

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G710	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  09/11/2015
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 55883 RING NECK DR OSCEOLA, IN 46561
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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: September 8, 9, 10, and 11, 2015</p> <p>Facility number: 003864 Provider number: 15G710 AIM number: 200460480</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/17/15.</p>	W 0000		
W 0186  Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation and interview, the facility failed to provide sufficient staff to provide for the needs of 2 of 2 sampled clients (clients #1 and #2) during the morning observation period.</p>	W 0186	All staff, Managers and QIDP's will receive re-training on the minimum staffing requirements of the home. Call lists have been updated to include instructions for staff regarding contacting	10/11/2015

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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W 0249 Bldg. 00	<p>Findings include:</p> <p>Clients #1 and #2 were observed at the group home during the 9/8/15 observation period from 6:26 A.M. until 8:10 A.M. Upon entering the group home, clients #1 and #2 were seated in wheelchairs in the living room of the facility. One direct care staff was in the group home and at 6:33 A.M. she stated, "I am waiting for more staff to come in before I can do much else." Clients #1 and #2 sat in their wheel chairs in the living room of the facility from 6:26 A.M. until 7:11 A.M. without interaction, training or active treatment services.</p> <p>Residential Director #1 was interviewed on 9/9/15 at 10:17 A.M. Residential Director #1 stated, "There are supposed to be two staff working in the morning."</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has</p>		<p>additional professional staff should their on-call supervisor fail to be present at the home if the home is short staffed. Weekly spot checks of the time entry system will be completed for the next 3 months by the director to ensure that the home is maintaining proper staffing. Managers and Q's from other homes and/or the director are also completing weekly unannounced house visits for the next 3 months to ensure that the home is maintaining the minimum staffing requirements. Monitoring after the 3 months will revert to the ongoing monitoring in place which includes time verification of the time entry system, on site supervision from the assigned manager, quarterly unannounced site visits of the management team. The Director will monitor compliance and all corrections will be in place by 10/11/15.</p>		

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	<p>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 observation, record review, and interview, the facility failed to implement active treatment programs during times of opportunity for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed at the group home during the 9/8/15 observation period from 6:26 A.M. until 8:10 A.M. Upon entering the group home, clients #1 and #2 were seated in wheelchairs in the living room of the facility. One direct care staff was in the group home and at 6:33 A.M. she stated, "I am waiting for more staff to come in before I can do much else." Clients #1 and #2 sat in their wheel chairs in the living room of the facility from 6:26 A.M. until 7:11 A.M. without interaction, training or active treatment services. Direct care staff #1 did not prompt or assist client #1 in putting away up to 3 items, saying yes or no, or assist the client in putting a napkin on the table. Direct care staff #1 did not prompt or assist client #2 in choosing an item</p>	W 0249	<p>All staff have been retrained on the proper implementation of active treatment and goals and objectives identified in the ISP. The QIDP and Residential Manager will monitor all staff by completing unannounced spot checks three times on first shift, three times on second shift and three times on third shift to ensure proper implementation of active treatment goals and objectives. Once competency is ensured through those checks, the management staff will conduct monthly spot checks at various times to ensure that continuous active treatment and ISP goals are implemented. These will be documented on a staff observation form which will be turned into the director monthly so compliance can be monitored.</p>	10/11/2015

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	<p>presented to him, or to assist the client in meal preparation.</p> <p>Client #1's record was reviewed on 9/8/15 at 8:53 A.M. Review of client #1's 5/1/15 Individual Support Plan indicated the client had the following active treatment objectives which could have been implemented during the 9/8/15 observation period: "1. Put away up to 3 items. 2. Say yes or no. 3. Assist in putting napkin on table."</p> <p>Client #2's record was reviewed on 9/8/15 at 9:27 A.M. Review of client #2's 8/1/15 Individual Support Plan indicated the client had the following active treatment objectives which could have been implemented during the 9/8/15 observation period: "1. Choose an item presented to him, and, 2. Assist in meal preparation."</p> <p>Residential Director #1 was interviewed on 9/9/15 at 10:17 A.M. Residential Director #1 stated, "There are supposed to be two staff working in the morning. Staff (direct care staff) should have been implementing client objectives and engaging the clients in active treatment."</p> <p>9-3-4(a)</p>			
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W 0268  Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed to assure 1 of 2 sampled clients (client #1's) hair was neat and combed.</p> <p>Findings include:</p> <p>Client #1 was observed at the group home during the 9/8/15 observation period from 6:26 A.M. until 8:10 A.M. During the observation period, client #1's hair was disheveled and needed combing. Direct care staff #1, #2, #3, and #4 did not prompt or assist client #1 in combing his hair.</p> <p>Residential Director #1 was interviewed on 9/9/15 at 10:17 A.M. Residential Director #1 stated, "Staff (direct care staff #1, #2, #3, and #4) should have prompted or assisted [client #1] to comb his hair to have a nice appearance."</p> <p>9-3-5(a)</p>			W 0268	<p>All staff have been re-trained on completing grooming and personal hygiene needs for all individuals. Ct#1's ISP has been updated to include a daily goal for assisting with hair brushing. The residential manager and QIDP will complete weekly observations to ensure effectiveness of training and progress on goal. These observations will be documented on the ISP data sheet and will be turned in monthly to the director to ensure compliance.</p>		10/11/2015

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W 0382  Bldg. 00	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview, the facility failed to ensure medications were locked except when they were being prepared for administration for 2 of 2 sampled clients (clients #1 and #2) and 2 additional clients (clients #3 and #4).</p> <p>Findings include:</p> <p>Clients #1, #2, #3, and #4 were observed during the group home observation period on 9/9/15 from 6:26 A.M. until 8:10 A.M. Upon entering the facility, prescription medications belonging to the clients were observed on the counter in the open laundry/medication area. One staff, direct care staff #1, was in the facility and walked through the facility with the surveyor leaving the medications on the counter and unlocked. The medications were accessible to clients #1, #2, #3, and #4 who lived in the group home.</p> <p>Residential Director #1 was interviewed on 9/9/15 at 10:17 A.M. Residential</p>	W 0382	<p>Staff have received additional training on the proper storage of medications. This training included securing the medications in the locked cabinet prior to leaving the medication area. The QDDP, Residential Manager or nurse will complete spot checks for one month to ensure that the medication storage policy is being followed. These unannounced spot checks will be completed three times on first shift, three times on second shift, three times on third shift. Thereafter, weekly spot checks will be completed. Observations will be documented on a Medication Administration Tracking form and turned into the director monthly so compliance can be monitored.</p>	10/11/2015

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W 0473 Bldg. 00	<p>Director #1 stated, "Medications are to be locked when they aren't being administered."</p> <p>9-3-6(a)</p> <p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview, the facility failed to ensure the clients received scrambled eggs and hash browns at an appropriate temperature, within 15 minutes upon removal from the temperature control device, for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>Clients #1 and #2 were observed at the group home during the 9/9/15 observation period from 6:26 A.M. until 8:10 A.M. Upon entering the group home at 6:26 A.M., cooked hash brown potatoes were in a frying pan on the stove. At 6:46 A.M., direct care staff #1 prepared scrambled eggs. After preparing the eggs, direct care staff #1 turned off all heat sources on the stove. The scrambled eggs and hash brown</p>	W 0473	All staff have received retraining on food preparation including serving of food at the required temperature and within 15 minutes from removing from temperature controlled device. All staff will be monitored by the QIDP, residential manager, or nurse to ensure that foods are being served within 15 minutes of removal from temperature controlled device. Mealtime observations will be completed at three breakfast times, three lunch times, and three dinner times to ensure that staff are implementing proper procedures. Once competency is ensured through these checks, management staff will conduct weekly observations of meals. These will be documented on the dining checklist which will be turned into the director monthly so compliance can be monitored.	10/11/2015	

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	<p>potatoes remained on the stove, unheated, until clients #1 and #2 ate their morning meal, which included the scrambled eggs and hash brown potatoes at 7:31 A.M.</p> <p>Residential Director #1 was interviewed on 9/9/15 at 10:17 A.M. Residential Director #1 stated, "Foods should be kept warm or cold until they (clients #1 and #2) eat."</p> <p>9-3-8(a)</p>						