refusals) as a targeted behavior." The BC indicated he did not have a count of the number of times client #4 had refused her medications. The BC indicated client #4's interdisciplinary team did not feel medication refusals needed to be addressed more than how they were addressing them currently. The BC indicated the staff prompt according to the schedule. Client #4 had an incentive plan. The BC indicated client #4 knew the consequences of medication refusals. The BC indicated the			

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	psychiatrist spoke to client #4 about taking her medications. On 5/21/15 at 1:29 PM, the nurse indicated client #4's medication refusals was a behavior issue. The nurse indicated the staff give her three prompts and then the doctor was notified when she refused her medications. The nurse indicated the nurse tell client #4 the consequences of not taking her medications. The nurse indicated client #4's doctors tell client #4 to take her medications. The nurse indicated client #4 had a right to refuse her medications. The nurse indicated client #4 did not have a plan to address medication refusals but the staff follow the facility's policy (three prompts and notified physician). The nurse stated, "might need to address in a health care plan." The nurse indicated she had an informal plan of fixing client #4 lettuce wraps if client #4 went 30 days with no medication refusals. The nurse indicated she fixed client #4 lettuce wraps one time when she met 30 days with no refusals. The nurse indicated her plan was informal and not a written plan. The nurse stated it was a "verbal nursing plan." 9-3-2(a)			
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on record review and interview for 1 of 2 clients in the sample (#4), the	W 0125	**W 125** Protection of Clients Rights: Restriction/removal of	06/25/2015

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	facility failed to ensure client #4 had the right to due process in regard to the staff removing her shoes during a behavioral incident. Findings include: On 5/14/15 at 1:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/3/15, client #4 reported to the Manager she had been physically abused by staff. In her initial report, client #4 reported staff #4 and staff #11 pulled her off of her bed by her feet causing her to hit her head on the floor. Client #4 reported the staff also covered her with a blanket. The investigation, dated 4/8/15, indicated the allegation was not substantiated. The investigation indicated, "Follow-up: Concern about why shoes were restricted. BC (Behavior Clinician) confirmed that they should not have been and he has since reviewed restrictions with staff while specifically citing this incident. The training focused on avoiding power struggles." An email in the investigation from the Director to the Program Coordinator and the BC, dated 4/21/15 at 8:00 AM, indicated, "Please review the statements		shoes **Corrective action for resident(s) found to have been affected** Although there are instances in the client's plan where shoes with laces need to be removed, that did not apply to the incident reviewed in the citation. The BC will review the restriction with staff to ensure that they understand the restriction and do not restrict items that the IDT has not recommended and that the HRC has not approved. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Training on shoe restriction. **How corrective actions will be monitored to ensure no recurrence** The BC and managers train staff members with the BC taking the lead on behavior-related training. They all are supervised by the director who will ensure that these trainings occur.	

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	associated with this abuse allegation. Also attached is [client #4's] BSP (behavior support plan). I don't see why staff were requesting that she take off her shoes. She does not have a restriction to not wear shoes in her bedroom. If staff told her that they were going to remove them if she wouldn't, it starts to make sense that she would feel her rights were being violated. I realize she is a handful, but this incident probably would have been avoided altogether if they had not initiated that power struggle. If it's not in the plan, it should not be restricted. Given that it was in all the statements and the behavior report as the cause of the issue, this should have been part of the investigation and addressed at the time rather than just looking to see that they denied abuse. This would have gone under the heading of 'Were additional allegations/concerns raised as a result of the investigation process?' Here are a couple of questions: 1) Am I reading this wrong about shoe restriction in the bedroom? 2) If this is an issue, how do you propose we resolve it?" An email from the BC to the Director and Program Coordinator, dated 4/21/15 at 8:16 AM, indicated, "[Name of Director], You are right that there is no restriction about her wearing shoes in her room. The restriction is about storing items with			

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	strings, etc. including shoes, in her room due to her history of tying things around her neck. During staff training on Thursday I briefly revisited my training on power struggles and specifically addressed this incident as an example of what not to do. I emphasized that since she is 1:1 (one on one staffing) when awake all they had to do was monitor her for her safety and may have avoided the restraints etc...." On 5/20/15 at 12:02 PM, a review of client #4's record was conducted. Client #4's 1/1/15 BSP indicated in the BSP Addendum 1: Specific Restrictions section, "[Client #4's] shoes generally do not have shoestrings. This should continue because she sometimes wraps things around her neck as a suicidal gesture/attempt. If she has shoes with shoestrings, the shoes will be kept in a secure location when not being worn." There was no documentation in client #4's BSP indicating staff should remove her shoes during a behavioral incident. On 5/14/15 at 2:48 PM, the BC stated, "Staff overstepped their bounds." The BC indicated there was no plan for staff to remove her shoes. On 5/14/15 at 2:52 PM, the BC indicated there was a restriction to not store her shoes in her room due to strings.			

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	On 5/14/15 at 2:56 PM, the Program Coordinator indicated it was a rights restriction to take away her shoes. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS 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 6 of 46 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the facility neglected to implement its policies and procedures to prevent client to client abuse and Pica (ingesting non-nutritive substances), submit the results of an investigation to the administrator within 5 working days and conduct an investigation of client to client abuse. Findings include: On 5/14/15 at 1:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:	W 0149	**W 149** Staff Treatment of Clients: Prevention of client-to-client abuse & pica, all investigations completed within five working days, and conducting investigation of peer abuse. **Corrective action for resident(s) found to have been affected**In order to prevent client-to-client abuse, a competency-based training will be conducted across staff that outlines the issue and the requirement to prevent it. Similarly, a competency-based training will be conducted across staff members on preventing pica. The manager will receive training by the director on the requirement by both policy and regulation to conduct investigations for all peer incidents and that they must be completed within five working days of the incident. **How facility will identify other residents potentially affected &**	06/25/2015

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	1) On 2/18/15 at 5:25 PM, client #4 asked staff if she could get a magazine from the television stand. As she was walking over she reached over and hit client #2 on the head. Client #2 was not injured. The investigation, dated 2/20/15, indicated the facility substantiated abuse. The Recommendations indicated, "Staff have been retrained during 2/19 staff meeting over proper spacing between clients and staff positioning." On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of client #4 physically punching, biting, kicking or hitting another person with the potential to cause harm to that person or attempting to do so). The BSP indicated, in part, "Immediately tell [client #4] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at all times...." On 5/14/15 at 3:01 PM, the Residential Manager (RM) indicated client to client aggression was abuse and the facility should prevent abuse. The RM indicated the facility had a policy and procedure prohibiting abuse of the clients.		**what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients.**Measures or systemic changes facility put in place to ensure no recurrence** Competency-based training for prevention of both peer-to-peer abuse and pica and manager training on investigation requirements. In addition, a tracking form will be put in place to ensure that all incidents that require investigations are properly investigated. **How corrective actions will be monitored to ensure no recurrence** The BC and managers train staff members with the BC taking the lead on behavior-related training. Manager is supervised by the director. All managers and the BC are supervised by the director who will ensure that these trainings occur.	

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	2) On 2/21/15 at 7:15 PM, client #3 cursed at a peer and then jumped up and ran toward the peer. Client #1 stepped in to defend the peer. Client #3 scratched, hit, kicked and hit client #1 on the top of her head. Client #1 hit and kicked client #3. The Bureau of Developmental Disabilities Services incident report, dated 2/22/15, indicated, "Staff acted as quickly as possible to separate clients according to their plans." Neither client was injured. The investigation, dated 2/25/15, indicated the facility substantiated abuse. On 5/20/15 at 11:03 AM, a review of client #1's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated, in part, "Immediately tell [client #1] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at all times...." On 5/20/15 at 11:07 AM, a review of client #3's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of			

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	physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated, in part, "Immediately tell [client #3] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety all all times...." On 5/14/15 at 3:01 PM, the Residential Manager (RM) indicated client to client aggression was abuse and the facility should prevent abuse. The RM indicated the facility had a policy and procedure prohibiting abuse of the clients. 3) On 4/1/15 at 3:30 PM, the group home management staff received a fax from client #1's work supervisor. Client #1 was employed at a local nursing home in the housekeeping department. The group home provided a staff while client #1 was at work to help coach her in completing her job duties. In the fax, the housekeeping manager reported that staff #1 had yelled at client #1 on several occasions regarding her job. According to the manager, staff #1 also commented to her that she did not know how client #1 still had a job because she was slow and that staff #1 would like to "knock her in the head because she is slow and needs constant attention." It was also reported staff #1 used the "F word" in the hallways			

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	on several occasions. The investigation results were signed by the administrator on 4/13/15. The facility unsubstantiated the allegation based on the administrator's interview with the work supervisor who indicated staff #1 was "definitely not abusive" as indicated in the investigation. On 5/14/15 at 3:01 PM, the Residential Manager (RM) indicated the results of investigations should be sent to the administrator within 5 working days. 4) On 5/2/15 at 7:00 AM, client #4 exited her room during shift change. Client #4 darted across the room and grabbed the remote control. Staff attempted to remove the remote from her possession. Client #4 was able to take the back off and swallow one of the batteries before staff was able to get her to release it. She was transported to the hospital but not admitted. She was to return for follow up in 3 days if the battery had not passed through her bowels. On 5/20/15 at 1:47 PM, a review of client #4's May 2015 Health Care Coordination note indicated, in part, "5-2-15 Pica AA battery this morning, to [initials of hospital]. To monitor BM's for passage.			

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	Behaviors continue for 3.5 hours... 5-11-15 passed battery after nurse left. No rectal bleeding or discomfort reported." On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had a targeted behavior of Pica (defined as eating, chewing, or placing inedible objects into her mouth). The BSP indicated, "[Client #4] has one-to-one supervision during waking hours and 15 minute checks when she is asleep in order to monitor her... Consistent with [client #4's] approved-BSP, there are two room sweeps per shift. The [former name of facility] procedure for room sweeps is separate from this BSP Summary. It is intended to keep the environment clear of items this (sic) might be ingested...." The BSP Addendum 1: Specific Restrictions indicated, "[Client #4] engages in some behavior that is dangerous to her. This includes Pica (she had swallowed items that had to be surgically removed)... Increased scrutiny on restricting small items. [Client #4] has a history of swallowing small objects. We cannot remove everything from her and do not want to. On the other hand, we need to try to keep her safe. Staff will be more vigilant and will be asked to try to be			

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	proactive and keep small items from her possession. All battery operated devices, e.g. (that is) remote controls, CD players, etc. (unless the battery compartments require a screw be removed in order to open it) will be kept in a secure location when not in use. Staff will maintain possession of remote controls during use. The use of any other battery operated items will be supervised by staff and they must be in a position to observe [client #4] and the device during its use. This device will be returned to the secure location when done...." On 5/14/15 at 3:01 PM, the Program Coordinator (PC) indicated the staff should implement the client's program plan as written. On 5/20/15 at 11:22 AM, the PC indicated the remote control was supposed to be locked up and it was not locked up. The PC indicated the staff failed to follow the plan as written. The PC stated the plan had been in place "for some time." The PC indicated there was a sheet to track the location of the remotes during shift change. The PC indicated he taped the battery compartment since the incident. The PC indicated he was not sure if the incident was investigated. The PC indicated he was sure the incident was not investigated as neglect (staff failing to implement her plan as written).			

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	On 5/14/15 at 2:48 PM, the Behavior Clinician (BC) indicated the staff left the remote in the living room or the counter. He was not sure where the remote was located. The BC indicated client #4 noticed the remote around shift change. The BC indicated the staff did not put the remote away and she swallowed a battery from the remote. The BC stated it was "staff error for not following the restriction." The BC indicated the staff failed to implement the plan as written. 5) On 5/7/15 at 5:00 PM, client #4 spoke inappropriately about client #3's family member being deceased. Client #3 lunged at client #4. Client #4 grabbed client #3 hair. Neither client was injured. On 5/14/15 at 2:58 PM, the RM stated, "I don't believe I have all the information together for that one." The RM indicated he was aware on 5/14/15 that it was day 5 and needed to complete the investigation. The facility did not provide documentation indicating an investigation was conducted. On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined			

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	as any instance of [client #4] physically punching, biting, kicking or hitting another person with the potential to cause harm to that person or attempting to do so). The BSP indicated, in part, "Immediately tell [client #4] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at all times...." On 5/14/15 at 3:01 PM, the Residential Manager (RM) indicated client to client aggression was abuse and the facility should prevent abuse. The RM indicated the facility had a policy and procedure prohibiting abuse of the clients. 6) Observations were conducted at the group home on 5/14/15 from 3:29 PM to 5:48 PM and 5/20/15 from 6:39 AM to 9:03 AM. During the observations, client #3's right forearm had a 4 inch by 4 inch bruise (black, brown, green and yellow). During the observations, client #1 had a bruise on her right eye. On 5/14/15 at 3:57 PM, the Manager indicated client #1's black eye was from a client to client incident with client #3. On 5/14/15 at 4:07 PM, client #3 indicated the bruise on her forearm was from a bite from client #1. Client #3 indicated she bit client #1 during the			

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	incident as well. On 5/9/15 at 7:00 PM, the BDDS report, dated 5/10/15, indicated, "On 5-9-15 at 7pm [client #3] became upset at house mate for making inappropriate comments. Without warning [client #3] went toward house mate (sic) staff blocked attempt. As staff blocked attempt without warning [client #1] came up and hit [client #3] in (sic) head and bit [client #3] rite (sic) forearm. [Client #3] then hit [client #1] in rite (sic) eye staff separated [clients #1 and #3] from each other.... [Client #1] then went to her room and attempted to elope out bedroom window staff blocked attempt. [Client #1] then attempted to hit and kick staff attempts were blocked [client #1] started crying and then calmed down." The Plan to Resolve section indicated, "Both [client #1] and [client #3] were checked for injuries (sic) [client #3] had red area on rite (sic) forearm from bite (sic) [client #1] had redness to rite (sic) eye...." On 5/20/15 at 11:03 AM, a review of client #1's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated,			

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	in part, "Immediately tell [client #1] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at all times...." On 5/20/15 at 11:07 AM, a review of client #3's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated, in part, "Immediately tell [client #3] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety all all times...." On 5/14/15 at 3:01 PM, the Residential Manager (RM) indicated client to client aggression was abuse and the facility should prevent abuse. The RM indicated the facility had a policy and procedure prohibiting abuse of the clients. A review of the facility's Group Home Abuse and Neglect policy, dated 12/5/12, was conducted on 5/14/15 at 3:12 PM. The policy indicated, in part, "[Former name of facility] does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse.			

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	Physical abuse is any action that could lead to bodily harm, including corporal punishment, like spanking or hitting or pinching. Verbal abuse is speaking, writing or gesturing in a derogatory manner to a client or in proximity of a client. 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 failure to provide appropriate care, food, medical care or supervision. Exploitation includes any deliberate misplacement of individual's money, wrongful use of an individual's money or belongings. If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the AWS Residential Director. If an AWS employee is accused of abuse or neglect they will be sent home without pay until a preliminary investigation is completed and appropriate safeguards are put into place. If the charges are substantiated disciplinary action will be taken which may include termination. Results of the investigation must be reported within 5 days. All corrective action will be written and disseminated to the appropriate entities." 9-3-2(a)			

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W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 46 incident/investigative reports reviewed affecting clients #3 and #4, the facility failed to conduct an investigation of client to client abuse. Findings include: On 5/14/15 at 1:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 5/7/15 at 5:00 PM, client #4 spoke inappropriately about client #3's family member being deceased. Client #3 lunged at client #4. Client #4 grabbed client #3 hair. Neither client was injured. On 5/14/15 at 2:58 PM, the Residential Manager (RM) stated, "I don't believe I have all the information together for that one." The RM indicated he was aware on 5/14/15 that it was day 5 and needed to complete the investigation. The facility	W 0154	**W 154** Staff Treatment of Clients: Peer abuse investigation requirement. **Corrective action for resident(s) found to have been affected** The manager will receive training by the director on the requirement by both policy and regulation to conduct investigations for all peer incidents and that they must be completed within five working days of the incident. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Manager training on investigation requirements and a tracking form will be put in place to ensure that all incidents that require investigations are properly investigated. **How corrective actions will be monitored to ensure no recurrence** The manager is supervised by the	06/25/2015

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	did not provide documentation indicating an investigation was conducted. 9-3-2(a)		director, and they meet regularly. The director is responsible to train the manager and will ensure that this training occurs.	
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 46 incident/investigative reports reviewed affecting client #1, the facility failed to report the results of an investigation to the administrator within 5 working days. Findings include: On 5/14/15 at 1:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 4/1/15 at 3:30 PM, the group home management staff received a fax from client #1's work supervisor. Client #1 was employed at a local nursing home in the housekeeping department. The group home provided a staff while	W 0156	**W 156** Staff Treatment of Clients: All investigation completed within 5 working days .**Corrective action for resident(s) found to have been affected** The manager will receive training by the director on the requirement by both policy and regulation to conduct investigations for all peer incidents and that they must be completed within five working days of the incident. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Manager training on	06/25/2015

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	client #1 was at work to help coach her in completing her job duties. In the fax, the housekeeping manager reported that staff #1 had yelled at client #1 on several occasions regarding her job. According to the manager, staff #1 also commented to her that she did not know how client #1 still had a job because she was slow and that staff #1 would like to "knock her in the head because she is slow and needs constant attention." It was also reported staff #1 used the "F word" in the hallways on several occasions. The investigation results were signed by the administrator on 4/13/15. The facility unsubstantiated the allegation based on the administrator's interview with the work supervisor who indicated staff #1 was "definitely not abusive" as indicated in the investigation. On 5/14/15 at 3:01 PM, the Residential Manager (RM) indicated the results of investigations should be sent to the administrator within 5 working days. 9-3-2(a)		investigation requirements and a tracking form will be put in place to ensure that all incidents that require investigations are properly investigated. **How corrective actions will be monitored to ensure no recurrence** The manager is supervised by the director, and they meet regularly. The director is responsible to train the manager and will ensure that this training occurs.	
W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must			

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	be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans. Findings include: 1. Please refer to W104. For 4 of 4 clients living in the group home (#1, #2, #3 and #4), the QIDP failed to ensure: 1) the walls in the common areas were free of scuffs, stains, marks and discoloration and a chair in the living room was in good condition, 2) the staff sanitized the hand washed dishes after dinner and 3) the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored the clients' program plans. 2. Please refer to W124. For 1 of 2 clients in the sample (#4), the QIDP failed to offer client #4 and her guardian information regarding acceptable alternatives to taking her medication including providing information of the attendant risks of any recommended treatments or interventions and of her right to refuse treatment, training or	W 0159	**W 159** Qualified Mental Retardation Professional (QMRP). **Corrective action for resident(s) found to have been affected** The facility Behavior Clinician (BC), who has an MS in Clinical Psychology and over 30 years' experience with people with ID, will assume the role of QIDP. He is active on the team, including participating in all meetings, and he spends significant time in both the home and day program. A procedure will be put in place to document his time monitoring all plans. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** The BC will assume the facility QIDP role. **How corrective actions will be monitored to ensure no recurrence** The BC will be responsible for monitoring programs as the QIDP. The BC reports to the director, and they meet regularly.	06/25/2015

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	services. 3. Please refer to W149. For 6 of 46 incident/investigative reports reviewed affecting clients #1, #2, #3 and #4, the QIDP failed to implement its policies and procedures to prevent client to client abuse and Pica (ingesting non-nutritive substances), submit the results of an investigation to the administrator within 5 working days and conduct an investigation of client to client abuse. 4. Please refer to W227. For 1 of 2 clients in the sample (#4), the QIDP failed to develop a program plan to address client #4's refusals to take her medications. 5. Please refer to W249. For 4 of 4 clients living in the group home (#1, #2, #3 and #4), the QIDP failed to ensure the staff implemented the clients' behavior plans as written to prevent client to client aggression and Pica (ingesting non-nutritive substances). 6. Please refer to W356. For 1 of 2 clients in the sample (#3), the QIDP failed to ensure client #3 returned to the dentist to have a filling. 7. Please refer to W440. For 4 of 4 clients living in the group home (#1, #2, #3 and #4), the QIDP failed to ensure staff conducted quarterly evacuation drills for each shift. 8. Please refer to W488. For 4 of 4 clients living in the group home (#1, #2, #3 and #4), the QIDP failed to ensure the clients were involved with preparing meals. 9. On 5/21/15 at 10:34 AM, the QIDP (Director) indicated in an email, "I am the QIDP at the facility, and [name of Program Coordinator] is the			

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	QIDPd (designee). He and I are in close contact on continuous basis. That includes face to face contact most Wednesdays in [name of city] as well as our regular IDT (interdisciplinary team) meeting via conference call to discuss incidents on Mondays. The Wednesday meetings include an agenda that is documented. I can provide those if needed. The IDT meetings are documented as well and are in client files. Periodically I also go to the homes, and I also see the clients participating in day program. I do not keep a special log of those interactions and am unaware of the regulation requiring that. If I need to begin that practice, I can do that. I was just unaware it was a requirement." The QIDP's email was in response to questions from the surveyor, "[Name of Director], you are listed as the QIDP on the form we give out for each survey. Do you have documentation of the amount of time you spent at [name of group home], on site, for the past 6 months? If so, please email the documentation to me. Do you have documentation of observations being conducted at the facility-operated day program to ensure the staff implemented the clients ' program plans consistently across the two environments? If so, please email the documentation to me." The QIDP did not provide documentation of the observations he conducted at the group home and the facility-operated day program. There was no documentation provided indicating the QIDPd (designee) completed observations at the group home and the facility-operated day program. 9-3-3(a)			
W 0227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN			

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Bldg. 00	The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 2 clients in the sample (#4), the facility failed to develop a program plan to address client #4's refusals to take her medications. Findings include: On 5/20/15 at 1:47 PM, a review of client #4's Health Care Coordination (HCC) notes was conducted. The HCC notes indicated client #4 refused to take her medications on the following dates: On 5/19/15 at 6:00 PM and 8:00 PM. On 5/18/15 at 8:00 AM and 2:00 PM. On 5/17/15 at 8:00 PM. On 5/13/15 at 8:00 AM. On 5/12/15 at 2:00 PM and 8:00 PM. On 3/5/15 at 8:00 AM and 12:00 PM. On 1/12/15 at 8:00 PM. On 1/4/15 refused meds all day. On 12/5/14 staff report 8:00 PM and 10:00 PM. On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had the following targeted behaviors: physical aggression (defined as punching, biting, kicking or	W 0227	**W 227** Individual Program Plan: Plan addressing medication refusals. **Corrective action for resident(s) found to have been affected** In order to provide adequate information to the client and her guardian, the Behavior Clinician will generate a list of risks and benefits of taking psychotropic medication. Whenever the client refuses, the staff members should use the entire window of time to get the medication administered. If that fails, staff will call the on-call manager. Usually refusals occur when the client is agitated/escalated, so it is not considered a positive to address the issue with her at that time. Within a week, the manager who took the call will review with the list with the client, sign and date the list, then fax/email to the guardian. **How facility will identify other residents potentially affected & what measures taken** Housemates do not have similar pattern of medication refusal, so it only applies to the one client. **Measures or systemic changes facility put in place to ensure no recurrence** Risk/benefit list generated, reviewed with client, and faxed/emailed to guardian. **How corrective actions will be**	06/25/2015

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	hitting another person with the potential to cause harm to that person or attempting to do so), elopement (defined as leaving a designated area without notifying her staff and walking out of their line of sight at a distance where staff is unable to safely supervise her), self-injurious behavior (defined as making threats to harm herself by banging her head or any other self-inflicted act that threatens her own physical safety), Pica (defined as eating, chewing, or placing inedible objects into her mouth) and inappropriate sexual behavior (defined as taking/tearing her clothing off and threatening to accuse staff of raping her, attempting to or touching her genitals and attempting to wipe any secretions on staff and/or attempting to touch or grope staff or others in a sexual way). The BSP indicated, "...She had a history of refusing to participate in scheduled activities and her medications, often stating 'It is my right to refuse.' In order to maximize consistency and structure within [client #4's] environment, the following criteria have been established: The daily schedule consists of those activities that are routine, such as medication times, hygiene, home maintenance, work or day program (if applicable), meals, and scheduled recreation activities. Other tasks or		**monitored to ensure no recurrence** The BC will generate the list, which will be distributed to all managers who participate in the on-call rotation. Those managers will review, as needed, with the client when she is calm within one week of the incident. The director supervises both the BC and the managers and will ensure that these actions take place.	

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	choices of activities are not considered part of the daily schedule and should not count against her. [Client #4] should be given 1 prompt, for each task in the schedule. This should not be a threat, but simply a reminder that she needs to participate if she wants to earn his (sic) soda at the end of the day." The BSP did not include a targeted behavior of refusing to take her medications. Client #4's Individual Support Plan (ISP), dated 10/1/14, indicated client #4 had a training objective to take her medications at their prescribed time. The ISP indicated, in part, "[Client #4] requires staff's assistance with medication administration and is not able to complete this task safely, as she will attempt to overdose herself, she often refuses to take her medications and will say things like 'I ma (sic) not taking my seizure meds so that I can have lots of seizures and die,' staff are to continue to offer the medications until the allotted time limit." On 5/21/15 at 11:09 AM, the Program Coordinator (PC) stated client #4's medication refusals were "usually due to behavior." The PC stated there was "not necessarily a plan." The PC indicated client #4's medication refusals were a recent issue. The PC stated "she may			

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	need one (a plan)." The PC stated, "there's a pattern of refusals." On 5/21/15 at 1:05 PM, the Behavior Clinician (BC) indicated client #4 used to have an informal plan the nurse implemented with her for taking her medications. The BC indicated the nurse was not implementing the plan anymore. The BC indicated client #4 taking her medications was part of her reward system. The BC indicated client #4 was expected to follow her routine including taking her medications. The BC stated he "could add (medication refusals) as a targeted behavior. The BC indicated he did not have a count of the number of times client #4 had refused her medications. The BC indicated client #4's interdisciplinary team did not feel medication refusals needed to be addressed more than how they were addressing them currently. The BC indicated the staff prompt according to the schedule. Client #4 had an incentive plan. The BC indicated client #4 knew the consequences of medication refusals. The BC indicated the psychiatrist spoke to client #4 about taking her medications. On 5/21/15 at 1:29 PM, the nurse indicated client #4's medication refusals was a behavior issue. The nurse indicated the staff give her three prompts			

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	and then the doctor was notified when she refused her medications. The nurse indicated the nurse tell client #4 the consequences of not taking her medications. The nurse indicated client #4's doctors tell client #4 to take her medications. The nurse indicated client #4 had a right to refuse her medications. The nurse indicated client #4 did not have a plan to address medication refusals but the staff follow the facility's policy (three prompts and notified physician). The nurse stated, "might need to address in a health care plan." The nurse indicated she had an informal plan of fixing client #4 lettuce wraps if client #4 went 30 days with no medication refusals. The nurse indicated she fixed client #4 lettuce wraps one time when she met 30 days with no refusals. The nurse indicated her plan was informal and not a written plan. The nurse stated it was a "verbal nursing plan." 9-3-4(a)			
W 0249 Bldg. 00	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			

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	number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure the staff implemented the clients' behavior plans as written to prevent client to client aggression and Pica (ingesting non-nutritive substances). Findings include: On 5/14/15 at 1:00 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 2/18/15 at 5:25 PM, client #4 asked staff if she could get a magazine from the television stand. As she was walking over she reached over and hit client #2 on the head. Client #2 was not injured. On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of client #4 physically punching, biting, kicking or hitting another person with the potential to cause	W 0249	**W 249** Program Implementation: Prevention of Peer aggression and pica. **Corrective action for resident(s) found to have been affected** In order to prevent client-to-client abuse, a competency-based training will be conducted across staff that outlines the issue and the requirement to prevent it. Similarly, a competency-based training will be conducted across staff members on preventing pica. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Competency-based training for prevention of both peer-to-peer abuse and pica. **How corrective actions will be monitored to ensure no recurrence** The BC and managers train staff members with the BC taking the lead on behavior-related training. They both are supervised by the director who will ensure that these trainings occur.	06/25/2015

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	harm to that person or attempting to do so). The BSP indicated, in part, "Immediately tell [client #4] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at all times...." The staff failed to position themselves to prevent client to client abuse. On 5/14/15 at 3:01 PM, the PC indicated the staff should implement the client's program plan as written. 2) On 2/21/15 at 7:15 PM, client #3 cursed at a peer and then jumped up and ran toward the peer. Client #1 stepped in to defend the peer. Client #3 scratched, hit, kicked and hit client #1 on the top of her head. Client #1 hit and kicked client #3. The Bureau of Developmental Disabilities Services incident report, dated 2/22/15, indicated, "Staff acted as quickly as possible to separate clients according to their plans." Neither client was injured. On 5/20/15 at 11:03 AM, a review of client #1's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated, in part, "Immediately tell [client #1] to			

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	'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at all times...." The staff failed to position themselves to prevent client to client abuse. On 5/20/15 at 11:07 AM, a review of client #3's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated, in part, "Immediately tell [client #3] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety all all times...." On 5/14/15 at 3:01 PM, the Program Coordinator (PC) indicated the staff should implement the client's program plan as written. 3) On 5/2/15 at 7:00 AM, client #4 exited her room during shift change. Client #4 darted across the room and grabbed the remote control. Staff attempted to remove the remote from her possession. Client #4 was able to take the back off and swallow one of the batteries before staff was able to get her to release it. She was transported to the			

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	hospital but not admitted. She was to return for follow up in 3 days if the battery had not passed through her bowels. On 5/20/15 at 1:47 PM, a review of client #4's May 2015 Health Care Coordination note indicated, in part, "5-2-15 Pica AA battery this morning, to [initials of hospital]. To monitor BM's for passage. Behaviors continue for 3.5 hours... 5-11-15 passed battery after nurse left. No rectal bleeding or discomfort reported." On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had a targeted behavior of Pica (defined as eating, chewing, or placing inedible objects into her mouth). The BSP indicated, "[Client #4] has one-to-one supervision during waking hours and 15 minute checks when she is asleep in order to monitor her... Consistent with [client #4's] approved-BSP, there are two room sweeps per shift. The AWS procedure for room sweeps is separate from this BSP Summary. It is intended to keep the environment clear of items this (sic) might be ingested...." The BSP Addendum 1: Specific Restrictions indicated, "[Client #4] engages in some			

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	behavior that is dangerous to her. This includes Pica (she had swallowed items that had to be surgically removed)... Increased scrutiny on restricting small items. [Client #4] has a history of swallowing small objects. We cannot remove everything from her and do not want to. On the other hand, we need to try to keep her safe. Staff will be more vigilant and will be asked to try to be proactive and keep small items from her possession. All battery operated devices, e.g. (that is) remote controls, CD players, etc. (unless the battery compartments require a screw be removed in order to open it) will be kept in a secure location when not in use. Staff will maintain possession of remote controls during use. The use of any other battery operated items will be supervised by staff and they must be in a position to observe [client #4] and the device during its use. This device will be returned to the secure location when done...." On 5/14/15 at 3:01 PM, the PC indicated the staff should implement the client's program plan as written. On 5/20/15 at 11:22 AM, the PC indicated the remote control was supposed to be locked up and it was not locked up. The PC indicated the staff failed to follow the plan as written. The PC stated the plan had been in place "for some time." The PC			

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BENCHMARK HUMAN SERVICES	9110 N CR 700 W SCIPIO, IN 47273

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	indicated there was a sheet to track the location of the remotes during shift change. The PC indicated he taped the battery compartment since the incident. On 5/14/15 at 2:48 PM, the Behavior Clinician indicated the staff left the remote in the living room or the counter. He was not sure where the remote was located. The BC indicated client #4 noticed the remote around shift change. The BC indicated the staff did not put the remote away and she swallowed a battery from the remote. The BC stated it was "staff error for not following the restriction." The BC indicated the staff failed to implement the plan as written. 4) On 5/7/15 at 5:00 PM, client #4 spoke inappropriately about client #3's family member being deceased. Client #3 lunged at client #4. Client #4 grabbed client #3's hair. Neither client was injured. On 5/20/15 at 12:02 PM, a review was conducted of client #4's record. Client #4's Behavior Support Plan (BSP), dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of [client #4] physically punching, biting, kicking or hitting another person with the potential to cause harm to that person or attempting to do			

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	so). The BSP indicated, in part, "Immediately tell [client #4] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at all times...." The staff failed to position themselves to prevent client to client abuse. On 5/14/15 at 3:01 PM, the Program Coordinator (PC) indicated the staff should implement the client's program plan as written. 5) Observations were conducted at the group home on 5/14/15 from 3:29 PM to 5:48 PM and 5/20/15 from 6:39 AM to 9:03 AM. During the observations, client #3's right forearm had a 4 inch by 4 inch bruise (black, brown, green and yellow). During the observations, client #1 had a bruise on her right eye. On 5/14/15 at 3:57 PM, the Manager indicated client #1's black eye was from a client to client incident with client #3. On 5/14/15 at 4:07 PM, client #3 indicated the bruise on her forearm was from a bite from client #1. Client #3 indicated she bit client #1 during the incident as well. On 5/9/15 at 7:00 PM, the BDDS report, dated 5/10/15, indicated, "On 5-9-15 at			

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	7pm [client #3] became upset at house mate for making inappropriate comments. Without warning [client #3] went toward house mate (sic) staff blocked attempt. As staff blocked attempt without warning [client #1] came up and hit [client #3] in (sic) head and bit [client #3] rite (sic) forearm. [Client #3] then hit [client #1] in rite (sic) eye staff separated [clients #1 and #3] from each other.... [Client #1] then went to her room and attempted to elope out bedroom window staff blocked attempt. [Client #1] then attempted to hit and kick staff attempts were blocked [client #1] started crying and then calmed down." The Plan to Resolve section indicated, "Both [client #1] and [client #3] were checked for injuries (sic) [client #3] had red area on rite (sic) forearm from bite (sic) [client #1] had redness to rite (sic) eye...." On 5/20/15 at 11:03 AM, a review of client #1's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated, in part, "Immediately tell [client #1] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety at			

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	all times...." The staff failed to position themselves to prevent client to client abuse. On 5/20/15 at 11:07 AM, a review of client #3's BSP, dated 1/1/15, indicated she had a targeted behavior of physical aggression (defined as any instance of physical hitting, kicking, or biting another person with the potential to cause harm to that person). The BSP indicated, in part, "Immediately tell [client #3] to 'STOP' (or similar) while moving into position to keep her and others safe from harm. The priority is on client safety all all times...." On 5/14/15 at 3:01 PM, the Program Coordinator (PC) indicated the staff should implement the client's program plan as written. 9-3-4(a)			
W 0356 Bldg. 00	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for	W 0356	**W 356** Comprehensive Dental	06/25/2015

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	1 of 2 clients in the sample (#3), the facility failed to ensure client #3 returned to the dentist to have a filling. Findings include: On 5/20/15 at 11:07 AM, a review of client #3's record was conducted. Client #3's most recent Dental Exam, dated 10/8/14, indicated, in part, "Pt. (patient) needs to return for a filling." There was no documentation client #3 received a filling as indicated by the dentist. On 5/20/15 at 11:52 AM, the nurse indicated client #3 should have returned for a follow-up appointment as indicated on 10/8/14. On 5/20/15 at 1:47 PM, the nurse indicated in an email, "I did make an appointment for [client #3] at dental office. She will be seen Wed (Wednesday) 5-27-15 at 9:30am." 9-3-6(a)		Treatment: client follow-up for dental work. **Corrective action for resident(s) found to have been affected** The client had follow-up dental visit on May 27, 2015. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Follow-up appointment completed and staff across shifts will be trained to enter follow-up appointments onto the house calendar. **How corrective actions will be monitored to ensure no recurrence** The managers supervise staff, including ensuring that their training needs are met. The managers are supervised by the director, and they meet regularly. The director will ensure that the training takes place to prevent missed appointments in the future.	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS 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 living in the group home	W 0440	**W 440** Evacuation Drills: **Corrective action for**	06/25/2015

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	(#1, #2, #3 and #4), the facility failed to conduct quarterly evacuation drills for each shift. Findings include: A review of the facility's evacuation drills was conducted on 5/14/15 at 3:46 PM and indicated the following: During the day shift (7:00 AM to 3:00 PM), there were no drills conducted from 8/12/14 to 12/19/14. During the evening shift (3:00 PM to 11:00 PM), there were no drills conducted from 10/23/14 to 2/4/15. During the night shift (11:00 PM to 7:00 AM), there were no drills conducted from 5/14/14 to 1/15/15. This affected clients #1, #2, #3 and #4. On 5/20/15 at 11:32 AM, the Program Coordinator indicated the facility should conduct one drill per shift per quarter. 9-3-7(a)		**resident(s) found to have been affected** All drills will be conducted according to a drill schedule. In order to prevent the loss of paperwork, this will be faxed to the day program office where a backup file will be maintained. Managers will compare the drills received against the drill schedule. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Drill schedule in place with drill documentation faxed for backup and monitoring. **How corrective actions will be monitored to ensure no recurrence** The managers supervise the staff and ensure that all drills are conducted as required. The drills will be faxed to managers at the day program office. The managers will compare the drills faxed against the drill schedule and will follow-up with any drills that are not received.	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 4 of 4 clients living in the group home (#1,	W 0488	**W 488** Dining Areas and Service: Client involvement in meal preparation.**Corrective action**	06/25/2015

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	#2, #3 and #4), the facility failed to ensure the clients were involved with preparing meals. Findings include: An observation was conducted at the group home on 5/14/15 from 3:29 PM to 5:48 PM. At 4:19 PM, client #3 told staff #8 she wanted to assist with dinner preparation. Staff #8, who was in the kitchen getting items out and ready to cook, indicated he was getting items together for dinner. Client #3 was not asked to assist in the process. At 4:50 PM, staff #3 and #8 were in the kitchen cooking. Staff #8 put frozen chicken nuggets on a pan to cook. At 4:56 PM, client #3 indicated to staff #8 that she wanted to assist with dinner preparation. Staff #8 stated to client #3 that he was "just getting started." At 5:01 PM, staff #3 was opening cans of green beans. Staff #3 put margarine on the green beans. At 5:09 PM, staff #3 was stirring the green beans and instant potatoes. At 5:10 PM, staff #3 stirred the potatoes and staff #8 stirred the green beans. At 5:13 PM, staff #3 stirred the potatoes. Staff #8 put margarine on the top and the inside of the rolls. At 5:18 PM, staff #3 stirred the green beans. At 5:22 PM, staff #8 used the food processor to puree client #2's chicken nuggets with mayonnaise.		**for resident(s) found to have been affected** Training will occur across staff that encouraging client participation in mealtime preparation is required. **How facility will identify other residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Staff training on required encouragement of client participation in meal preparation. **How corrective actions will be monitored to ensure no recurrence** The managers supervise the staff and ensure that their training needs are met. The managers are supervised by the director, and they meet regularly. The director will ensure that the training takes place.	

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	At 5:25 PM, staff #7 put paper towels on the table for each client to use as napkins. Staff #3 put serving bowls on the table with the potatoes and green beans. Staff #3 put the rolls on the table and then served them to the clients. Client #2 was given her plate with green beans, potatoes and chicken nuggets already served and cut up/pureed. At 5:35 PM while the clients ate their dinner, staff #8 hand washed dishes in the kitchen. At 5:37 PM when client #1 finished her meal and took her dishes to the kitchen, staff #8 stated, "Just sit it right there and I'll get it." During the meal preparation, clients #1, #2, #3 and #4 were present and available to assist with meal preparation. The staff did not ask or prompt clients #1, #2, #3 and #4 to assist with meal preparation. An observation was conducted at the group home on 5/20/15 from 6:39 AM to 9:03 AM. At 8:33 AM, staff #4 prepared client #2's breakfast (instant oatmeal and a drink). Staff #4 got the bowl out, poured in the oatmeal, added water and put the bowl into the microwave. At 8:37 AM, staff #4 stirred the oatmeal. At 8:40 AM, staff #4 placed a neck napkin on client #2. Staff #4 gave client #2 her drink. Staff #4 stated to client #2, "I added some cinnamon to it." Client #2 was not involved in preparing her			

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	breakfast. At 8:47 AM after client #2 carried her dishes to the sink, staff #4 rinsed the dishes and placed the cup and bowl into the dishwasher. Client #2 was not prompted to assist in rinsing her dishes and putting them into the dishwasher. On 5/20/15 at 11:22 AM, the Program Coordinator (PC) indicated the clients should be involved with preparing their own meals to the extent they were able to safely participate (no sharps). The PC indicated safety was the first priority however there were tasks the clients were able to engage in during meal preparation. 9-3-8(a)			
W 9999 Bldg. 00	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met: 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job	W 9999	**W 9999** State Findings: TB (Mantoux) for staff member. **Corrective action for resident(s) found to have been affected** The staff member in question had transitioned to a part-time role, but was not keeping up with training and other requirements. She no longer works for the company and therefore is not in client contact. **How facility will identify other**	06/25/2015

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	duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. This state rule was not met as evidenced by: Based on record review and interview for 1 of 3 employee (staff #6) files reviewed, the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted. Findings include: On 5/15/15 at 10:49 AM, a review of the facility's employee files was conducted. Staff #6's most recent Mantoux was completed on 5/1/14. There was no documentation indicating staff #6 had an annual Mantoux since 5/1/14.		**residents potentially affected & what measures taken** All residents potentially are affected, and corrective measures address the needs of all clients. **Measures or systemic changes facility put in place to ensure no recurrence** Managers examined the TB test dates across the staff. All are in compliance with this requirement. **How corrective actions will be monitored to ensure no recurrence** The managers supervise the staff and ensure their training and other requirements. They receive an Email on a weekly basis that highlights expired TB dates among other things. All staff are in compliance.	

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	On 5/15/15 at 11:50 AM, the Human Resources Assistant indicated in an email, "What I sent to you for [staff #6] is the most current we have on file. On 5/15/15 at 11:59 AM, an email from the Human Resources Assistant indicated, in part, "Staff are required to get a TB test every year." On 5/20/15 at 11:19 AM, the Program Coordinator indicated staff should have an annual TB test. 9-3-3(e)			