

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 07/10/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 9110 N CR 700 W SCIPPIO, IN 47273
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W 0000 Bldg. 00	<p>This visit was for the Post Certification Revisit (PCR) to the recertification and state licensure survey completed on 5/26/15.</p> <p>Survey dates: July 9 and 10, 2015</p> <p>Facility number: 012529 Provider number: 15G794 AIM number: 201017530</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0104 Bldg. 00	<p>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 the clients' bedroom walls were in good repair and repainted as needed and the patio furniture was repaired or replaced.</p> <p>Findings include:</p>	W 0104	All managers and the assistant director will receive training on the Benchmark Continuous Quality Assessment (CQA) policy which includes a monthly report to indicate repairs needed to maintain the home and the condition of the furnishings and equipment. This training will be completed by the residential director. The managers and assistant director will complete an action plan and attach the to the CQA report	08/09/2015

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>On 7/9/15 from 3:50 PM to 5:13 PM an observation was conducted at the group home. At 3:50 PM, client #4 indicated she needed her bedroom repainted. Client #4 indicated there was a repaired hole in her closet that had not been painted. The unpainted repaired area in the closet was 24 inches by 30 inches. The repaired area was white in color and did not match the wall color. Client #4 indicated there was a hole in the wall behind her bedroom door. The hole was 1 inch by 3 inches. There was a hole in the outside wall measuring 4 inches 4 inches. Client #4's bedroom walls were marked, scuffed, discolored and stained throughout her room. On 7/9/15 at 3:53 PM, client #4 stated, "I want my room repainted."</p> <p>On 7/9/15 at 3:55 PM, client #2 indicated she wanted to show the surveyor her bedroom. Client #2's bedroom walls were scuffed, marked and discolored throughout the room.</p> <p>On 7/9/15 at 4:02 PM, client #3 indicated she wanted the surveyor to assess her bedroom. Client #3 showed the surveyor a 4 inch by 4 inch hole on her closet wall. Client #3 indicated she punched the wall causing the hole. Client #3 stated, on 7/9/15 at 4:05 PM, "I want my room repainted." Client #3's room had scuffs,</p>		<p>which will include the responsible party to complete a work order, notify the contractor and the timeframe for completion. These reports and action plans will be sent to the regional director after completion for review and to ensure compliance with standards of home maintenance. This process will occur monthly and progress will be discussed at the regularly scheduled weekly meetings to ensure immediate and ongoing compliance.</p>	

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	<p>marks and discoloration on the walls throughout her bedroom.</p> <p>On 7/9/15 at 4:09 PM, client #1 indicated she wanted the surveyor to assess her bedroom. One interior wall was covered with a large mural with a scene of horses on it. Part of the mural had been ripped off the wall. Client #1 indicated she wanted the mural taken down and her walls repainted. Client #1's bedroom walls were scuffed, marked, discolored and had numerous places where paint was chipped off the wall. Client #1's bedroom was missing the transition piece covering the area where the carpet in the living room met the laminate flooring in her bedroom. Client #1 indicated she had tripped on the carpet sticking up several times.</p> <p>On 7/9/15 at 4:15 PM, the Home Manager (HM) indicated maintenance was at the home last week. The HM indicated the clients' bedrooms needed to be repainted after repairing the holes in the walls. The HM indicated the transition piece in client #1's bedroom needed to be replaced.</p> <p>On 7/9/15 at 4:52 PM the patio furniture was assessed. Five of the six patio chairs were unable to be used due to the seats being torn and ripped. Client #4</p>			

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W 0154 Bldg. 00	<p>indicated she wanted to spend more time outside but due to not having any chairs to sit on so she could not sit outside. Staff #7 indicated she had worked at the group home for four months and the chairs had been ripped during her time working at the home. This affected clients #1, #2, #3 and #4.</p> <p>On 7/10/15 at 12:28 PM, the Assistant Director (AD) indicated the interdisciplinary team had discussed the need for the clients' bedrooms to be repainted. The AD indicated client #1 had been peeling the mural off her wall. The AD stated the facility was "working on the process." The AD indicated the clients' bedrooms needed to be repainted.</p> <p>This deficiency was cited on 5/26/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p> <p>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 2 of 2 incident/investigative reports</p>	W 0154	All managers and the assistant director will receive re-training on the Benchmark policy for	08/09/2015	

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	<p>reviewed affecting client #3, the facility failed to conduct thorough investigations of elopement.</p> <p>Findings include:</p> <p>On 7/9/15 at 12:33 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 5/30/15 at 12:30 PM, client #3 became upset and attempted to elope out the back door. The Bureau of Developmental Disabilities Services (BDDS) incident report indicated client #3 was redirected to her bedroom and she went into the closet. Client #3 calmed down. Two staff took two clients out of the home to give them a change to calm from the event. Client #3 and a peer were at the group home with a male staff member (not named in the BDDS report) who worked at another group home but was trained on client #3's plans. Client #3 called the on-call manager and claimed that she did not feel safe with the staff member because he was a man that she did not know. The on-call manager assured client #3 that another staff would be sent to the home to work with her. After calling staff at another group home, the on-call called the group home to inform the male staff that a female staff</p>		<p>investigations. This training will be completed by the regional director and will be documented on training forms. Staff will be required to document circumstances in which investigations are required. The regional director will review all incident reports to monitor the need for investigations and provide guidance and oversight as needed. Any incident reports and/or investigations will be discussed at the weekly meetings to ensure compliance and will be documented. All investigations will be reviewed and signed by the regional director or a compliance officer to monitor compliance and implementation of corrections or training as needed. This will be an ongoing quality assurance process.</p>	

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	<p>was coming to work with client #3. The manager asked the male staff to check on client #3. The male staff knocked on her door and asked client #3 if she was okay. Client #3 responded "yes." Client #3 then disabled the alarm from her window and climbed out. Client #3 started walking toward the other group home in the area. The female staff who was coming to work with client #3 saw client #3 walking and picked her up. There was no documentation the facility investigated the incident to determine if the male staff was negligent (failed to provide appropriate supervision to client #3 to prevent elopement).</p> <p>On 7/9/15 at 1:36 PM, a Case Conference note, dated 6/1/15, indicated the team met to discuss client #3's screaming and elopement. The note indicated, in part, "IDT reviewed the incident. It appears that staff who was instructed to go to [client #3's] home to assist was able to effectively intervene by picking [client #3] up & taking her to (sic) other group home as instructed by manager. Staff who were on outing with [client #3's] housemates returned promptly as instructed & returned her home. Male staff who was filling in at [client #3's] home was replaced with a female staff due to claim by [client #3] that he made her uncomfortable... All staff will be</p>			

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	<p>trained on 6/18 on leaving clients with unfamiliar staff & reminded to be aware of client gender preferences."</p> <p>On 7/10/15 at 12:43 PM, a review of client #3's Behavior Support Plan, dated 1/1/15, indicated client #3 had a targeted behavior of elopement. Elopement was defined as leaving a building, house, store, car or designated area without notifying staff - at a distance where staff members are unable to safely supervise. Client #3's plan indicated, "Due to risks of elopement, [client #3] will live in a secure setting that includes door and window alarms."</p> <p>On 7/9/15 at 1:34 PM, the Assistant Director (AD) indicated a formal investigation was not conducted. The AD indicated the facility viewed the incident as elopement and not neglect. The AD indicated the incident was reviewed during an IDT (interdisciplinary team meeting) on 6/1/15. On 7/10/15 at 12:28 PM, the AD indicated client #3 required 24 hour supervision due to a history of Pica (ingesting non-nutritive substances), self-injurious behavior and elopement. The AD indicated neglect was defined as not providing adequate care and supervision. The AD indicated the facility looked at client #3's supervision plan involving 15 minute</p>			

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	<p>checks, predominately after a behavior. The AD indicated the staff was following the plan. When asked how he knew the staff followed the plan, the AD indicated the facility talked with the staff who was present and reviewed the documentation. The AD indicated a formal investigation should have been conducted. The AD indicated the facility conducted an investigation but did not document the investigation. The AD stated this was a "very serious situation" and "didn't document in a format of a formal investigation."</p> <p>2) On 6/27/15 at 7:00 PM client #3 became upset after being informed she had not earned her special evening snack due to her being socially inappropriate earlier in the day. Client #3 went to her room with staff following closely. Staff attempted to discuss the situation with client #3. The BDDS report, dated 6/28/15, indicated, "[Client #3] attacked staff, hitting staff several time, pulled staff's hair and grabbed staff and hit her on the arm. Another staff member came to assist and [client #3] grabbed other staff member by the hair as well, refusing to let go. During this time, [client #3's] housemate called 911 for help. [Client #3] then released first staff members (sic) hair and hit second staff member several times. Staff members used an HRC</p>			

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	(Human Rights Committee) approved 2 person side body restraint for safety that lasted 2 and a half minutes. Staff assisted [client #3] to her bedroom where she attempted to choke herself, punched herself several times and she punched and banged her head on her closet wall. [Client #3] calmed down and went outside with staff. [Client #3] apologized to staff for the incident. [Client #3] asked if she could go to her bedroom to watch TV and a staff member went with her. After several minutes, the staff member told [client #3] that she was going to the restroom. When staff member returned she discovered that [client #3] had eloped from her bedroom window. Staff members alerted the on call manager and took housemates out to search for [client #3]. Manager instructed staff to contact authorities if [client #3] was not found in the nearby vicinity. Police were contacted and on call manager came to assist. En (sic) route to the home, police spotted [client #3] coming out of woods next to the group home and returned her home. Upon arrival, [client #3] told on call manager that staff member had punched her during her behavior and refused to stay at the home because she was afraid that she may harm staff... On call manager canceled initial 911 call... [Client #3] was out of staff view for			

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	<p>approximately 30 minutes... [Client #3's] window alarm has been repaired, however there is a system issue that has to be repaired by (sic) security company which caused it not to sound..."</p> <p>The facility's investigation, dated 7/1/15, indicated client #3's allegation of staff abuse was unsubstantiated. The facility did not investigate whether or not staff was negligent when client #3 eloped from the group home.</p> <p>On 7/9/15 at 1:40 PM, the AD indicated the staff thought client #3's window alarm was working at the time of the incident. The AD indicated the alarm had been replaced with a temporary alarm until the security company repaired the alarm. On 7/9/15 at 1:34 PM, the Assistant Director (AD) indicated a formal investigation was not conducted for client #3's elopement. The AD indicated the facility viewed the incident as elopement and not neglect. On 7/10/15 at 12:28 PM, the AD indicated client #3 required 24 hour supervision due to a history of Pica (ingesting non-nutritive substances), self-injurious behavior and elopement. The AD indicated neglect was defined at not providing adequate care and supervision. The AD indicated the facility looked at client #3's supervision plan involving 15</p>			

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W 0157 Bldg. 00	<p>minute checks, predominately after a behavior. The AD indicated the staff was following the plan. When asked how he knew the staff followed the plan, the AD indicated the facility talked with the staff who was present and reviewed the documentation. The AD indicated a formal investigation should have been conducted. The AD indicated the facility conducted the investigation but did not document the investigation. The AD stated this was a "very serious situation" and "didn't document in a format of a formal investigation."</p> <p>This deficiency was cited on 5/26/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 2 of 2 incident/investigative reports reviewed affecting client #3, the facility failed to take appropriate corrective action following two incidents of elopement by failing to put a system in place for staff to check the operational</p>	W 0157	All managers and the assistant director will receive re-training on the Benchmark policy for investigations. This training will be completed by the regional director and will be documented on training forms. Staff will be required to document circumstances in which	08/09/2015

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	<p>status of client #3's window alarms.</p> <p>Findings include:</p> <p>On 7/9/15 at 12:33 PM a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 5/30/15 at 12:30 PM, client #3 became upset and attempted to elope out the back door. The Bureau of Developmental Disabilities Services (BDDS) indicated report indicated client #3 was redirected to her bedroom where she went into the closet. Client #3 calmed down and two staff took two clients out of the home to give them a change to calm from the event. Client #3 and a peer were at the group home with a male staff member (not named in the BDDS report) who worked at another group home but was trained on client #3's plans. Client #3 called the on-call manager and claimed that she did not feel safe with the staff member because he was a man that she did not know. The on-call assured client #3 that another staff would be sent to the home to work with her. After calling another staff, the on-call called the group home to inform the male staff that another female staff was coming to work with client #3. The manager asked the male staff to check on</p>		<p>investigations are required. The regional director will review all incident reports to monitor the need for investigations and provide guidance and oversight as needed. Any incident reports and/or investigations will be discussed at the weekly meetings to ensure compliance and will be documented. All investigations will be reviewed and signed by the regional director or a compliance officer to monitor compliance and implementation of corrections or training as needed. This will be an ongoing quality assurance process.</p>				

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	<p>client #3. The male staff knocked on her door and asked client #3 if she was okay. Client #3 responded "yes." Client #3 then disabled the alarm from her window and climbed out. Client #3 started walking toward the other group home in the area. The female staff who was coming to work with client #3 saw client #3 walking and picked her up. There was no documentation the facility investigated the incident to determine if the male staff was negligent (failed to provide appropriate supervision).</p> <p>On 7/9/15 at 1:36 PM, a Case Conference note, dated 6/1/15, indicated the team met to discuss client #3's screaming and elopement. The note indicated, in part, "IDT reviewed the incident. It appears that staff who was instructed to go to [client #3's] home to assist was able to effectively intervene by picking [client #3] up & taking her to (sic) other group home as instructed by manager. Staff who were on outing with [client #3's] housemates returned promptly as instructed & returned her home. Male staff who was filling in at [client #3's] home was replaced with a female staff due to claim by [client #3] that he made her uncomfortable... All staff will be trained on 6/18 on leaving clients with unfamiliar staff & reminded to be aware of client gender preferences."</p>			

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	<p>2) On 6/27/15 at 7:00 PM client #3 became upset after being informed she had not earned her special evening snack due to her being socially inappropriate earlier in the day. Client #3 went to her room with staff following closely. Staff attempted to discuss the situation with client #3. The BDDS report, dated 6/28/15, indicated, "[Client #3] attacked staff, hitting staff several time, pulled staff's hair and grabbed staff and hit her on the arm. Another staff member came to assist and [client #3] grabbed other staff member by the hair as well, refusing to let go. During this time, [client #3's] housemate called 911 for help. [Client #3] then released first staff members (sic) hair and hit second staff member several times. Staff members used an HRC (Human Rights Committee) approved 2 person side body restraint for safety that lasted 2 and a half minutes. Staff assisted [client #3] to her bedroom where she attempted to choke herself, punched herself several times and she punched and banged her head on her closet wall. [Client #3] calmed down and went outside with staff. [Client #3] apologized to staff for the incident. [Client #3] asked if she could go to her bedroom to watch TV and a staff member went with her. After several minutes, the staff member told [client #3] that she was</p>			

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 07/10/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 9110 N CR 700 W SCIPIO, IN 47273
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	<p>going to the restroom. When staff member returned she discovered that [client #3] had eloped from her bedroom window. Staff members alerted the on call manager and took housemates out to search for [client #3]. Manager instructed staff to contact authorities if [client #3] was not found in the nearby vicinity. Police were contacted and on call manager came to assist. En (sic) route to the home, police spotted [client #3] coming out of woods next to the group home and returned her home. Upon arrival, [client #3] told on call manager that staff member had punched her during her behavior and refused to stay at the home because she was afraid that she may harm staff... On call manager canceled initial 911 call... [Client #3] was out of staff view for approximately 30 minutes... [Client #3's] window alarm has been repaired, however there is a system issue that has to be repaired by (sic) security company which caused it not to sound...."</p> <p>On 7/10/15 at 12:43 PM, a review of client #3's Behavior Support Plan, dated 1/1/15, indicated client #3 had a targeted behavior of elopement. Elopement was defined as leaving a building, house, store, car or designated area without notifying staff - at a distance where staff members are unable to safely supervise.</p>			

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W 9999 Bldg. 00	<p>The BSP did not include a plan for staff to check client #3's window alarm on a regular basis to ensure the alarm was operational. Client #3's plan indicated, "Due to risks of elopement, [client #3] will live in a secure setting that includes door and window alarms."</p> <p>On 7/10/15 at 12:28 PM, the AD indicated there was no plan in place for staff to regularly check client #3's window alarm to ensure the alarm was working. The AD stated, "No, I don't think we have an official plan."</p> <p>9-3-2(a)</p>	W 9999	There is no W9999 citation on the 2567 and no citation visible above. Please advise if there is something we need to address for W9999.	08/09/2015	