STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G739	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	16315 FEIGHNER RD ROANOKE, IN 46783

(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 a fundamental recertification and state licensure survey. Dates of Survey: December 17, 18, 22 and 23, 2015. Facility number: 011502 Provider number: 15G739 AIM number: 200889020 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed 12/31/15 by #09182.	W 0000		
W 0304 Bldg. 00	483.450(d)(5) PHYSICAL RESTRAINTS Restraints must be designed and used so as not to cause physical injury to the client. Based upon record review and interview, the facility failed for 1 of 2 sampled clients (client #1), to ensure techniques used to address behavior (restraints) did not result in injury. Findings include:	W 0304	All staff were retrained at the time of the incident on client #1's Behavior Support Plan and the redirection strategies for client #1, including the use of appropriate restraints as needed. All staff were retrained on proper Mandt techniques as specified in client #1's Behavior Support Plan. All behavior data and injury reports	01/22/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G739	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	16315 FEIGHNER RD ROANOKE, IN 46783

(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
	The facility's reportable incidents to the Bureau of Developmental Disabilities Services/BDDS, internal incident reports and investigations were reviewed on 12/17/15 at 5:03 PM and indicated the following. A BDDS report dated 6/5/15 indicated client #1 attempted to leave the group home, attempted to hit the staff with a chair and then attempted to leave the group home and attempted to hit staff again and was placed in a two person side body restraint. During the restraint, client #1 and staff became unbalanced and "went down on the ground. Staff immediately released him from the restraint. [Client #1] hit his face on the floor and got up and tried to hit staff. He was placed in a one person side body restraint lasting less than a minute when he calmed down and (was) released. He had a small amount of blood coming from his nose which resolved without treatment." A Post Fall Assessment dated 6/7/15, included with the report, indicated client #1 was being physically restrained immediately before the fall causing his head to hit the floor and a bloody nose. The Residential Director was interviewed on 12/17/15 at 5:10 PM and indicated		are monitored by the QIDP and the Residential Manager to ensure the training has been effective and there have been no incidents of this nature since. All injury reports are reviewed by the Residential Director to monitor compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G739		12/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	16315 FEIGHNER RD ROANOKE, IN 46783

(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
	client #1 had become injured when he and staff became unbalanced during the restraint and client #1 went down to the ground. 9-3-5(a)			
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, the facility failed to encourage 2 of 2 sampled clients (clients #1 and #2), and 2 additional clients (clients #3 and #4), to participate in the preparation of their breakfast meal. Findings include: Observations were completed at the group home on 12/18/15 from 6:30 AM until 7:55 AM. During the observation, staff #5 set the table and prepared toasted french toast, juice and milk for clients #1, #2, #3 and #4 without involving them in the preparation of the meal. Clients #1, #2, #3 and #4 came to the table and dished	W 0488	All staff have received retraining on appropriate meal preparation. Staff will actively encourage clients to eat independently to the extent possible and in accordance with their assessed abilities. Additionally the manager is completing meal observations which include verifying that the complete dining service is offered according to the developmental needs of the clients. The dining checklists will be submitted to the director to monitor compliance. The monitoring will occur on a weekly basis for three months.	01/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G739	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	16315 FEIGHNER RD ROANOKE, IN 46783

(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
	their plates with food prepared by staff #5 and placed on the table. The Residential Director was interviewed on 12/18/15 at 1:01 PM and indicated clients should be assisting in preparing their meals as able in the morning. 9-3-8(a)			