

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G738	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/23/2015
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 3224 W 1100 N MARKLE, IN 46770
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000  Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: December 22 and 23, 2015.</p> <p>Facility number: 011501 Provider number: 15G738 AIM number: 200889040</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 12/29/15 by #09182.</p>	W 0000		
W 0249  Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure his plan to prevent elopement behavior was</p>	W 0249	All staff received retraining on the Behavior Support Plan for client #1. This training included maintaining eye sight supervision when client #1 is outside of the home. The staff will	01/22/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>implemented.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 12/22/15 at 4:50 PM. A report dated 12/13/15 indicated client #1 left the home and went to the neighbor's house and asked the neighbors to call the police. The neighbors called the police and the police arrived to talk to client #1. The report indicated client #1 was out of the line of sight of staff for 5-6 minutes and staff were retrained on ensuring client #1's supervision needs were met.</p> <p>Client #1's records were reviewed on 12/23/15 at 11:01 AM. A BSP (Behavior Support Plan) dated 9/21/15 indicated client #1 had a targeted behavior of elopement and was to be within eyesight of staff at all times, and client #1 had a history of calling the police without cause.</p> <p>The Residential Director was interviewed on 12/22/15 at 4:55 PM and indicated client #1 had been able to get out of sight of staff.</p> <p>9-3-4(a)</p>		<p>be monitored by the QIDP and by the Residential Manager weekly for three months and their observations will be documented on the Behavior Intervention Observation Form which will be turned in to the director so compliance can be monitored.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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