

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G797	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/24/2016
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA RD LA FONTAINE, IN 46940
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 3/14, 3/15, 3/16, 3/17, 3/18, 3/21, 3/22, 3/23, and 3/24/2016.</p> <p>Facility Number: 0012563 Provider Number: 15G797 AIM Number: 201018540</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed 3/31/16 by #09182.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>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.</p> <p>Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) and 2 additional clients (clients #3 and #4), the facility failed to ensure clients #1, #2, #3, and #4 had unimpeded access to secured toothpaste and toothbrushes and failed to</p>	W 0125	<p>All staff will receive retraining on the Client Rights Policy. In addition, all staff will receive retraining on the restrictions in the Behavior Support Plans for clients #1, #2, #3, and #4. This training will focus on the importance of not restricting those things that the team – with HRC approval –</p>	04/23/2016

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>ensure the restriction had been assessed.</p> <p>Findings include:</p> <p>On 3/15/16 from 4:20pm until 6:35pm and on 3/16/16 from 5:55am until 8:55am, observations were conducted at the group home and clients #1, #2, #3, and #4's toothbrushes and toothpaste were kept locked inside the cabinet in the medication area. On 3/16/16 at 8:25am, GHS (Group Home Staff) #10 prompted client #1 to come to the medication area. GHS #10 unlocked a cabinet inside the medication area and removed client #1's oral hygiene supplies. GHS #10 indicated clients #1, #2, #3, and #4's oral hygiene supplies of toothbrushes and toothpaste were kept locked/secured inside the group home. When asked why clients #1, #2, #3, and #4's oral hygiene supplies were kept secured, GHS #10 indicated he did not know. At 8:25am, client #1 brushed her gums with a toothbrush and toothpaste which GHS #10 prepared for client #1. Client #1 was not able to access locked oral hygiene supplies, brushed her gums in the sink without a mirror, was not encouraged to wear her dentures, and drank from the faucet to rinse her mouth without redirection by the facility staff.</p> <p>On 3/17/15 at 10:05am, an interview with</p>		<p>has not determined need to be restricted. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Meaningful Day Tracking Form which will be submitted to the director so compliance can be monitored. The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes monthly CQA's by the management which will be submitted to the director on a monthly basis to monitor ongoing compliance.</p>	

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	<p>the Agency Licensed Practical Nurse (LPN) was conducted. The LPN indicated clients #1, #2, #3, and #4 had no medical reason to restrict their access to locked oral hygiene supplies of toothbrushes and toothpaste.</p> <p>On 3/17/16 at 10:05am, an interview with the Behavior Consultant (BC) and the Residential Manager (RM) was conducted. The BC and the RM both indicated clients #1, #2, #3, and #4 did not have an identified need for oral hygiene supplies of toothbrushes and toothpaste to be kept secured. The BC and RM both indicated clients #1, #2, #3, and #4 had not given consent for the locked items.</p> <p>Client #1's record was reviewed on 3/17/16 at 1:15pm. Client #1's 4/10/15 ISP (Individual Support Plan) and 9/21/15 BSP did not indicate an identified need to secure oral hygiene supplies of toothbrushes and toothpaste. Client #1's record did not indicate consent for secured toothbrushes and toothpaste.</p> <p>Client #2's record was reviewed on 3/17/16 at 12:30pm. Client #2's 4/10/15 ISP (Individual Support Plan) and 9/21/15 BSP (Behavior Support Plan) did not indicated the identified need to secure</p>			

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W 0157 Bldg. 00	<p>oral hygiene supplies of toothbrushes and toothpaste. Client #2's record did not indicate consent for secured toothbrushes and toothpaste.</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 1 of 2 allegations reviewed for incidents of staff to client verbal abuse (client #1), the facility failed to implement effective corrective action to address staff using foul and/or hurtful language to client #1.</p> <p>Findings include:</p> <p>On 3/14/16 at 2:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed for client #1.</p> <p>-A 6/24/15 BDDS report and a 6/24/15 "Investigation Report" both indicated client #1 "reported [Group Home Staff (GHS) #11] had called her names." The investigation indicated "...Summary... [Client #1's] statements contained inconsistencies. [Client #1] originally</p>	W 0157	All staff will receive retraining on the Abuse and Neglect Policy. There are four investigators assigned to that area. Upon review of all evidence the investigator will complete an investigation report and will determine if the allegation(s) are substantiated or unsubstantiated and will make recommendations as needed. The director will review all investigations to ensure compliance with the Abuse and Neglect Policy.	04/23/2016

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	<p>reported that [GHS #11] called her a son of a b---- and took all of her tickets (a reward for good behavior) away for no reason. During her interview [client #1] later said [GHS #11] called her a mother f----, and when asked again at the end of the interview [client #1] said [GHS #11] called her a b----, slut, and w----. The staff member who [GHS #11] was relieving (on duty) reported she was debriefing with [GHS #11] about why [client #1] didn't earn her tickets for the day. She told [GHS #11] that [client #1] called her a b----. She stated that [GHS #11] joked that [client #1] couldn't earn her tickets if [client #1] calls staff b---- and that [client #1] might as well have called staff a f----- b---- and a mother f--- --. The staff member reported that [client #1] and [GHS #11] were laughing during this time and that [GHS #11] was trying to lighten the mood because he knew this would make [client #1] laugh." The investigation indicated "Analysis and Findings...The allegation of abuse is unsubstantiated based on a preponderance of evidence. That evidence is described above...It appears that even though [GHS #11] was trying to lighten [client #1's] mood and get her to laugh, he made a poor choice in the language used. The language was not directed toward [client #1] or said in an abusive manner, but rather to make</p>			

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W 0249 Bldg. 00	<p>[client #1] laugh. Staff reported that [client #1] did laugh at [GHS #11]. Later in the evening staff report that [client #1] was upset with [GHS #11] because of the tickets and said she hated him." No corrective actions were available for review.</p> <p>On 3/18/16 at 9:35am, the Residential Manager (RM) and the Behavior Consultant (BC) indicated client #1's 6/2015 allegation was before their time to provide facility oversight of staff to client interactions. The BC indicated client #1 used foul language at times to communicate her displeasure with the facility staff. The RM and BC both stated it was not acceptable practice for the facility staff to use foul and/or hurtful language to "lighten the mood" and/or during their shifts of work at the group home. Both the RM and BC indicated no corrective action and no further information was available to review.</p> <p>9-3-2(a)</p> <p>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</p>			

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	<p>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 observation, interview, and record review, for 2 of 2 sampled clients (clients #1 and #2) and for 2 additional clients (clients #3 and #4), the facility failed to ensure clients #1, #2, #3, and #4's BSPs (Behavior Support Plans) were implemented to secure locked sharps when not in direct staff supervision for clients #1, #2, #3, and #4.</p> <p>Findings include:</p> <p>On 3/16/16 from 5:55am until 8:55am, observations were conducted at the group home and the cabinet containing the locked sharps which included knives, cutters, scissors, batteries, an ice pick, and other sharp objects was left unlocked and unsecured. At 8:55am, GHS (Group Home Staff) #7 and GHS #10 both indicated clients #1, #2, #3, and #4 had the identified need for sharp objects to have been kept locked for their safety. Both staff were shown the unlocked cabinet containing the unsecured sharp objects and both staff indicated the cabinet containing the facility's sharp objects was not locked and should have been.</p> <p>Client #1's record was reviewed on</p>	W 0249	All staff will receive retraining on the restrictions in the Behavior Support Plans for clients #1, #2, #3, and #4. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Meaningful Day Tracking Form which will be submitted to the director so compliance can be monitored. The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes monthly CQA's by the management which will be submitted to the director on a monthly basis to monitor ongoing compliance.	04/23/2016

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	<p>3/17/16 at 1:15pm. Client #1's 4/10/15 ISP (Individual Support Plan) and 9/21/15 BSP indicated client #1 needed staff supervision regarding locked sharp objects. Client #1's ISP and BSP both indicated client #1 lived in the group home and required staff supervision to teach her regarding locked sharp items. Client #1's plans indicated she required locked sharps to ensure safety.</p> <p>Client #2's record was reviewed on 3/17/16 at 12:30pm. Client #2's 4/10/15 ISP (Individual Support Plan) and 9/21/15 BSP (Behavior Support Plan) indicated client #2 should be supervised by the facility staff. Client #2's BSP indicated targeted behaviors of Physical Aggression, Bullying, Verbal Aggression, Elopement, SIB (Self Injurious Behavior), and "Suicidal Gestures." Client #2's BSP indicated she needed sharps secured at "all times" for her safety.</p> <p>On 3/17/16 at 10:05am, an interview with the Behavior Consultant (BC) and the Residential Manager (RM) was conducted. The BC stated facility staff should have ensured that "all" sharps were kept secured and locked when not directly supervised by the facility staff. The BC indicated the unsecured sharps should not have been left unsecured in</p>			

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W 0323 Bldg. 00	<p>the kitchen cabinet. The RM indicated clients #1, #2, #3, and #4 had the identified need for locked sharps to ensure their safety.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, for 2 of 2 sampled clients (clients #1 and #2), the facility failed to include an assessment of clients #1 and #2's hearing needs.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 3/17/16 at 1:15pm. Client #1's record indicated an 3/31/15 annual history and physical which indicated "Hearing adequate for daily communication needs" with a line through "yes and no" and "has hearing aid." Client #1's record did not indicate client #1's last hearing assessment. Client #1's 4/10/15 ISP (Individual Support Plan) indicated she wore a hearing aid in her right ear to hear.</p>	W 0323	The management staff will review annual appointments monthly and ensure that upcoming appointments are scheduled. Managers complete monthly quality assurance checks at the home which include appointments being completed. These are documented on a CQA and reviewed by the director for compliance. Action plans completed if applicable and are monitored by the compliance specialist.	04/23/2016

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W 0436 Bldg. 00	<p>Client #2's record was reviewed on 3/17/16 at 12:30pm. Client #2's record indicated an 3/20/15 annual history and physical which did not assess and/or screen her hearing needs. Client #2's record did not indicate client #2's last hearing assessment.</p> <p>On 3/17/15 at 10:05am, and on 3/24/16 at 1:15pm, an interview with the Agency Licensed Practical Nurse (LPN) was conducted. The LPN indicated clients #1 and #2 had no current hearing assessments available for review.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1) with adaptive equipment, the facility failed to teach and encourage client #1 to wear her prescribed ted hose (support stockings), dentures, and eye glasses at the group home.</p> <p>Findings include:</p>	W 0436	All staff will receive retraining on the requirement of wearing adaptive equipment. Management has purchased an extra supply of ted hose(support stockings) for client #1. The staff will be monitored by the QIDP and by the Residential Manager and their observations will be documented on the Medication Administration Tracking Form	04/23/2016

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	<p>On 3/15/16 from 4:20pm until 6:35pm and on 3/16/16 from 5:55am until 8:55am, observations were conducted at the group home with clients #1 and #2. During both observation periods client #1 did not wear her prescribed ted hose, dentures, and eye glasses. On 3/16/16 at 7:18am, GHS (Group Home Staff) #10 unlocked the medication cart which exposed a pair of broken eye glasses and indicated the pair belonged to client #1. On 3/16/16 at 8:25am, GHS #10 prompted client #1 to come to the medication area. At 8:25am, GHS #10 unlocked a cabinet, removed a toothbrush and toothpaste, and prepared a toothbrush with toothpaste for client #1. Client #1 brushed her gums in the sink without a mirror, was not encouraged to wear her dentures, was not encouraged to wear her prescribed eye glasses, did not wear her ted hose, and drank from the faucet to rinse her mouth without redirection by the facility staff. During both observation periods client #1 watched television, walked throughout the group home, ate meals, rinsed dishes in the sink, completed medication administration, looked at a calendar, and counted coins. During both observation periods client #1 consumed a mechanical soft diet and did not wear her dentures.</p>		<p>which will be submitted to the director so compliance can be monitored. The initial monitoring will occur three times weekly for three months with weekly review by the director. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes weekly monitoring by the management which will be submitted to the director on a monthly basis to monitor ongoing compliance.</p>	

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W 0440 Bldg. 00	<p>On 3/16/16 at 10:15am, client #1 stated she did not wear her ted hose because the hose "had holes in them."</p> <p>On 3/17/16 at 10:05am, and on 3/24/16 at 1:15pm, an interview with the Agency Licensed Practical Nurse (LPN) was conducted. The LPN indicated client #1 should have been taught and encouraged by the facility staff to wear her prescribed ted hose, eye glasses, and dentures. The LPN indicated she was unaware client #1's ted hose had holes in them.</p> <p>Client #1's record was reviewed on 3/17/16 at 1:15pm. Client #1's 4/10/15 ISP (Individual Support Plan) and 9/21/15 BSP indicated a goal/objective to wear her dentures daily with three verbal cues, to wear her ted hose daily with no more than two verbal cues, and "has glasses, staff encourage use and cleaning" which was documented on the medication administration record (MAR).</p> <p>9-3-7(a)</p> <p>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 (clients #1, #2, #3, and</p>	W 0440	Evacuation drills will be completed across shifts as	04/23/2016

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 9029 S AMERICA RD LA FONTAINE, IN 46940		
(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	
	<p>#4) living in the group home, the facility failed to conduct quarterly evacuation drills for the 7am-3pm shift of personnel.</p> <p>Findings include:</p> <p>On 3/16/16 at 1:30pm, a review of the facility's evacuation drills from 3/2015 through 3/2016 was conducted. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, and #4 between 4/9/15 at 2:10pm and 2/6/16 at 11:50am for the 7am - 3pm personnel shift.</p> <p>On 3/17/16 at 11:30am, an interview with the Residential Manager (RM) was conducted. The RM indicated the day shift of personnel was daily from 7:00am until 3:00pm. The RM indicated no additional evacuation drills were available for review.</p> <p>On 3/24/16 at 1:15pm, an interview with the Site Director (SD) was conducted. The SD indicated no further evacuation drills were available for review.</p> <p>9-3-7(a)</p>		<p>required. A drill schedule will be placed in the home. In addition, all drills will be placed on the home calendar. Finally, DSP staff members will receive training on how to follow schedule. The management is responsible for ensuring that drills take place. This includes placing the schedule in the home and transferring the dates and times to the home calendar. In addition, the management will follow-up after a drill is scheduled to ensure that it took place as scheduled. The management will submit the drills to the director on a monthly basis so that compliance can be monitored.</p>		