

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G798	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/23/2014
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8424 FANTASIA WAY FORT WAYNE, IN 46809
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Date of survey: December 18, 19 and 23, 2014.</p> <p>Facility number: 012577 Provider number: 15G798 AIM number: 201018530</p> <p>Surveyor: Kathy Wanner, QIDP.</p> <p>The following federal deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality review completed January 2, 2015 by Dotty Walton, QIDP.</p>	W000000		
W000149	<p>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.</p>			

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>Based on record review and interview, the facility neglected to follow their policy for abuse and neglect for 1 of 4 sampled clients (client #3) by failing to ensure client #3 was provided with twenty-four supervision and not left alone in the group home.</p> <p>Findings include:</p> <p>Facility records including the Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 12/18/14 at 2:40 P.M. The BDDS reports indicated the following:</p> <p>-a BDDS report dated 9/19/14 for an incident on 9/18/14 at 3:05 P.M. indicated "On 9/18/14 at 3:05 P.M. the Qualified Intellectual Disabilities Professional (QIDP) arrived at the [name] home and discovered that [client #4] was home alone. The nurse was called and completed a physical assessment of [client #4] without findings. The staff working had left the home to pick up other consumers from day service and was suspended upon his return. The residential director immediately initiated an investigation. All staff involved in the incident were interviewed as well as [client #4]. Through the investigation it was determined that [client #4] and two of his</p>	W000149	<p>Staff were immediately trained on ensuring that the whereabouts for all the clients are accounted for at each and every shift change by completing a shift change report.</p> <p>The residential manager monitors the shift change report weekly, and the documentation is turned in monthly to the residential director for review to ensure compliance to prevent a re occurrence and ensure appropriate supervision levels for the individuals.</p>	01/22/2015

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	<p>housemates had taken the day off from work to go to the zoo. When the routine staff came in to begin his shift, he was not informed that [client #4] was in the home and in his room. The staff person left with the other two housemates to go pick up others from work. Through interviews it was determined that [client #4] did not receive appropriate supervision for approximately 25 minutes due to this oversight. Staff have been trained to ensure that all clients (sic) whereabouts are accounted for at each and every shift change by completing a shift change report. [Client #4] stated he did not feel unsafe."</p> <p>An interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) on 12/23/14 at 9:50 A.M. The QIDP stated, "Yes, (client #4) does need twenty-four supervision."</p> <p>An interview was conducted with the Residential Director on 12/18/14 at 3:42 P.M. The RD indicated client #4 should not have been left unsupervised and it was against facility policy to not provide appropriate supervision for a client. The RD stated: "We made the new shift change report system right away to ensure this does not happen again."</p> <p>The facility's Group Home Abuse and</p>			

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	Neglect policy dated 12/2013 was reviewed on 12/23/14 at 12:12 P.M. and indicated the following: "AWS does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse...Neglect includes failure to provide appropriate care, food, medical care or supervision." 9-3-2(a)			