STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF PROVIDER OR SUPPLIE		825 ME	ADDRESS, CITY, STATE, ZIP C ENDLESON DR IOND, IN 47374	CODE	
(X4) ID SUMMARY PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
recertification a This visit include complaint #INGComplaint #INGComplaint #INGFederal and stat the allegations a W122, W149, W W210, W318, W Dates of Survey and 22, 2014.Dates of Survey and 22, 2014.Facility Number Provider Numb AIMS NumberSurveyor: Vick These deficience findings in accor Quality Review Ruth ShackelforN000102483.410 GOVERNING BO	200154234: Substantiated, te deficiencies related to are cited at W102, W104, W153, W154, W159, W331. y: September 8, 10, 11, 12 er: 000904 er: 15G390 : 100233320 ie Kolb, RN cies also reflect state ordance with 460 IAC 9. y completed 9/29/14 by	W000000			

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. PRINTED:

10/24/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG governing body and management requirements are met. Based on observation, record review and W000102 See 104, 122, and 318 10/17/2014 interview, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sample clients (A, B and C) and 4 additional clients (D, E, F and G). The governing body failed to exercise general policy and operating direction over the facility to prevent the neglect of client G resulting in a fractured hip and failed to ensure client C's medical needs were met. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were reported immediately to the administrator and/or to the BDDS (Bureau of Developmental Disabilities Services) and APS (Adult Protective Services) according to state law for client E and to ensure all allegations of abuse/neglect, all client to client abuse and all injuries of unknown origin were thoroughly investigated and/or an investigation was conducted for clients A, B, C, D, E and F. The governing body failed to exercise general policy and operating direction over the facility to ensure client A's, B's and C's records were maintained, to ensure a full and complete accounting of client A's and C's funds and expenditures,

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y6

Y6CM11 Facility II

Facility ID: 000904 If

If continuation sheet Page

PRINTED:

10/24/2014

Page 2 of 179

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION 00		TE SURVEY IPLETED
		15G390	B. WING				22/2014
NAME OF I	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP COD	E	
BENCH	IARK HUMAN SEI	RVICES	825 MENDLESON DR RICHMOND, IN 47374				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX ΓAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETIC DATE
	and to ensure th	ne facility was maintained					
	and in good rep	air for the clients living in					
	the home (clien	ts A, B, C, D, E and F).					
	Findings includ	e:					
	1. The governin	ng body failed to exercise					
	general policy a	and operating direction					
	over the facility	to prevent the neglect of					
	client G resultin	ng in a fractured hip and to					
	ensure client C'	s medical needs were met.					
	The governing	body failed to exercise					
	general policy a	and operating direction					
	over the facility	to ensure all allegations					
	of abuse were r	eported immediately to					
	the administrate	or and/or to the BDDS					
	(Bureau of Dev	elopmental Disabilities					
	Services) and A	APS (Adult Protective					
	Services) accor	ding to state law for client					
	E and to ensure	all allegations of					
		all client to client abuse					
	and all injuries	of unknown origin were					
	thoroughly inve	estigated and/or an					
		as conducted for clients					
	-	nd F. The governing body					
		se general policy and					
		tion over the facility to					
		s, B's and C's records					
		d, to ensure a full and					
		nting of client A's and C's					
	-	nditures, and to ensure the					
	-	intained and in good					
	-	ients living in the home					
	-	, D, E and F). Please see					
	(chefits A, B, C	, D, E and F). Please see					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		00	. ,	TE SURVEY MPLETED	
		15G390	B. WINC			- 09/	/22/2014	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP C	CODE		
NAME OF	PROVIDER OR SUPPLIE	R		825 ME	NDLESON DR			
BENCH	MARK HUMAN SEI	RVICES		RICHM	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	W104.							
	2. The governi	ng body failed to ensure						
	-	the Condition of						
		lient Protections for						
	-	D, E, F and G. The						
		failed to prevent the						
		t G resulting in a fractured						
	-	o ensure client C's medical						
	-	in regard to client C's						
		nd seizures. The						
	-	failed to ensure all						
		buse were reported						
		the administrator and/or						
		Bureau of Developmental						
	Disabilities Ser	vices) and APS (Adult						
	Protective Serv	ices) according to state						
	law for client E	. The governing body						
	failed to ensure	all allegations of						
	abuse/neglect, a	all client to client abuse						
	and all injuries	of unknown origin were						
	thoroughly inve	estigated and/or an						
	investigation w	as conducted for clients						
	A, B, C, D, E a	nd F. Please see W122.						
	3. The governir	g body failed to ensure						
	-	the Condition of						
	-	lealth Care Services for						
	_	D, E, F and G. The						
		failed to ensure the						
		ices met the needs of the						
		ility nursing services						
		p and implement a						
		care that included how						
	I T T T T T T T T T T T T T T T T T T T		1				1	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE CC	DNSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING UU B. WING		00	COMPLETED 09/22/2014		
		D		STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF	PROVIDER OR SUPPLIE	ĸ		825 ME	NDLESON DR			
BENCH	MARK HUMAN SEI	RVICES		RICHM	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		monitor and assist client						
	-	e day inside and outside						
		regard to client C's						
	-	nd seizures, to ensure						
		hysical Therapy)						
		ressed client C's						
	-	fine/gross motor skills						
	· ·	s and getting on and off						
		and to ensure client C's						
		nmendations were						
		facility nursing services						
		and revise client G's Risk						
		gard to client G's injuries						
		ure an assessment from						
	· · ·	al Therapy/Occupational						
		ompleted and to assess						
		ent G in regard to skin						
		entified skin breakdown						
		The facility nursing						
		to develop and implement						
		of care to address client						
		nedications and medical						
	-	cility nursing services						
		all medications were						
	labeled with the							
	-	age, route, time to be						
		narmacy recommendations						
		ensure annual physical						
		nd routine screening for						
		of cancer for clients B and						
		nual hearing, vision and						
		ons for clients A, B and C,						
		l TB (Tuberculosis)						
	testing and/or s	creening for clients B and						

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION	(X3) DATE	IB NO. 0938-0391 SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUII B. WIN	LDING G	00	COMPL 09/22	
	ROVIDER OR SUPPLIE		•	825 MEN	DDRESS, CITY, STATE, ZIP CODE NDLESON DR DND, IN 47374	•	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF C, to ensure qua assessments for ensure the pharm quarterly review regimens for cli ensure all drugs compliance with orders for client Please see W31	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) arterly nursing/health clients A, B and C, to macist conducted vs of the clients' drug ents A, B and C and to were administered in h the clients' physicians' is B, C, D, E, F and G. 8. relates to complaint		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W000104	policy, budget, ar the facility. Based on obser- interview for 3 and C) and for 4 F and G), the go exercise genera direction over the neglect of clien- hip and to ensur- were met.	DDY bdy must exercise general ad operating direction over vation, record review and of 3 sampled clients (A, B 4 additional clients (D, E, overning body failed to 1 policy and operating he facility to prevent the t G resulting in a fractured re client C's medical needs	WO	00104	In addition tobelow, please see W110, W140, W149, W153, and W154. Correctiveactionforresident(s)fd dtohavebeenaffected Maintenance work order was submitted on 10-7-14 by theRD. maintenance department will fixt linoleum, the plaster, the veneer, shower curtain, and the door knot These will be fixed by the maintenancedepartment or outsid	The he the b.	10/17/201

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

PRINTED: 10/24/2014 FORM APPROVED OMB NO. 0938-0391

TATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	LETED
		15G390	A. BUILDING B. WING		- 09/22	/2014
LL ME OF S				EET ADDRESS, CITY, STATE, ZIP (CODE	
NAME OF 1	PROVIDER OR SUPPLIE	R		MENDLESON DR		
BENCH	MARK HUMAN SEF	RVICES	RIC	HMOND, IN 47374		
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		DECTION	(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	ALLINGINIALE	DATE
	general policy a	nd operating direction		10-17-14.		
	over the facility	to ensure all allegations				
	of abuse were re	eported immediately to		Howfacilitywillidentify		
	the administrate	or and/or to the BDDS		ntspotentiallyaffectedar surestaken	nuwnatinea	
	(Bureau of Dev	elopmental Disabilities		All residentscould be aff	fected	
	·	PS (Adult Protective		andcorrective action will		
	,	ding to state law for client		needsof all clients.		
	· · · · ·	all allegations of				
		U		Measuresorsystemiccha		
	-	Il client to client abuse		putinplacetoensurenore		
	5	of unknown origin were	-			
	0,	stigated and/or an		maintenance by theRegi	-	
	-	as conducted for clients		on 10-1-14 and 10-3-14.		
	A, B, C, D, E ar	nd F.	The GHM and the Qwill be retrained			
			on conducting and follow			
	The governing l	oody failed to exercise		monthly Quality		
	general policy a	nd operating direction		EnvironmentalChecks by	y the RD on	
	over the facility	to ensure client A's, B's		10-3-14.		
		were maintained, to		Howcorrectiveactionsw	illhomonito	
		d complete accounting of		redtoensurenorecurren		
		's funds and expenditures,		The GHM will submital		
		e facility was maintained		maintenance requests to	the	
		air for the clients living in		AWS/Benchmark mainte	enance	
	0 1	ts A, B, C, D, E and F).		department and willcopy		
	the nome (chem	IS A, D, C, D, E and F).		The maintenance departs		
	Din din an in also d			document on each reque they fulfilled the mainter		
	Findings include	e:		requestand will turn a co		
				to the GHM.	PJ Cuck III	
		were conducted at the		Monthly a member of the	e	
		A's, B's, C's, D's, E's and		management team condu	ict an	
	F's home) on 9/8/14 between 3:30 PM			environmental quality ch		
	and 7:15 PM.			and turn itinto the RD fo	-	
	A portion of	the linoleum was missing		and compliance. A mem		
	on the floor betw	ween the shower and the		management is in each h	-	
	sink, the plaster	along the shower stall		and will report anyfacilit maintenance concerns to		
		0		mannenance concerns to		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet Page 7 of 179

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE C	ONSTRUCTION		ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		15G390	B. WI			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIF	P CODE	
DENOU					ENDLESON DR		
BENCHI	MARK HUMAN SE	RVICES		RICHIV	10ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		abinet around the sink was					
		ed and peeling. The					
		was stuck on the rod in an					
		nd very difficult to move					
	and/or slide into	o a closed position for					
	showering.						
	The door kno	b on client A's door was					
	broken and han	ging from the door.					
	Interview with	the RM (Residential					
	Manager) and (QIDP (Qualified					
		abilities Professional) #1					
		15 PM indicated the					
		be maintained and in good					
	repair at all tim	-					
	2 The governir	ng body failed to exercise					
	-	and operating direction					
		to ensure the client A's,					
	5	ords were maintained.					
	Please see W11						
		0.					
	2 The governin	ng body failed to exercise					
	•	and operating direction					
		to ensure a full and					
	-						
	-	nting of client A's and C's					
	-	nditures. Please see					
	W140.						
	4 751 .	1 1 0 1 1					
	-	ng body failed to exercise					
	e	and operating direction					
	-	to prevent the neglect of					
		ng in a fractured hip and to					
	ensure client C	s medical needs were met.					

STATEME							
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		APLETED
		15G390	B. WIN	G			22/2014
NAME OF	PROVIDER OR SUPPLIEI	{			ADDRESS, CITY, STATE, ZIP CC	DE	
	MARK HUMAN SEF				NDLESON DR OND, IN 47374		
					UND, IN 47574		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	COMPLETIC DATE
		ody failed to exercise					
		nd operating direction					
		to ensure all allegations					
	-	ported immediately to					
		r and/or to the BDDS and					
		to state law for client E					
	and to ensure all						
		Il client to client abuse					
	-	of unknown origin were					
		stigated and/or an					
		is conducted for clients					
	-	d F. Please see W149.					
	<i>A</i> , <i>D</i> , <i>C</i> , <i>D</i> , <i>L</i> an	a 1.11ease see w 1+9.					
	5. The governing	g body failed to exercise					
		nd operating direction					
	-	to ensure all allegations					
		ported immediately to					
		r and to the BDDS and					
		to state law for client E.					
	Please see W153	3.					
	6. The governing	g body failed to exercise					
	-	nd operating direction					
	• • •	to ensure all allegations					
	-	, client to client abuse					
	-	nknown origin were					
	-	stigated and/or an					
		s conducted for clients					
	-	d F. Please see W154.					
	This federal tag	relates to complaint					
	#IN00154234.	relates to complaint					
	9-3-1(a)						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COM	PLETED
		15G390	B. WING		09/2	2/2014
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIE	R	825 M	ENDLESON DR		
BENCH	IARK HUMAN SEF	RVICES	RICHM	10ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	IN	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
W000110	recordkeeping sy separate record f Based on record 3 of 3 sample cl facility failed to records. Findings includ Client A's recor 9/10/14 at 2 PM reviewed on 9/1 record was revi- AM. The clients the clients' curra and/or program Interview with I PM indicated L employment wi and LPN #1 fill January through facility hired LI #4 worked four terminated her of facility on Augu- indicated she w	develop and maintain a stem that includes a for each client. I review and interview for lients (A, B and C), the maintain the clients' e: d was reviewed on I. Client B's record was 0/14 at 3 PM. Client C's ewed on 9/11/14 at 10 s' records did not include ent medical information	W000110	Correctiveactionforresident(dtohavebeenaffected Filing days were held on 10-2 10-3-14. On these dates all m files and medicalfiles were fil with all required documentation the current 12months. These will be maintainedby the QID the LPN with assistance from Medical Floater and theGHM Howfacilitywillidentifyother ntspotentiallyaffectedandwh surestaken All residentscould be affected andcorrective action willaddre needsof all clients. Measuresorsystemicchanges putinplacetoensurenorecurre The QIDP and LPNwill be reformed account on filing and purging all client documentation. Documentati be filed at least monthlyand p year information purged account AWS/Benchmark purging pol A QIDP-d has been hiredto m filing. This QIDP-d willmain files daily and turn a monthly audits into the QIDP and theR	-14 and ain led on for charts P and the reside atmea ess the facility ence rained t on is to revious reding to icy. aintain tain file	10/17/2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 10 of 179

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Howcorrectiveactionswillbemonito During interview with QIDP (Qualified redtoensurenorecurrence Intellectual Disabilities Professional) #1 A QIDP-d has beenhired to maintain and #2, the RM (Residential Manager), filing. This QIDP-dwill maintain LPN #1 and LPN #2 on 9/12/14 at 3:15 files daily and turn monthly file PM: audits into the QIDP and the RDto ensure 100% compliance. The RM indicated the clients' records The RD will conduct random file were currently being stored in her office audit to ensure compliance with in card board boxes and in stacks/reams purging and filing at of papers on the floor, not filed and not leastquarterly. organized. QIDP #1 and the RM stated they had to sort through "piles of paper" to find the requested survey items and still were not able to find everything requested. QIDP #1 stated the clients' records had not been filed for "Six to twelve months and maybe longer" and "We are still trying to locate things." The RM and both QIDPs both indicated they were hired in May 2014. The RM stated the facility had recently had a large turnover of administrative staff and stated, "We are still not sure where everything is." QIDP #1 stated they were unable to do their jobs efficiently because "of the mess we walked into." QIDP #1 stated the responsibility of maintaining the clients' records was the responsibility of the QIDPs, "But they (the previous QIDPs) apparently weren't doing their job because it hasn't been done for a long time." QIDP #1 stated she did not know the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11 Facility ID: 000904 If continuation sheet Page 11 of 179

PRINTED:

10/24/2014

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/22/2014	
	PROVIDER OR SUPPLIE		825 MI	ADDRESS, CITY, STATE, ZIP CO ENDLESON DR 10ND, IN 47374	DDE	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
W000122	records were in were in." 9-3-1(a) 483.420 CLIENT PROTEC	"as bad a shape as they				
	protections requi Based on interv the facility failed of Participation of 3 sampled cl additional clien facility failed to and procedures: To prevent th resulting in a fr To ensure nu and implemented in regard to clie seizures. To ensure all reported immed and/or to the BI Developmental APS (Adult Pro according to sta To ensure all abuse/neglect, a	iew and record review, ad to meet the Condition : Client Protections for 3 ients (A, B and C) and 4 ts (D, E, F and G). The properties of client G actured hip. rsing services developed ed a specific plan of care ent C's frequent falls and allegations of abuse were liately to the administrator DDS (Bureau of Disabilities Services) and tective Services) tte law for client E. allegations of all client to client abuse of unknown origin were	W000122	Please see W149, W153,	and W154.	10/17/201

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BI	UILDING	00		
		15G390	В. W	ING		09/	/22/2014
				STREET	ADDRESS, CITY, STATE, ZIF	P CODE	
NAME OF	PROVIDER OR SUPPLIE	.R		825 ME	ENDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHM	10ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	DROUNDED/C DLAN OF C	NORDECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)		DATE
	investigation w	as conducted for clients					
	A, B, C, D, E a	nd F.					
	Findings includ	e:					
	1 The facility f	ailed to implement their					
	abuse/neglect p	•					
	• •	ne neglect of client G					
	resulting in a fr	-					
	-	rsing services developed					
		ed a specific plan of care					
	-	ent C's frequent falls and					
		•					
		cluded how the staff were					
		assist client C throughout					
		nside the home, in the					
		hroom and while outside					
		n the facility van. The					
		services failed to ensure					
		hysical Therapy)					
	assessment add	ressed all of client C's					
	mobility needs	in regard to client C's fine					
	and gross moto	r skills, going up and					
	down steps and	getting on and off the					
	facility van.						
	To ensure all	allegations of abuse were					
		liately to the administrator					
	-	DDS (Bureau of					
		Disabilities Services) and					
	-	tective Services)					
		ite law for client E.					
	-	allegations of					
		all client to client abuse					
	-	of unknown origin were					
	-	estigated and/or an					
	I Inoroughly inve	sugaled and/or an			1		1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014
	PROVIDER OR SUPPLIE		825 M	ADDRESS, CITY, STATE, ZIP CODE ENDLESON DR 10ND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIO DATE
	investigation wa	as conducted for clients ad F. Please see W149.			
	allegations of all immediately to to to the BDDS (B Disabilities Serve Protective Servi law for client E. 3. The facility fa allegations of all	ailed to ensure all buse were reported the administrator and/or ureau of Developmental vices) and APS (Adult ces) according to state Please see W153. ailed to ensure all buse/neglect, client to injuries of unknown			
	and/or an invest clients A, B, C, W154. This federal tag	oughly investigated igation was conducted for D, E, F and G. Please see relates to complaint			
	#IN00154234. 9-3-2(a)				
W000130	The facility must of clients. Therefore privacy during tre personal needs. Based on observ	F CLIENTS RIGHTS ensure the rights of all e, the facility must ensure atment and care of vation and interview for 1 (E), the facility failed to	W000130	Corrective action for resident(s) found to have beenaffected All consumers are tohave privacy	

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

STATEME:	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(\mathbf{V}_{2}) MULTIDLE C	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
THE LEAN	OF CORRECTION	15G390	A. BUILDING	00	09/22/2014
		100000	B. WING		03/22/2014
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				ENDLESON DR	
BENCH	MARK HUMAN SEF	RVICES	RICHN	10ND, IN 47374	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	ensure client E	was provided privacy		while changing or showering. All	
	while showering	g and dressing.		staff will receive retraining on	
				privacy for clients while showerin changing and the records of training	-
	Findings includ	e:		will be placed in the employee	ing
	-			HRfile.	
	Observations w	ere conducted at the			
		n 9/10/14 between 5:30		How facility will identify other	
	-	M. At 7:10 AM staff #4		residents potentiallyaffected and	1
		soom with client E		what measures taken	
				All consumers couldpotentially b affected and corrective action pla	
	-	E to get dressed after		will address the needs of all client	
	-	nt E was standing on a		will address the needs of all cheft	5.
		ing nothing but a top and		Measures or systemic changes	
		ff #4 was bent down at		facility put in place toensure no	
		nd trying to get client E to		recurrence	
	step into the par	nt legs she was holding.		Staff will be trained to provide	
	The bathroom d	loor was fully open and		clients privacy whileshowering of	
	the wet towel un	nder client E's feet was in		changing. This record oftraining be placed in the employee HR file	
	front of the doo	r. Staff #4 did not close		proof of training.	<i>z</i> as
	the door and/or	provide client E privacy		proof of training.	
		g and/or dressing.		How corrective actions will be	
				monitored to ensure norecurren	ce
	During interview	w with QIDP (Qualified		The GHM, Supervisors, and QID	
	-	abilities Professional) #1		will monitor for all healthand safe	ety
		esidential Manager) on		issues including privacy at the	hor
	· · ·	•		weekly and daily visits. One mem of management stays in the	UCI
		PM, QIDP #1 indicated		homeweekly until 7pm to provide	eon
		provide the clients		the spot training. This will include	
		athing, toileting and		the necessity for teachingstaff hor	
	-	M stated the staff "should		monitor health and safety of the	
	have closed the	door."		clients. The member of managen	
				will record theirobservations and	-
	9-3-2(a)			teachable moments on the Manag	er
				Observation Log.	
				Also a member of management w conduct random pop invisits at	111
				varying times on different shifts a	

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet Page 15 of 179

	R MEDICARE & MEDI						1B NO. 0938-0391
	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	15G390	A. BUIL		00		2/2014
		100000	B. WINC			00/22	2014
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	ARK HUMAN SE				ENDLESON DR IOND, IN 47374		
					IOND; IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ТЕ	COMPLETION DATE
IAU	REGULATORIO	R LSC IDENTIFTING INFORMATION)		IAU	days at least weekly.		DATE
					A member of management staff w	vill	
					conduct observations in the home		
					daily to provide on the spot training	ng	
					and ensure the completion ofactiv	ve	
					treatment both formal and		
					informal. The managers will reco		
					their observations and visits on the MOL.		
					MOL.		
W000140	483.420(b)(1)(i)						
	CLIENT FINANC	-					
		establish and maintain a					
		res a full and complete ents' personal funds					
	entrusted to the facility on behalf of clients.						
	Based on interv	W00	0140	Corrective action for resident(s)		10/17/201	
	2 of 3 sampled			found to have been affected			
	facility failed to			The AWS/Benchmarkclient finance			
	2	nting of the clients' funds			policy is already in place. All consumer finances, deposits and		
	and expenditure			expenditures, are to be tracked on	the		
				cash on hand ledger. When a			
	Findings includ			clientrequests money from the CC	ЭH		
	Findings include.				bag, the client and a staff must sig	gn	
	Client A's finar	cial records were			that the consumerhas been given	1	
		1/14 at 1:30 PM.			money. When a new depositis mainto the COH bag, the client and t		
		ds indicated the following			staff must sign that money hasbee		
		om client A's COH and			deposited.		
					The day services PCwill audit the		
	3/7/14 for \$12.0	nt for "workshop":			COH bag at the day program at le		
					weekly to ensure the correctmone	ey is	
	3/19/14 for \$16				present and will initial the ledger. The GHM or GHS will au	dit	
	3/28/14 for \$12				the COH bag at the home at least		
	4/21/14 for \$6.0				weekly toensure the correct mone		
	4/21/14 for \$20				present and will initial the ledger.	-	
	4/30/14 for \$18						
	5/9/14 for \$5.00				How facility will identify other		
	5/22/14 for \$20	25			residents potentially affected and	1	1

	R MEDICARE & MEDIO NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	B NO. 0938-0391 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	
		15G390	A. BUILDI	ING		09/22/	/2014
			B. WING	TDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			ENDLESON DR		
BENCH	MARK HUMAN SEF	RVICES			IOND, IN 47374		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	-	ГAG	DEFICIENCY)	IE.	DATE
	6/15/14 for \$20	.00			what measures taken		
	6/23/14 for \$20	.00			All consumers couldpotentially b		
	7/3/14 for \$40.0				affected and corrective action pla		
	7/28/14 for \$12				will address the needs of all client	S.	
		00 a check written to			Maasuras or systemia changes		
		workshop by the RM			Measures or systemic changes facility put in place toensure no		
					recurrence		
		nager). The CFTR did			The Day Services PCand GHM v	vere	
		ent A's signature.			retrained on client finances by the	e	
		cial records indicated no			RD on 10-3-14.		
	-	of the money given to			The PC and GHM orGHS will au	ıdit	
	client A for the	workshop. All of the			the COH bags at least weekly to	.11	
	CFTRs were no	t signed by the client.			ensure the money is correct andwinitial the ledger.	/111	
	Client C's finan	cial records were			How corrective actions will be		
	reviewed on 9/1	1/14 at 1:45 PM.			monitored to ensure norecurrer		
	Client C's recor	ds indicated the following			Monthly the DPC willgive a co		
	withdrawals fro	m client C's COH for			of each clients COH ledger to	the	
	"workshop":				GHM for tracking and to keep in the monthly finance packet.		
	2/4/14 for \$10.0	00			The originalfinance packet will	be	
	5/29/14 for \$10				turned into the RD for review a		
	7/3/14 for \$40.0				signature beforeforwarding to		
		cial records indicated no			corporate AWS/Benchmark cl		
					finance compliance specialist.		
	-	of the money given to					
		workshop. All of the					
	CF I Ks were no	t signed by the client.					
	Interview with	the RM on 9/11/14 at 1:45					
	PM indicated m	oney was stored in the					
		inet for clients A and C					
		p. The RM indicated she					
		heck for cash out of each					
		necking accounts, cash the					
		place the money in the					
		ion cabinet for the staff to					
	lockeu meuicati	ion cabinet for the staff to					

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet Page 17 of 179

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	onstruction 00	î î	TE SURVEY IPLETED	
		15G390	B. WING		- 09/2	22/2014	
NAME OF I	PROVIDER OR SUPPLIE		STREET	ADDRESS, CITY, STATE, ZIP	P CODE		
NAME OF 1	KOVIDER OK SUFFEII			ENDLESON DR			
BENCHN	ARK HUMAN SE	RVICES	RICHM	10ND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	•	and C for the vending					
	machines at wo	rk. The RM stated client					
	C had been taki	ing her own pop "But					
	apparently she	just started taking money					
	again for some	reason." The RM					
	indicated client	s A and C did not have to					
	sign a CFTR, "I	But you know, that's a					
		e RM indicated the facility					
	-	edger of the money that					
	-	e medication room and/or					
		money the clients received					
	-	e to the workshop. When					
	-	h money was in the					
		wer, the RM indicated she					
		The RM indicated the					
		have no more than \$50.00					
		t one time. The RM					
		he money in the					
		m, clients A and C would					
		\$50.00 in the home at					
		eir was no specific record					
	-	the medication room and					
		cess to the money in the					
	medication room	m.					
	9-3-2(a)						
W000149	483.420(d)(1)						
	STAFF TREATM	IENT OF CLIENTS					
		develop and implement					
		nd procedures that prohibit glect or abuse of the client.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOD MEDICADE & MEDICAD SEDVICES

	R MEDICARE & MEDIC			ONETRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPLETED	
ANDILAN	or connection	15G390	A. BUILDING	00	09/22/2014	
		156590	B. WING		09/22/2014	
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
				ENDLESON DR		
BENCHN	1ARK HUMAN SEF	RVICES	RICHN	/IOND, IN 47374		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		review and interview for	W000149	Corrective action for resident(s) 10/17/2014	
	3 of 3 sampled of	clients (A, B and C) and 4		found to have beenaffected Risk plans, ISPs,and BSPs for al	1	
	additional client	s (D, E, F and G), the		consumers are updated annually		
	facility failed to	implement written policy		as needed when newdiagnoses of		
	and procedures:			behaviors present. The LPNwill		
	-	e neglect of client G		update the risk plan and the QID	Р	
	resulting in a fra	-		will update the ISP to reflect		
	-	rsing services developed		howclient C should be assisted w		
		d a specific plan of care		ambulating due to falls and seizu		
	-	nt C's frequent falls and		These plans will be updated no la than10-17-14.	ater	
	•	luded how the staff were		RD retrained allgroup home staff	fat	
		assist client C throughout		staff meetings on 10-1-14 and		
		-		10-3-14 on the AWSAbuse/Negl	ect	
		side the home, in the		Policy as well as the Incident		
		nroom and while outside		Reporting Policy. This will inclu-		
		the facility van. The		what is abuse/neglect, whatincide		
		services failed to ensure		are reportable, and the mandate f immediate reporting to the QIDP		
		hysical Therapy)		The RD will pass out Incident Ro		
		essed all of client C's		cardsthat provide a reminder of v		
	mobility needs i	n regard to client C's fine		incidents are reportable. Also th		
	and gross motor	skills, going up and		RD will place a reminder of		
	down steps and	getting on and off the		whatincidents are reportable on t		
	facility van.			Staff Communication Board in th	ne	
	To ensure all	allegations of abuse were		medicationroom. RD will retrain theQIDP, LPN and	nd	
		iately to the administrator		the GHM on necessary compone		
	and/or to the BI	•		of investigations. This will inclu		
		Disabilities Services) and		conducting thoroughinterviews of		
	-	tective Services)		relevant individuals, and immedi	ate	
		te law for client E.		reporting.		
	-				.,	
		allegations of		Howfacilitywillidentifyotherres ntspotentiallyaffectedandwhatr		
	-	ll client to client abuse		surestaken	пса	
	-	of unknown origin were		All residentsare affected and		
		stigated and/or an		correctiveaction will address		
	•	as conducted for clients		theneeds of all clients.		
	A, B, C, D, E ar	nd F.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 19 of 179

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G390	B. WING		09/22	2/2014
				T ADDRESS, CITY, STATE, ZIP COD	E	
NAME OF	PROVIDER OR SUPPLIE	ËR		IENDLESON DR	_	
BENCHI	MARK HUMAN SEI	RVICES	RICH			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	OPRIATE	DATE
				Measuresorsystemicchange	esfacility	
	Findings includ	e:		putinplacetoensurenorecur		
				RD retrained allgroup home		
	1. The facility's	reportable and		staff meetings on 10-1-14 ar		
	-	-		10-3-14 on the AWSAbuse/	e e	
	•	cords were reviewed on		Policy as well as the Incider Reporting Policy. This will		
		M. The 8/6/14 BDDS		what is abuse/neglect, whati		
	<u>^</u>	l on 8/6/14 at 7:30 AM		are reportable and the mand		
		er balance and fell inside		immediate reporting to theQ		
		nt G] was taken by		The RD will pass out Incide	ntReport	
	ambulance to the	ne emergency room due to		cards that provide a reminde		
	pain in her right	t hip/leg. [Client G] was		incidents are reportable. Al		
	admitted to [nat	me of hospital] after		RD will place a reminder of		
		a fracture to her hip		whatincidents are reportable Staff Communication Board		
	1 -	ry for a partial hip		medicationroom. Any curre		
		Client G] also sustained a		home staff notattending one		
		r left elbow, not requiring		meetings will be removed fr		
	more than a bar			schedule until theyreceive th		
		0		training from the RD or a de		
		follow up BDDS report		representative. The RD will		
	-	ent G] had a fall that		on these trainings and will gi	ve copies	
		oken hip, hospitalization		to HR to be placed in each		
		p replacement." The		employee's HR file. The RD retrained theQIDP,	the LPN	
	-	indicated no investigation		and the GHM on 10-3-14 or		
	of client G's inj	ury resulting in a fracture.		necessary components		
				ofinvestigations. This inclu-	ded	
	The 5/10/14 I/A	(Incident/Accident)		conductingthorough intervie		
	report and BDE	OS report indicated while		relevant individuals, and im		
	-	G with her shower staff		reporting. The RD will sign		
		right index finger was		these trainings and will give HR to be placed in each emp		
		"large black and red		HR to be placed in each emp HR file. Each client will als		
		nuckle. The report		asked about theirhome and l		
		G did not know how she		environment in their quarter		
		and was transported to the		meetings. This will be docu		
	-	-		on the meeting notesand sav		
	-	or an evaluation where she		their main chart in the office		
	was diagnosed	with a bruise, given pain		The RD retrained theQIDP a	and LPN	

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 20 of 179

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

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING	00	COMPLETED 09/22/2014		
		100000	B. WING				
NAME OF I	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP COI	DE		
DENGU							
RENCH	IARK HUMAN SE			10ND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)		
PREFIX	<u>`</u>	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP			
TAG		OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	medication and	l returned to the facility.		on 10-3-14 on updating ISI			
				Risk plans as well as sendin for pt/ot assessments as nee	-		
	The 12/5/13 B	DDS report indicated on					
	12/5/13 at 3:10	PM while trying to board		Howcorrectiveactionswill	bemonito		
	the group home	e van, client G fell up the		redtoensurenorecurrence			
		he van and landed on the		Incidents are to bereported			
	-	report indicated the staff		immediately. The RDwill			
	-	tch client G from landing		email to document the date			
		nent. "She (client G)		notified to be included with	the		
	-	ies of scrapes and redness		investigation packet. The investigationpacket is then	sent to the		
		eek, right rib area and right		RD for original signature.			
	-			sends the original investiga			
	-	t indicated client G's		to the Vice President for or			
	-	ility to climb the van steps would be		signature. The Vice Presid			
	assessed.			the original investigationpa			
	~			the Director of Compliance			
		rd was reviewed on		original signature. Once al signatures are obtained, the			
	9/10/14 at 1 PN			of Compliance scans the			
		cord indicated an elderly		investigation packet to the	RD to		
	woman over 90) years of age and		file.			
	diagnoses of, b	ut not limited to,		The RD will review100% of			
	Osteoporosis (I	brittle bones), Urinary		reports. Allincident reports			
	Incontinence, H	High Blood Pressure,		submitted to the RD as soo	-		
	Dementia (loss	of memory) and Arthritis		are submitted and theRD re incident reports. If anincid			
		on of one or more joints).		is not correct or needs addi			
				information the RD willnot			
	Client G's nurs	ing notes, not all inclusive,		QIDP to submit a follow up	5		
	indicated:						
		ght) small finger with dark					
		bruise to palm side at first					
	-	Appears could have been					
	-	d in something."					
		e sized deep purple bruise					
		(abdomen). Area in					
	alignm	nent with counter at house	1				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĩ,		DNSTRUCTION 00	r í	TE SURVEY MPLETED
		15G390	A. BU B. WI			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP ENDLESON DR	P CODE	
BENCH	BENCHMARK HUMAN SERVICES				OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETIC DATE
IAU	3."	K LSC IDENTIFTING INFORMATION)		IAU			DATE
		ch) oblong bruise to outer					
		of arm between should					
	-						
		ler) and elbow. Area is					
		height to line up with					
		par in bathroom. [Client G]					
		he might have bumped it.					
		n't hurt honey, don't worry,					
		ght.' she stated."					
		om bus steps. No apparent					
	injury.						
		ng to rt (right) hip/buttock,					
	rib area						
		Il Physical Exam some					
		weakness PT (Physical					
	-	y) for muscle					
	-	hening."					
		t G] got up to go to the					
		om when she bumped into					
		l frame. Noted quarter size					
	bruise,	dark blue/purplish in color					
	on upp	er left thigh/peri area."					
	1/30/14 PT Eva	I- "Difficulty ascending					
	steps to	get into van. Difficulty					
	rising f	rom chair, worsening over					
	past fev	w months.					
	Recom	mendations for PT tx					
	(treatm	ent) for 6 - 8 weeks."					
	2/10/14 "Mamm	no (Mammogram)					
	comple	eted Study indicates					
	-	prosis, fracture risk is					
	-	ered high."					
		en by PT for gait balance					
		engthening. Dischg					

	R MEDICARE & MEDI					_		B NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON		(2	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00			
		15G390	B. WIN	IG		_	09/22/	2014
NAME OF	PROVIDER OR SUPPLII	B		STREET AI	DDRESS, CITY, STATE, ZI	P CODE		
					NDLESON DR			
BENCH	MARK HUMAN SE	RVICES		RICHMC)ND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	HE APPROPRIATE	:	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		arged) from PT at this time.						
	Recom	mended that staff continue						
	to assis	st patient PRN (as needed)						
	for safe	ety especially in/out of						
	van."							
	5/22/14 "Revie	wed report of injury from						
	5/10/14	4 in which client (G) was						
		ed to have large black and						
	-	a of discoloration with						
	swellir	ng on index finger"						
		ved health care concern						
		n which it is reported that						
		G) has redness on her						
		from frequent loose stools						
		ne day prior. Instructed staff						
		y the Desitin cream client						
		lered for redness to peri						
		-						
		nd report back if the area						
		ns or does not show signs of						
	healing							
		ved report of injury that						
		(G) has a bruise and a scab						
		left arm/elbow. Client (G)						
	-	that she fell out of bed and						
		how she got the bruise."						
	7/24/14 "Recei	ved and reviewed health						
	care co	oncern form dated for						
	7/19/14	4 which discusses client						
	(G's) a	reas of concerns on left and						
	right b	uttocks. These areas have						
	-	ddressed and are slowly						
		g. Record of training on						
		re and toileting developed						
		nt to the group home						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì.	IULTIPLE CO	onstruction 00	(X3) DATE SURVEY COMPLETED 09/22/2014	
		15G390	B. WI				
				STREET.	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIE	.R		825 ME	ENDLESON DR		
BENCH	MARK HUMAN SEI	RVICES		RICHM	IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	I SHOLILD RE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	er and the day service					
	coordin	nator for training." Client					
	G's rec	ord indicated no further					
	nursing	g notes after the note of					
	7/24/14	4. Client G's nursing notes					
	indicat	ed nursing services did not					
	assess	and/or monitor client G's					
	buttock	and/or skin issues.					
	Client G's Risk	Summary dated 10/1/13					
	indicated client	G was at risk for					
	Osteoporosis ar	nd had a history of falls.					
	-	ndicated client G was					
	-	xercise program to help					
	-	ower extremities. The					
	-	indicated the staff were to					
		reach of client G at all					
	times when clie	ent G was ambulating in					
		nd provide hands on assist					
		lating on uneven or					
		ces. The Risk Summary					
		how the staff were to					
		tor client G in regard to					
		off the facility van and					
		d/or in her bedroom to					
		t's safety from falls.					
		2					
	Client G's recor	d indicated:					
	No screening	for bone density and/or					
	routine annual	•					
		nt from PT/OT					
		Therapy) in regard to					
	client G's fine a						
		ability to go up and down					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390		ILDING	00		OMPLETED 0/22/2014	
			B. WI		ADDRESS, CITY, STATE, ZIF			
NAME OF	PROVIDER OR SUPPLIE	ER			CODE			
BENCH	MARK HUMAN SE	RVICES			NDLESON DR OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	steps and/or to	get on and off the facility						
	van.							
	No IDT (Inte	erdisciplinary Team) notes						
	and/or meeting	s in regard to client G's						
	ambulatory nee	ds and/or injuries.						
	No daily skin	n assessments by the staff						
		e in regard to skin						
	breakdown.							
	oroundo wii.							
	The facility rec	ords indicated no						
		n regard to client G's						
	-	nown origin reported on						
	e e e e e e e e e e e e e e e e e e e	13, 10/30/13 and 7/19/14.						
	10/7/15, 10/25/	15, 10/50/15 and //19/14.						
	Interview with	staff #5 on 9/10/14 at 6						
		he was working the						
		/14 when client G was						
	e e	5 indicated there were						
	e e e e e e e e e e e e e e e e e e e	e home the morning of						
		y, one staff in the kitchen,						
		medication room and one						
		room assisting another						
		ower. Staff #5 indicated						
		ad already assisted client						
	· · · · ·	wer and client G had						
		(client G's) bedroom when						
		rd a noise and found client						
		n the hallway outside of						
		oom. Staff #5 stated, "She						
	, ,	she was ok, denied hurting						
		ust wanted to get up.						
		to get up she couldn't. We						
	-	olling desk chair and lift						
	her up into the	chair. We knew something						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CO	ONSTRUCTION 00	CO	TE SURVEY MPLETED	
		15G390	B. WI			09/	22/2014	
NAME OF	PROVIDER OR SUPPLIE	'R		STREET A	ADDRESS, CITY, STATE, ZIP COE	DE		
	MARK HUMAN SEI			825 MENDLESON DR RICHMOND, IN 47374				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE	
	was wrong and	that's when we called						
	911." Staff #5 i	ndicated client G was						
	elderly and had	issues with memory loss						
	and did not alw	ays remember how she						
	was injured. Sta	aff #5 indicated no staff						
	were with clien	t G at the time of her last						
	fall. Staff #5 sta	ated, "It gets kinda crazy						
	at times and we	(the staff) aren't always						
	right with her w	vhen she's up."						
	Interview with	the facility's LPN on						
	9/11/14 at 1 PM	1 indicated LPN #3						
	terminated emp	loyment with the facility						
	on 12/31/13 and	d LPN #1 filled in for the						
	facility from Ja	nuary through April 2014						
	when the facilit	y hired LPN #4 in April						
	2014. LPN #4 v	worked four months and						
		rminated her employment						
		on August 15, 2014. The						
		ve done my best to try to						
	· · ·	t being here all the time						
	5 0	in when they don't have						
		n rough." The LPN						
		ad provided all nursing						
		d notes she was able to						
		G. The LPN indicated						
		e to locate client G's last						
	PT assessment.							
		d Intellectual Disabilities						
	· · · · ·	1, the RM (Residential						
		he facility's LPN were						
		9/12/14 at 3:15 PM.						
	The RM and	QIDP #1 indicated they						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	NSTRUCTION	ſ	X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	·	COMPL	ETED
		15G390	A. BUI B. WIN			-	09/22/	2014
NUME OF				_	DDRESS, CITY, STATE, ZIP C	CODE		
NAME OF	PROVIDER OR SUPPLIE	ĸ		825 ME	NDLESON DR			
BENCH	MARK HUMAN SE	RVICES		RICHMO	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	=	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)			DATE
		locate a PT assessment for						
	client G.							
	The LPN ind	icated client G's Risk						
	Summary was l	ast updated 10/1/13 when						
	LPN #3 was sti	ll with the facility.						
	QIDP #1 stat	ed the facility filing						
	system was beh	ind six to twelve months						
	"or more" and t	hey were unable to find						
	all of client G's	assessments and records.						
	QIDP #1 ind	icated there were no IDT						
	meetings in reg	ard to client G's health,						
	mobility and or	injuries.						
	QIDP #1 ind	icated she did not conduct						
		in regard to client G's						
	•	lted in a fracture. QIDP						
		l. I didn't think I would						
		vestigation." When asked						
		erved, QIDP stated "No."						
		uld there be a possibility						
		have fallen and/or injured						
	•	the date she was found on						
	_	#1 stated, "I guess it's						
		what you mean." QIDP #1						
	-	nployment with the						
		n May 2014 and she was						
		she needed to conduct an						
		r a fall resulting in a						
	-	#1 indicated all reportable						
	-	re records were provided						
	for review.	e records were provided						
	101 review.							
	An amail from	the RM on 9/15/14 at 9						
		typically" the staff assist						
	client G in getti	ng out of bed, showering,						

	R MEDICARE & MEDI						MB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I	MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	or conduction	15G390	A. BU	ILDING	00	09/22/2014		
		196990	B. WI				2/2014	
NAME OF I	PROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP CODE	E		
					ENDLESON DR IOND, IN 47374			
	MARK HUMAN SE		1		UND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	COMPLETIC DATE	
TAG		,		IAU			DATE	
		getting dressed and the						
		llow behind her (client G)						
		her." On 8/6/14 staff had						
		G with her shower, drying						
		lient G had finished her						
		vent to the living room to						
		until the staff were ready						
		to the center. "[Client G]						
		and went to her bedroom						
	for something.	A staff was busy with						
	giving meds, a	staff was busy helping						
	other clients wi	th getting dressed and						
	another staff w	as helping with breakfast.						
	No staff was rig	ght beside her or behind						
	her at the time	of the fall."						
	2. Observations	s were conducted at the						
	group home on	9/8/14 between 3:30 PM						
	and 7:15 PM. I	During this observation						
	period client C	wore a brace on her left						
	lower leg and w	valked with a forward lean						
	and an unstead							
	Observations w	vere conducted at the						
	group home on	9/10/14 between 5:30						
	AM and 8:35 A							
		riod client C was out of						
	bed at 6 AM ar							
		wearing only socks on her						
		ce on her left lower leg.						
	Client C's gait	-						
	The facility's re reviewed on 9/	portable records were $10/14$ at 10 AM						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) I	DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BI	ILDING	00	C	COMPLETED
		15G390	A. BU B. WI			— o	9/22/2014
			D. 111	-	ADDRESS, CITY, STATE, ZII	P CODE	
NAME OF	PROVIDER OR SUPPLIE	R			ENDLESON DR		
BENCHI	MARK HUMAN SEI	RVICES			IOND, IN 47374		
				ID	, 		(X5)
(X4) ID PREFIX		IMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	DATE
mo		,		mo			Diffe
		DDS report indicated					
		C did not receive her 1 PM					
		Divalproex 250 mg					
		rams) for seizure control					
	on 5/26	5/14.					
	The 6/16/14 BI	DDS report indicated					
	client (C did not receive her 7 AM					
	dose of	Divalproex 250 mg on					
	6/14/14						
	Client C's recor	d was reviewed on					
		M. Client C's record					
		oses of, but not limited to,					
	-	er and Cerebral Palsy (a					
		•					
	-	ture, muscle tone and					
		lting from brain damage).					
	-	2014 physician's orders					
		C was taking Depakote					
		rams) three times a day,					
	Lamictal 100 m	ig twice a day,					
	Oxcarbazepine	600 mg twice a day and					
	Onfi 20 mg twi	ce a day for control of					
	seizures.						
	Client C's Seizu	re Reports indicated:					
		34 PM client C was					
		g to set the table and "got					
		d began to pee her pants."					
		PM client C "yelped,					
	-	n the floor after grabbing					
		tch and said she was okay."					
		10 PM client C "Yelped,					
	grabbe	d her crotch, pee'd (sic) and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG took off for the bathroom." On 6/9/14 at 4:30 PM client C "Yelped, shook, pee'd (sic) herself and took off for the bathroom holding her crotch." On 6/15/14 at 5:47 PM client C "Was at the dinner table eating her dinner and talking to staff. Client (C) let out a yelp or cry, then her whole body stiffened, eyes got big and she was holding her private area, because she started peeing." On 6/16/14 at 7:51 PM client C "Yelped, grabbed crotch and wet on the couch and immediately got up to go change her clothes." On 6/17/14 at 6:17 PM client C "Yelped, shook, pee'd (sic) on the floor and started saying she's sorry." On 6/22/14 at 5:25 PM client C "Yelled out, whole body stiffened and she grabbed her private area because she wet herself." On 6/28/14 at 4:10 PM client C "yelled, her body stiffened at first then started shaking. Client was also holding her private area but didn't pee." On 7/1/14 at 5:30 PM client C "started shaking and her head was shaking and [client C] kept saying I'm sorry and her body shook and was shaking." On 7/6/14 5:31 PM client C was eating Facility ID: 000904

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11

If continuation sheet

Page 30 of 179

PRINTED:

10/24/2014

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	te survey /pleted 22/2014			
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C	ODE				
BENCHMARK HUMAN SERVICES			825 MENDLESON DR RICHMOND, IN 47374						
X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH		(X5) COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE			
	her din	ner and "grown (sic) and							
	chew h	er food. Kept eaten her							
	dinner								
		:50 PM client C was							
	-	in a chair and "said a few							
	words,	wet herself and shook."							
		Fall Assessment forms							
	indicated								
		55 AM while at the DP							
		rogram) client C was							
		g up the sidewalk incline to							
		and she tripped on her feet I. The assessment indicated							
		to prevent future falls							
		t client to point toes							
		d and plant feet before							
		ting to walk."							
	-	7:50 AM client C was							
	"walki	ng to the bathroom to get							
	some v	vater to take her pills when							
		ned into a chair and fell on							
		t." The assessment							
		ed actions to prevent future							
		Try to make sure she is							
		g okay to the whatever it is							
	-	bing and maybe keep an							
	-	her more when walking without her shoes."							
		20 AM client C rode to							
		on the house bus, exited							
		and was walking up a							
		ncline to enter the DP and							
	fell.								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet Page 31 of 179

	R MEDICARE & MEDI					L		B NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	JLTIPLE CON	NSTRUCTION	(X	3) DATE (COMPL	
AND FLAN	OF CORRECTION	15G390	A. BUII	DING	00		09/22/	
		156390	B. WIN				09/22/	2014
NAME OF F	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP	CODE		
					NDLESON DR			
BENCHN	/IARK HUMAN SE	RVICES		RICHMC	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	RRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)			DATE
	On 7/5/14 at 12	:50 PM client C was						
	going o	lown some steps and was						
	holding	g onto the railing. "After						
	taking	a step and having both feet						
		ep she lost her balance a						
		t still had her right hand on						
		ing (sic)." The Assessment						
		ed client C was wearing a on her left ankle and						
		ed immediate actions to						
	-	t future falls "Walk in front						
		nt and have someone walk						
	behind							
		:45 PM client C was at						
	-	up home in the living room						
		s arguing with a peer.						
		the peer went to hit client						
		nt C took a step back and						
	lost he	r balance, fell and knocked						
	over a	lamp.						
	On 8/18/14 at 1	:30 PM client C was						
	walkin	g to the break room at the						
	DP and	l fell.						
	Client C's nursi	ng notes indicated						
	5/3/14 "Receive	ed report of seizure in						
		client had seizure activity						
		ssisting with prepping						
		Client had urinary						
		nence but was able to						
		her clothes with assist of						
	-	lo injury to report."						
		ved report of injury form						
	from 5	/16 (5/16/14) in which it is						

	R MEDICARE & MEDI					OMB NO. 0938-0	
	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 15G390	LDING	00	((X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	ER	STREET A	ADDRESS, CITY, STATE, ZIP CO	DDE		
				NDLESON DR			
	MARK HUMAN SE			OND, IN 47374			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH	ECTION	(X5) COMPLET	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)		DATE	
		d that client fell out of her					
	-	the van when coming					
		rom group home outing.					
		ort no treatment was					
	needed						
	5/24/14 "Receiv	ved report of seizure. Per					
	report						
	with ro	ommates. She was joking					
	around	with peer and then					
	grabbe	d herself and was incont					
	(incont	inent) of urine. Per report,					
		tated she wanted to go					
		out did was oriented to self					
		l no (sic) show signs of					
		ion (sic)."					
		C's doctor "is aware that					
		lid not have her Divalproex					
	•	tab at 1 PM on this day."					
		ed post fall assessment					
		which it is reported that					
		ell walking up a slight					
		into the main center					
		g. No reports of injury					
	noted."						
		red report of seizure on					
		in which it is reported that and 5 seconds of seizure					
	activity during evening meal. Client ran to bathroom when						
	-	ceased, no reports of					
	injury						
		wed report of seizure 5/9/14 in which it is					
	reporte	d that client had 10					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING B. WING	00		MPLETED 22/2014
				ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIE	CR	825 ME	ENDLESON DR		
BENCH	MARK HUMAN SE	RVICES	RICHM	IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		s of seizure activity with				
		nence. Client has no				
	· ·	of injury with this				
	incider					
		ved report of seizure				
	-	/ from 6/15/14. Client				
		o have 15-20 seconds of				
	-	7. Client had episodes of				
		nence during activity."				
	-	of seizure form received.				
		x 30 second duration. No				
		reported. Client (C) seen by				
	-	of neurologist] on this				
		ew orders obtained to				
	-	ncrease of Onfi to 20 mg				
		rams) BID (twice a day)."				
		ed report of fall with no				
		"Received report of injury				
		ch it is stated that client got				
		her chair, hit her left leg				
		l on buttocks. Client				
	-	d no medical intervention				
		to this incident and has				
		complaints of pain or				
	other."					
		ed report of fall with no				
	injury.					
		ed report of seizure form				
		rure lasting 20 seconds				
		o injury to report."				
		wed report of injury for				
		te in which it is stated that				
		anded on her bottom while				
	attemp	ting to get off of the van		1		

	R MEDICARE & MEDI							B NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	C	X3) DATE	
AND PLAN	OF CORRECTION	15G390	A. BUI	LDING	00	COMPLETED 09/22/2014		
	136390		B. WIN				09/22/	2014
NAME OF 1	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CO	DE		
					NDLESON DR			
	MARK HUMAN SEI	RVICES		RICHING	OND, IN 47374			-
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE			(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	OLD BE PROPRIATE	E	COMPLETIC
IAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE			DATE
		eclining assistance from						
		lient denies injury. No						
		l intervention was required						
		to this incident."						
	7/20/14 "Receiv	ved report of seizure for						
	this dat	te. Seizure lasted approx 1						
	minute	per this report. Client was						
	not inju	ared and returned to her						
	usual le	evel of daily activities						
	shortly	after seizure ended."						
	7/21/14 "Receiv	ved report of fall on						
		in which it is reported						
		ent fell and knocked over a						
		Per staff she has a red area						
	on her							
		C) sent to [name of						
		l] ER (Emergency Room)						
	-	date in the early morning						
		in which she stuck (sic)						
		· /						
		d and was bleeding. Client						
		ated in the ER where head						
		ceration) was sutured. She						
		ed at home and was						
		ed by staff per protocol						
		euro checks."						
		ed report of seizure dated						
		No injury to report."						
	8/7/14 "Receive	ed to (sic) report of						
	seizure	on this date each lasting						
	approx	(approximately) 30						
	second	s. No injury to report."						
		was seen in the ER to						
	have su	itures removed.						
	8/13/14 client C	I's doctor signed order for						

	F OF HEALTH AND HU R MEDICARE & MEDI							RM APPROVI B NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	p	K3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED		
		15G390	A. BUI B. WIN				09/22/	/2014
			D. Wh		DDRESS, CITY, STATE, ZIP COD	E		
NAME OF	PROVIDER OR SUPPLIE	ER			NDLESON DR			
BENCH	ARK HUMAN SEI	RVICES			OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	1	ID				(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	LD BE		COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	OPRIATE		DATE
	client t	o have a PT (Physical						
		y) evaluation.						
	-	ved three reports of						
		on this client (C) for						
		e occasions on this date.						
	-	(sic) seizure each lasted						
		en (sic) one minute, no						
	5	s have been reported."						
		tion and treatment.						
		C had a seizure lasting 15						
	second	-						
		s. (Received) a (sic) injury						
	-	stating that [client C] was						
		g in the break room at the						
		op and lost her balance						
		l landing on her right hip.						
		ssisted her to here (sic) feet						
		e was assessed for injury.						
	None n							
		PM client C had a 30						
		seizure. "Started to shake						
		s incontinent. No injury."						
		PM client C had a seizure						
		itting in a chair that lasted						
		nute. "Hand shaking and						
		continent. No injury."						
	8/22/14 at 5:40	PM client C had a 30						
	second	seizure while sitting at the						
	dinner	table. No injury.						
	8/22/14 at 7:30	PM client C had a seizure						
	while s	itting on the couch. Client						
	C was	shaking all over and was						
	inconti	nent of urine. No injury.						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì	ULTIPLE CO LDING	ONSTRUCTION	. ,	E SURVEY PLETED	
		15G390	B. WIN			- 09/2	2/2014	
NAME OF	PROVIDER OR SUPPLIE	P	STREET ADDRESS, CITY, STATE, ZIP CODE					
					ENDLESON DR			
BENCH	MARK HUMAN SE	RVICES		RICHM	IOND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIC	
TAG		<i>I</i> client C had a 30 second		TAG	DEFICIENCET		DATE	
		e. No injury.						
		PM client C had a 30						
		l seizure while getting off						
		ility van at church. "Body						
		ed, got goose bumps and						
		'No' during seizure. Also						
		inent of urine. No injury."						
		ment of arme. Ito injury.						
	Client C's nursi	ing notes indicated no						
		ents of client C by the						
		fter falls and/or seizures.						
	Client C's PT e	valuation dated 8/26/14						
	indicated "Pt (p	patient) is a 40 yo (year						
	old) female wit	h CP and a resident of a						
		he (client C) has recently						
		ed incidence of falls as						
	-	of declining posture which						
		r balance and safety while						
	e 1	sents today in a left AFO						
		hotic) with left LE (lower						
	• /	rnally rotated starting at						
	-	s decreased strength						
	-	and flexion contracture (a						
	-	nuscle tissue and tendons, joint into a flexed						
		-						
	position) of left UE (upper extremity). She has a severe forward head with increased thoracic kyphosis (an excess curvature in the upper back causing a							
							1	
							1	
	hump). Berg balance assessment (a test to measure balance) was performed in						1	
		-						
		ed a 31/56. Any score less						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CON	NSTRUCTION	(X3) DATE SURVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DDVG	00	CO	MPLETED	
		15G390	A. BUIL B. WINC			09/22/2014		
			D. WINC	-	DDRESS, CITY, STATE, ZIP CO	ODE		
NAME OF 1	PROVIDER OR SUPPLIE	ER			NDLESON DR			
BENCH	MARK HUMAN SEI	RVICES			OND, IN 47374			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	PECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF	OULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	than 46 indicate	es an increased risk for						
	falls. This patie	nt would benefit from PT						
	to address abov	e issues to decreased						
	likelihood of fa	lls."						
	The PT asses	sment indicated client C						
	was not assesse	d in regard to transfers						
	and was not ass	essed for her ability to go						
	up and down th	e steps. Client C's PT						
	evaluation indic	cated no assessment of						
	client C's ability	y to get on and off the						
	facility van. Cli	ent C's PT assessment						
	indicated no lev	vel of assistance and/or						
	supervision by	the staff that client C						
	required at the group home and/or the							
	-	essment indicated no						
	recommendatio	ns to address how the						
	facility staff we	ere to supervise/monitor						
	-	t C throughout the day to						
	prevent injury f							
	Client C's Risk	Summary dated 10/1/13						
	indicated client	C was at risk for falls and						
	had a history of	falls. The Summary						
	-	ent C] has a history of						
	falls. [Client C]	was evaluated to [name						
	of hospital] phy	vsical therapy. Most recent						
	PT evaluation v	vas completed 4/15/13						
	and re-eval 8/1/	13 resulting in discharge						
	from PT 8/19/1	3. Pt (patient) requires						
		valking on uneven ground						
	-	ndent on level ground.						
		mpt [client C] when						
	-	t toe forward. Staff are to						
		ly to be sure it is on						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIPLE CO	ONSTRUCTION		ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390		ILDING	00	COMPLETED 09/22/2014	
			B. WI		ADDRESS, CITY, STATE, ZIP C		
NAME OF	PROVIDER OR SUPPLIE	R		825 ME	ODE		
BENCH	MARK HUMAN SEI	RVICES			OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		will assist [client C] in					
	-	ercise program 5 days a					
	week scheduled	l while at the center					
	Monday thru Fr	riday. If [client C] falls					
	staff are to asse	ss to see if treatment is					
	necessary. Staff	f will notify nurse of fall.					
	Staff will comp	lete injury report along					
	-	ssessment and document					
	-	ursing notes. Nurse will					
	review nursing	-					
	-						
	(Medication Administration Record) at least monthly."						
		d indicated no IDT					
	(Interdisciplinat	ry Team) meetings in					
		C's increased number of					
	seizures and fal	ls. Client C's record					
	indicated no lab	tests and/or Depakote					
	(Divalproex) le	vels in regard to client C's					
	increased seizur	re activity. Client C's					
	ISP/Risk Summ	nary failed to indicate how					
	the staff were to	o supervise/monitor and					
	assist client C th	hroughout the day while					
	ambulating to p	revent further injury from					
		ISP/Risk plan failed to					
		e staff were to monitor					
	client C through	nout the day due to					
	seizures in regard to while was alone						
	•	le in the bathroom and/or					
	alone in her bedroom. QIDP (Qualified Intellectual Disabilities						
		d Intellectual Disabilities					
		1, the RM (Residential					
	<i>,</i>	he facility's LPN were					
	ivianager) and t	ne facility S LFIN were					

	R MEDICARE & MEDI					370. 5	OMB NO. 0938-03		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	AULTIPLE CC	ONSTRUCTION	· · ·	OATE SURVEY		
AND I LAN	OF CORRECTION	15G390	A. BU	ILDING	00	- 09/22/2014			
		156390	B. WI	_					
NAME OF 1	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP	CODE			
					ENDLESON DR				
BENCH	MARK HUMAN SE	RVICES		RICHM	OND, IN 47374				
(X4) ID		STATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF COR				(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIC		
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCE)		DATE		
		9/12/14 at 3:15 PM.							
		ated she was unable to							
		of client C's records in							
	-	to the client's visits with							
		rologist and the client's lab							
		The LPN stated, "I know							
		wher neurologist recently							
		r Onfi medication was							
	increas								
	QIDP #1 indica	ited she was unable to							
		any IDT meetings in regard							
	to clien	nt C's increased seizures							
	and rec	curring falls. QIDP #1							
	stated,	"I know I haven't had any							
	meetin	gs since I've been here."							
	The LPN stated	l, "She [client C] just							
	recentl	y went to PT."							
	When asked ho	w are the staff to							
	superv	ise, monitor and assist							
	client (C throughout the day to							
	ensure	client C's safety in regard							
	to falls	, the RM indicated client C							
	ambula	ated independently and the							
	staff as	ssist her as needed.							
	QIDP #1 indica	ated no changes in client							
	-	e, client C's ISP and/or							
		ummary in regard to							
		ed falls, injury with falls							
		creased seizures.							
		ited the PT evaluation and							
	-	rapy did not address client							
		eds at the facility and at the							
	DP.								
		ited the staff were to							
		ited the starr were to							

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I	MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/22/2014	
AND FLAN	OF CORRECTION	15G390	A. BU B. WI	JILDING NG	00		
NAME OF	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZII	P CODE	
BENCH	MARK HUMAN SEI	RVICES			ENDLESON DR IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	Dericienci (DATE
		client C's Risk Summary.					
	-	e RM indicated they were the facility as of May 2014					
		re still getting to know the and their needs.					
	Chemis	and men needs.					
	3 The facility's	reportable records were					
		10/14 at 10 AM. The					
		report indicated on 6/7/14					
		ity staff overheard another					
		ent E "that she (client E)					
	-	iet and go to her room					
	-	s tired of hearing her					
		staff reported this on					
		ff training on abuse and					
	neglect." The fa	cility records indicated					
	the facility staff	failed to report an					
	allegation of ab	use immediately to the					
	administrator a	nd to APS.					
	Interview with	QIDP (Qualified					
	Intellectual Dis	abilities Professionals) #1					
		15 PM indicated all					
	allegations of a	buse were to be reported					
	-	the administrator and to					
		APS within 24 hours of					
	knowledge of the						
	abuse/neglect/n	nistreatment.					
	4. The facility's	reportable and					
	investigative re	cords were reviewed on					
	9/10/14 at 10 A	M.					
	The 2/20/14 BI	DDS report indicated on					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COME	e survey pleted 2/2014	
NAME OF	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE					
BENCH	MARK HUMAN SE	RVICES			ENDLESON DR OND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
		PM client E became						
		vo of her housemates,						
	clients A and D							
		eport/Summary indicated						
	-	e home were sitting down						
		ning meal. The report did						
		ich clients and/or staff						
		ne at the time of the abuse.						
	The Report ind	icated statements from						
	two staff and cl	ient E was asked why she						
	hit clients A an	d D. Client D stated,						
	"That girl hit m	e." Client A stated "She						
	hit me hard on	my back, very hard." The						
	facility records	did not indicate a						
	thorough invest	tigation was conducted.						
		DDS report indicated on						
	-	t F] has orders to take						
		outrin, Evista, Pepcid,						
		ybutynin, Risperdal,						
	· · · · · ·	vastatin, Thera-tab and						
		:00 AM. It was discovered						
	÷ .	med (medication) buddy						
		4 that none of these						
		d been given the morning						
		medications had been						
		ven on the MAR						
		lministration Record), but						
	all of the pills were still present in the med packs [Client F's] team needs to investigate how this happened and who is	•						
	-	he facility records						
	indicated no inv	-						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE CO	ONSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COM		
		15G390	B. WI	NG		09/	22/2014	
NAME OF	PROVIDER OR SUPPLIE	R		STREET A	P CODE			
			825 MENDLESON D					
BENCH	MARK HUMAN SEF	RVICES		RICHM	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	E APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		DDS report indicated on						
) AM client A hit client C						
	**	t arm. "During the course						
		nt C] continued to						
		nt A] and they exchanged						
		mes They also slapped or						
		everal times, never						
	e ,	ries. This continued until						
	9:30 pm when [client C] and her						
	housemate wen	t to their separate						
	bedrooms." The	e 5/29/14 Investigative						
	-	ry indicated statements						
	from two staff a	and clients A and C. The						
	-	did not indicate a						
	thorough invest	igation was conducted.						
	The 5/28/14 BE	DDS report indicated on						
	5/27/14 at 6 PM	I client D told client E to						
	"shut up" and h	it client E on the back of						
	the head with an	n open hand. The 5/30/14						
	Investigative Re	eport/Summary indicated						
	statements from	one staff and clients D						
	and E. The facil	lity records did not						
	indicate a thoro	ugh investigation was						
	conducted.							
	The 6/12/14 BE	DDS report indicated on						
		7/14 at 8 AM a facility staff overheard						
	another staff telling client E "that she							
		ed to be quiet and go to						
	her room because she was tired of hearing her (client E). The staff reported							
	this on 6/12/14 at a staff training on abuse and neglect." The 6/19/14							

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TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON	NSTRUCTION	(X3) DA	TE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COM	APLETED	
		15G390	A. BUIL B. WINC			09/	22/2014	
			D. WINC		DDRESS, CITY, STATE, ZIP COD	F		
AME OF	PROVIDER OR SUPPLIE	R			NDLESON DR	JODE		
BENCH	MARK HUMAN SEF	RVICES			DND, IN 47374			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT			
REFIX		NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE OPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	-	eport/Summary indicated						
		n the staff accused of						
	abuse and the st	taff that reported the						
	abuse and clien	t E. The investigative						
	records indicate	e no further staff and/or						
	client interview	s. The facility records did						
	not indicate a th	norough investigation was						
	conducted.							
	The 8/4/14 BDI	DS report indicated on						
	8/4/14 at 8:50 A	AM while at the DP client						
	E approached c	lient B from the rear and						
		nt B with an open hand						
		right shoulder blade. The						
		ative Report/Summary						
	indicated statem							
		ents B and E. The						
		dated 8/4/14 for client B						
		B was non verbal. The						
		did not indicate a						
		igation was conducted.						
	librough myest	igation was conducted.						
	During interview	w with QIDP (Qualified						
	•	abilities Professional) #1						
		esidential Manager) on						
		PM, QIDP #1 and the RM						
	indicated when							
		conducting and clients and all staff in the						
	-	e time of the client to						
		buld be noted in the						
		perwork and all staff and then be interviewed for the						
	-	be considered thorough.						
	QIDP #1 indica	ted she had provided all						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE C	ONSTRUCTION			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	00			
		15G390	B. W	'ING		09/22/2014		
NAME OF	PROVIDER OR SUPPLIE	ER		P CODE				
DENOU					ENDLESON DR			
BENCH	MARK HUMAN SEI	RVICES		RICHN	10ND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF O		(X5)	
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	•	nd reportable incidents for						
	review.							
		icies were reviewed on						
	9/10/14 at 10 A							
		evised "Indiana Abuse						
	0 1	olicy indicated "AWS does						
		se, neglect or exploitation						
		any person Alleged,						
	suspected or act	tual abuse, (which must be						
	reported to Adu	It Protective Services or						
	Child Protective	e Services as indicated)						
	which includes	but is not limited to:						
	physical abuse,	including but not limited						
	to: intentionally	touching another person						
	in a rude, insole	ent or angry manner,						
	willful infliction	n of injury Alleged,						
	suspected or act	tual neglect which						
	includes but is r	not limited to: failure to						
	provide appropr	riate supervision, care or						
	training, failure	to provide a safe, clean						
	and sanitary en	vironment, failure to						
	provide food an	d medical services as						
	needed"							
	The 6/13/13	revised "Incident						
		nvestigation Policy -						
		ted "Peer to peer						
		results in significant						
		up Homes: All peer to						
		is reportable; including						
		eer-to-peer aggression.						
		pes of incidents requires						
	-							
	completion of an investigation Any injury to an individual when the cause is							

CENTERS FOR	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039	
	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF F	PROVIDER OR SUPPLIE	ĒR	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
				IENDLESON DR		
BENCHI	ARK HUMAN SE	RVICES	RICH	MOND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RATE COMPLETION DATE	
140		,	IAG		DATE	
		r the injury could be				
	indicative of ab	-				
	-	ny injury to an individual				
		of the injury is unknown				
	5 5	equires a medical				
		eatment Investigating				
		he investigator conducts				
		collects written statement				
		nt individuals. Upon				
	review of all ev	idence the investigator				
	will complete th	ne Investigative Report				
	and will determ	ine if the allegation(s) are				
	substantiated or	unsubstantiated and will				
	make recomme	ndations as needed."				
	This federal tag #IN00154234.	relates to complaint				
	9-3-2(a)					
W000153	483.420(d)(2)	IENT OF CLIENTS				
	-	ensure that all allegations				
	of mistreatment,	neglect or abuse, as well as				
		wn source, are reported				
		ne administrator or to other dance with State law				
	through establish					
	-	d review and interview for	W000153	Correctiveactionforresident(s))foun 10/17/201	
	1 of 1 allegation	n of abuse reviewed, the		dtohavebeenaffected		
	-	b immediately report all		RD retrained allgroup home sta	ff at	
	-	buse to the administrator		staff meetings on 10-1-14 and	-1	
	-	DDS (Bureau of		10-3-14 on the AWSAbuse/Neg Policy as well as the Incident	glect	
		•		Reporting Policy. This will inc	lude	
	-	Disabilities Services) and		what is abuse/neglect, whatinci		
	APS (Adult Pro	otective Services)		what is abuse/neglect, whatincie	uents	

	NT OF DEPLOYER 1975	VI) DROUIDER (GUDRUIER (GUT		OMB NO. 0938-0 (X3) DATE SURVEY		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMP	
		15G390	B. WING		09/22/2014	
NAME OF	PROVIDER OR SUPPLIEI	3		TADDRESS, CITY, STATE, ZIP CODE		
				ENDLESON DR		
BENCH	MARK HUMAN SEF	RVICES	RICHI	MOND, IN 47374		_
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP	^{BE} RIATE	COMPLET
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	according to star	te law for client E.		are reportable, and the mandat		
				immediate reporting to theQIE The RD will pass out Incident		
	Findings include	e:		cards that provide a reminder of	-	
				incidents are reportable. Also		
	The facility's ren	portable records were		RD will place a reminder of		
	reviewed on 9/1			whatincidents are reportable or	n the	
				Staff Communication Board in		
	The 6/12/14 BD	DS (Bureau of		medicationroom.		
		Disabilities Services)		RD will retrain theQIDP, LPN		
	-	,		the GHM on necessary compo		
	-	on 6/7/14 at 8 AM a		of investigations. This will inc		
	-	erheard another staff		conducting thoroughinterview		
	telling client E "	that she (client E) needed		relevant individuals, and imme reporting.	chate	
	to be quiet and g	go to her room because		reporting.		
	she was tired of	hearing her (client E).		Howfacilitywillidentifyotherr	eside	
	The staff reported	ed this on $6/12/14$ at a		ntspotentiallyaffectedandwha		
	-	abuse and neglect." The		surestaken		
	-	indicated the facility staff		All residentsare affected and		
	-	an allegation of abuse		correctiveaction will address		
	-	the administrator and to		theneeds of all clients.		
	APS	the administrator and to		Measuresorsystemicchangesf	acility	
	Ars			putinplacetoensurenorecurre	-	
	T 1 /			RD retrained allgroup home st		
	Interview with (staff meetings on 10-1-14 and		
		ibilities Professional) #1		10-3-14 on the AWSAbuse/Ne	glect	
		15 PM indicated all		Policy as well as the Incident		
	allegations of ab	ouse were to be reported		Reporting Policy. This will in		
	immediately to t	the administrator and to		what is abuse/neglect, whating		
	the BDDS and A	APS within 24 hours of		are reportable and the mandate		
	knowledge of th	e		immediate reporting to the QII The RD will pass out Incident		
	abuse/neglect/mistreatment. This federal tag relates to complaint			cardsthat provide a reminder o		
				incidents are reportable. Also		
				RD will place a reminder of		
	#IN00154234.	relates to complaint		whatincidents are reportable or	n the	
	#11N00134234.			Staff Communication Board in		
				medicationroom. Any current		
	9-3-2(a)			home staff notattending one of	these	1

	MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(V2) MI		NSTRUCTION	X3) DATE	IB NO. 0938-03
	F CORRECTION	IDENTIFICATION NUMBER:			00	COMPI	
		15G390	A. BUIL				/2014
		100000	B. WINC			00/22	2011
NAME OF PI	ROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP CODE		
	ARK HUMAN SE	DVICES			NDLESON DR OND, IN 47374		
					GND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETI
IAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG			DATE
					meetings will be removed from the schedule until theyreceive this	e	
					training from the RD or a designat	ted	
					representative. The RD will sign		
					on these trainings and will give co		
					to HR to be placed in each		
					employee's HR file.		
					The RD will retrain the QIDP, the		
					LPN, and the GHM on necessary		
					components of investigations. The	is	
					included conducting thorough		
					interviewsof all relevant individua	-	
					and immediate reporting. The RD will sign off on these trainings	•	
					and will give copies to HR to be		
					placed in each employee's HR file		
					Each client will also be asked about		
					theirhome and living environment	in	
					their quarterly meetings. This wil	l be	
					documented on the meeting notesa	and	
					saved in their main chart in the		
					office.		
					Howcorrectiveactionswillbemoni	ito	
					redtoensurenorecurrence		
					Incidents are to bereported to the I		
					immediately. The RDwill write an		
					email to document the date and tir notified to be included with the	ne	
					investigation packet. The		
					investigation packet. The	the	
					RD for original signature. The RI		
					sends the original investigationpac		
					to the Vice President for original		
					signature. The Vice President sen	ds	
					the originalinvestigation packet to		
					the Director of Compliance for		
					original signature. Once all		
					signatures are obtained, theDirecto	or	
					of Compliance scans the		
					investigation packet to the RD to		1

STATEMEN	T OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	IB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPI	
		15G390	A. BUILDING B. WING		09/22	/2014
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R	825 MI	ENDLESON DR		
BENCHN	1ARK HUMAN SEF	RVICES	RICHM	10ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
				file. The RD will review 100% of		
				incident reports. All incident		
				reports are submitted to the R		
				soon as they are submitted a	nd	
				the RD reviews allincident reports. If an incident reportis	s not	
				correct or needs additional	SHOL	
				information the RD will notify	the	
				QIDP tosubmit a follow up rep	port.	
V000154	483.420(d)(3)					
		ENT OF CLIENTS				
		have evidence that all				
	alleged violations are thoroughly investigated.					
	•	l review and interview for	W000154	Correctiveactionforresident(s)	oun	10/17/2014
	11 of 18 allegations of abuse/neglect,		W 000154	dtohavebeenaffected	oun	10/17/2014
	-	buse and injuries of		RD retrained allgroup home staf	fat	
		reviewed, the facility		staff meetings on 10-1-14 and		
		a thorough investigation		10-3-14 on the AWSAbuse/Neg	lect	
		igation was conducted for		Policy as well as the Incident Reporting Policy. This will incl	ude	
	clients A, B, C,	•		what is abuse, neglect, exploitation		
	chents A, D, C,	D; E, F and O.		and injuries of unknown origin,	what	
	Findings includ			incidents are reportable, and the		
	r manigs merua	C.		mandate for immediate reporting the QIDP. The RD will pass out		
	1. The facility's	reportable and		Incident Report cardsthat provid		
	-	cords were reviewed on		reminder of what incidents are		
	•	M. The 8/6/14 BDDS		reportable. Also the RD will pla	ice a	
				reminder of whatincidents are		
	(Bureau of Developmental Disabilities Services) report indicated on 8/6/14 at 7:30 AM client G "lost her balance and fell inside her home. [Client G] was			reportable on the Staff Communication Board in the		
				medicationroom.		
				RD retrained theQIDP, LPN and	the	
				GHM on necessary components	of	
	-	ance to the emergency		investigations. This will include		
	-	n in her right hip/leg.		conducting thoroughinterviews of		
		admitted to [name of -rays showed a fracture		relevant individuals, and immed reporting.	iate	
	nospital after A	-rays showed a fracture		· r · · · · · · · · · · · · · · · · · ·		1

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

PRINTED: 10/24/2014 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC				OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G390	B. WING		09/22/2014
	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF 1	PROVIDER OR SUPPLIE	ĸ	825 ME	ENDLESON DR	
BENCH	MARK HUMAN SEP	RVICES	RICHM	10ND, IN 47374	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	BE COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	to her hip requir	ring surgery for a partial			
	hip replacement	t. [Client G] also		Howfacilitywillidentifyother	
		ration to her left elbow,		ntspotentiallyaffectedandwha	atmea
		ore than a bandage."		surestaken All residentsare affected and	
	· ·	follow up BDDS report		All residentsare affected and correctiveaction will address	
				theneeds of all clients.	
	-	nt G] had a fall that			
		oken hip, hospitalization		Measuresorsystemicchanges	facility
	· · ·	replacement." The		putinplacetoensurenorecurre	-
	facility records	indicated no investigation		RD retrained allgroup home st	
	of client G's inj	ury resulting in a fracture.		staff meetings on 10-1-14 and	
				10-3-14 on the AWSAbuse/No	eglect
	Client G's recor	d was reviewed on		Policy as well as the Incident	
		I. Client G's nursing		Reporting Policy. This will in	
		-		what is abuse/neglect, whating	
		clusive, indicated:		are reportable and the mandate	
		ht) small finger with dark		immediate reporting to theQII	
		bruise to palm side at first		The AWS Reportable Incident Policystates that any unknown	
	joint. A	ppears could have been		injuries over 3 inches in size in	
	pincheo	l in something."		way or indicative of abuse are	-
	10/23/13 "dime	sized deep purple bruise		reported. This is the policy that	
		(abdomen). Area in		staff will be trained on. The R	
		ent with counter at house 3		pass out Incident Report cards	that
	•	G's home)."		provide a reminder of what inc	idents
				are reportable. Also theRD w	
		ch) oblong bruise to outer		place a reminder of what incid	ents
	-	of arm between should		are reportable on the	
		ler) and elbow. Area is		StaffCommunication Board in	
		height to line up with		medication room. Any current home staff not attending one of	
	towel b	ar in bathroom. [Client G]		meetings will beremoved from	
	states s	he might have bumped it.		schedule until they receive this	
	'It doesn't hurt honey, don't worry,		training from the RD or adesig		
		ght.' she stated."		representative. The RD willsi	
		0		on these trainings and will giv	-
	7/19/14 "Received report of client (G) has a brui			copies to HR to be placed in	
		,		eachemployee's HR file.	
		left arm/elbow. Client (G)		The RD retrained theQIDP, th	e LPN,
	reports	that she fell out of bed and		and the GHM on necessary	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet Page 50 of 179

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

	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G390	B. WING		09/22/2014
NAME OF 1	PROVIDER OR SUPPLIE	R	STREET	TADDRESS, CITY, STATE, ZIP CODE	
NAME OF 1	FROVIDER OR SUFFLIE	ις Γ	825 M	ENDLESON DR	
BENCH	MARK HUMAN SEF	RVICES	RICH	MOND, IN 47374	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROVIDER'S DI AN OF CORRECTI	ON (X5)
PREFIX	(EACH DEFICIE)	Y MUST BE PRECEDED BY FULL PREFIX CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		DBE COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	that is h	now she got the bruise."		components of investigations	
		-		included conducting thorough	
	The facility reco	ords indicated no		interviewsof all relevant indiv	-
	-	regard to client G's		and immediate reporting. The	
	•	•		will sign off on these training	
	e e e e e e e e e e e e e e e e e e e	own origin reported on		and will give copies to HR to	
	10/7/13, 10/23/	13, 10/30/13 and 7/19/14.		placed in each employee's HI Each client will also be asked	
				theirhome and living environ	
	Interview with s	staff #5 on 9/10/14 at 6		their quarterly meetings. This	
	AM indicated sl	ne was working the		documented on the meeting n	
	morning of 8/6/	14 when client G was	saved in their main chart in the		
	-	indicated there were		office.	
	5	e home the morning of			
		, one staff in the kitchen,		Howcorrectiveactionswillbe	monito
		medication room and one		redtoensurenorecurrence	
				Incidents are to bereported to	
		room assisting another		immediately. The RDwill wr email to document the date ar	
		ower. Staff #5 indicated		notified to be included withth	
	· · · · ·	d already assisted client		investigation packet.	
	G with her show	ver and client G had		Theinvestigation packet is the	en sent
	returned to her (client G's) bedroom when		to the RD for original signatu	
	all the staff hear	d a noise and found client		RD sends the original	
	G on the floor in	n the hallway outside of		investigationpacket to the Vic	ce
		om. Staff #5 stated, "She		President for original signature	re. The
		he was ok, denied hurting		Vice President sends the	
	```	ist wanted to get up.		originalinvestigation packet to	
		<b>U</b>		Director of Compliance for or	•
		to get up she couldn't. We		signature. Once all signatures obtained, theDirector of Com	
	-	olling desk chair and lift		scans the investigation packet	-
	-	chair. We knew something		RD to file.	
	was wrong and	that's when we called		The RD will review100% of i	incident
	911." Staff #5 in	ndicated client G was		reports.	
	elderly and had issues with memory loss		The AWS Policy on Reportat	ble	
	and did not always remember how she			Incidents states that anyinjury	/ of
		ff #5 indicated no staff		unknown origin must be repo	
	5	G at the time of her last		investigated if it is 3 inches in	
				any direction or indicative of	
	1 111. Staff #5 sta	ted, "It gets kinda crazy		abuse. This is the policy that	staff

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet Page 51 of 179

ГАТЕМЕ	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CO	DNSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPLETED	
		15G390	B. WING			09/22	2/2014
AME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ENCH	MARK HUMAN SEF	RVICES			ENDLESON DR OND, IN 47374		
(4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ſ	(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	]	ГAG	DEFICIENCY)		DATE
		(the staff) aren't always			will be trained on.		
	right with her w	when she's up.			All allegations of abuse or negle exploitation will bereported and		
					investigated per AWS policy. I		
	QIDP (Qualifie	d Intellectual Disabilities			allegation is found to not be	i uli	
	Professional) #1	l, the RM (Residential			substantiated that will bedocun	nented	
	Manager) and the	he facility's LPN were			on the incident report follow up	<b>)</b> .	
	interviewed on	9/12/14 at 3:15 PM.					
	QIDP #1 indi	icated she did not conduct					
	an investigation	in regard to client G's					
	injury that resul	ted in a fracture. QIDP					
	stated, "She fell	. I didn't think I would					
		vestigation." When asked					
		erved, QIDP stated "No."					
		uld there be a possibility					
		nave fallen and/or injured					
	-	the date she was found on					
	<u>^</u>	#1 stated, "I guess it's					
		vhat you mean." QIDP #1					
	-	nployment with the					
		n May 2014 and she was					
		he needed to conduct an					
		r a fall resulting in a					
	e	#1 indicated all reportable					
	-	re records were provided					
	for review.	e records were provided					
		the RM on 9/15/14 at 9					
		typically" the staff assist					
		ng out of bed, showering,					
		getting dressed and the					
		low behind her (client G)					
		her." On 8/6/14 staff had					
		3 with her shower, drying					
	and dressing. C	lient G had finished her			1		

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. BUILDING B. WING	WING		(X3) DATE SURVEY COMPLETED 09/22/2014	
	PROVIDER OR SUPPLIEI MARK HUMAN SEF		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO		ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE EXICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	sit in her chair u to take client G got (sic) up and something. A sta meds, a staff wa clients with gett staff was helpin, was right beside time of the fall.' 2. The facility's investigative rec 9/10/14 at 10 Al The 2/20/14 BD Developmental report indicated client E became housemates, clie 2/24/14 Investig indicated the cli sitting down to a The report did n and/or staff were of the abuse. Th statements from was asked why s Client D stated, A stated "She hi very hard." The	reportable and cords were reviewed on M.					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP	CODE	
BENCH	MARK HUMAN SEI	RVICES			ENDLESON DR OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	4/20/14 "[Clien	DDS report indicated on tF] has orders to take					
	Metformin, Ox	utrin, Evista, Pepcid, ybutynin, Risperdal,					
	Vitamin D at 7:	vastatin, Thera-tab and 00 AM. It was discovered					
	check on 4/21/1	med (medication) buddy 4 that none of these					
	of 4/20/14. The	d been given the morning medications had been					
	(Medication Ad	ven on the MAR Iministration Record), but					
	med packs [C	vere still present in the Client F's] team needs to					
		this happened and who is ne facility records vestigation.					
		DDS report indicated on					
	on the upper lef	) AM client A hit client C t arm. "During the course					
	aggravate [clier	nt C] continued to and they exchanged					
	hit each other se	mes They also slapped or everal times, never					
	9:30 pm when [	ries. This continued until client C] and her					
	bedrooms." The	t to their separate e 5/29/14 Investigative					
	from two staff a	ry indicated statements and clients A and C. The did not indicate a					
	-	igation was conducted.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZI	P CODE	
BENCHMARK HUMAN SE	RVICES		ENDLESON DR IOND, IN 47374		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
<ul> <li>5/27/14 at 6 PM</li> <li>"shut up" and H</li> <li>the head with a</li> <li>Investigative R</li> <li>statements from</li> <li>and E. The fact</li> <li>indicate a thora</li> <li>conducted.</li> <li>The 6/12/14 BI</li> <li>6/7/14 at 8 AM</li> <li>another staff te</li> <li>(client E) need</li> <li>her room becau</li> <li>hearing her (client E)</li> <li>hearing her (client E)</li> <li>a statement from</li> <li>abuse and negl</li> <li>Investigative R</li> <li>a statement from</li> <li>abuse and negl</li> <li>Investigative R</li> <li>a statement from</li> <li>abuse and the se</li> <li>abuse and client</li> <li>records indicate</li> <li>client interview</li> <li>not indicate a the</li> <li>conducted.</li> <li>The 8/4/14 BD</li> <li>8/4/14 at 8:50 A</li> <li>Program) client</li> <li>from the rear at</li> <li>with an open h</li> </ul>	DDS report indicated on <i>A</i> client D told client E to at client E on the back of an open hand. The 5/30/14 eport/Summary indicated in one staff and clients D ality records did not ough investigation was DDS report indicated on a facility staff overheard lling client E "that she ed to be quiet and go to use she was tired of at a staff training on ect." The 6/19/14 eport/Summary indicated in the staff accused of thatf that reported the at E. The investigative ed no further staff and/or <i>ys</i> . The facility records did horough investigation was DS report indicated on AM while at the DP (Day t E approached client B and one time on her right . The 8/4/14 Investigative				

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G390		(X2) MULTIPLE CO A. BUILDING B. WING	00	CON 09/2	X3) DATE SURVEY COMPLETED 09/22/2014	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR				
-	IARK HUMAN SEI			IOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
/000159	from two staff a statement form indicated client facility records thorough invest During intervie Intellectual Dis- and the RM (Re 9/12/14 at 3:15 RM indicated w investigation al home/area at th client abuse sho investigative pa clients should th investigations a for review. This federal tag #IN00154234. 9-3-2(a)	and clients B and E. The dated 8/4/14 for client B B was non verbal. The did not indicate a igation was conducted. w with QIDP (Qualified abilities Professional) #1 esidential Manager) on PM, QIDP #1 and the when conducting an l clients and all staff in the e time of the client to ould be noted in the uperwork and all staff and hen be interviewed for the be considered thorough. ted she had provided all and reportable incidents					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y6CM11

111 Facility ID: 000904

0904 If cont

If continuation sheet Page

Page 56 of 179

PRINTED:

10/24/2014

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/24/2014 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC				OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G390	B. WING		09/22/2014
NAME OF I	PROVIDER OR SUPPLIE	• •	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	FROVIDER OR SUFFLIEF	< compared with the second sec	825 ME	ENDLESON DR	
BENCH	/IARK HUMAN SER	VICES	RICHM	IOND, IN 47374	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Based on observ	ation, interview and	W000159	In addition tobelow, please see	10/17/2014
	record review for	record review for 3 of 3 sample clients		W140, W210, W225, W240, W2	49,
	(A, B and C) and	d 4 additional clients (D,		W262, W263, W312, and W488.	
		facility QIDP (Qualified		Corrective action for resident(s	
		bilities Professional)		found to have beenaffected	,
		te, coordinate and		The QIDP was retrained by the R	D
	•	ent's active treatment		on conducting monthly reviews of	
		ents active treatment		client objectives on10/3/14. This	
	program.	1.4		includes reviewing, tracking, and	
	The QIDP failed			reporting on the objectives. The	
	· · ·	nd C's objectives were		QIDP will write and submit a	
		d and revised quarterly.		Monthly Summary report to the I andCompliance Officer by the 20	
	-	lete accounting of client		of the following month.	
	A's and	C's funds and		of the following month.	
	expendi	tures.		How facility will identify other	
	The Interdiscipli	inary Team (IDT)		residents potentiallyaffected and	d
	assessed	d/reassessed client A's		what measures taken	
	repeated	l refusals to take her		All consumers couldpotentially b	
	prescrib	ed medications and		affected and corrective action pla will address the needs ofall client	
	-	to comply with medical		will address the needs ofall chem	5.
		s, client B's fine and gross		Measures or systemic changes	
	-	kills, client C's pattern of		facility put in place toensure no	
		ed falls and seizures and		recurrence	
				The QIDP willreceive the objection	
		o ambulate over uneven		tracking from the Team Leader n	
		s, inclines, going up and		later than the 1stbusiness day of t	
		eps and getting on and off		month. The QIDP willreview the monthly objectives, track them, a	
		lity van and client G's		then report on them on themonth	
		tory needs to prevent		summary report.	<i>.</i>
		injury from falls.			
	Vocational asses	ssments were conducted		How corrective actions will be	
	and the	clients' present and future		monitored to ensure norecurrer	
	employ	ment options were		The QIDP will report on the mon	-
		d for clients A, B and C.		objectives on a monthlysummary	
		SP (Individual Support		report. The QIDP will turn eachmonthly report into the RD a	nd
		havior Support Plan)		the Compliance Officer no later t	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 57 of 179

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG the 20thof each month. The QIDP addressed how the staff were to will review and discuss objectives at supervise/monitor and assist each quarterly meeting, record client C throughout the day to meeting notes on themeeting notes prevent further injury from falls form, and fill out the Meeting and how the staff were to Checklist which will be turnedinto the RD within 24 hour of each supervise and monitor client C meeting. due to seizure activity. The QIDP failed to ensure client A's ISP/BSP addressed what the staff were to do when client A refused her medications and/or refused to comply with medical requests. The staff implemented the clients' dining plans and provided formal and informal training when opportunity existed for clients B, D, E and F. The facility's HRC (Human Rights Committee) reviewed, approved and monitored client A's and C's restrictive programs. Written informed consent from the clients and/or the clients' legal representatives for the clients' restrictive programs including the use of behavior modification medication for clients A and C and the locking of the sharps within the home for client A. Client A's use of Sertraline was included in client A's BSP (Behavior Support Plan) with a specific plans of reduction to reduce and eventually eliminate the behaviors Facility ID: 000904

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11

If continuation sheet

Page 58 of 179

PRINTED:

10/24/2014

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IIII TIPI E CC	ONSTRUCTION		OMB NO. 0938-03 TE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING B. WING			COM	COMPLETED 09/22/2014	
NAME OF I	PROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP	CODE		
	IARK HUMAN SE				NDLESON DR OND, IN 47374			
							(375)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
	for wh	ich the Sertraline was to						
	target.							
	The staff provi	ded training in meal						
	prepar	ation and family style						
	dining	when formal and informal						
		g opportunities existed and						
		are the clients prepared and						
	-	l their own lunches for the						
		ogram for clients A, B, C,						
	D, E a	nd F.						
	Findings includ	le:						
	1. Client A's re	cord was reviewed on						
	9/10/14 at 2 PM	1. Client A's 10/1/13 ISP						
	indicated object	tives:						
		eth for thirty seconds.						
	To clean her be							
	To make one d							
	To bathe indep	•						
		sure activity of her choice.						
	-	item in the community						
		ceive the correct change.						
		nd talk about her feelings. ame her medications and						
		e why she takes them.						
		rd indicated the QIDP did						
		nt A's objectives from						
		arough May 2014.						
	Client D'a race	rd was reviewed on						
		A. Client B's 10/1/13 ISP						
	indicated objec							
	To identify coi							

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ILII TIPI E COI	NSTRUCTION	(X3) D	OMB NO. 0938-03 ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			00	· · ·	MPLETED
		15G390	A. BU B. WI	ILDING		09	/22/2014
			D. WI		DDRESS, CITY, STATE, Z	TIP CODE	
NAME OF I	PROVIDER OR SUPPLI	EK		825 MEI	NDLESON DR		
BENCH	/ARK HUMAN SE	RVICES		RICHMO	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO T	THE APPROPRIATE	COMPLETIC
TAG		OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC	Y)	DATE
		cold water knob.					
	-	sil down between bites.					
	To clean her be						
		eth for 15 seconds.					
	-	e steps in making one					
	dinner						
	-	shower independently.					
	To participate i choice	in a leisure item of her					
	Client B's reco	rd indicated the QIDP did					
	not review clie	nt B's objectives from					
		rough May 2014.					
	Client C's reco	rd was reviewed on					
	9/11/14 at 10 A	M. Client C's 10/1/13 ISP					
	indicated object						
	To clean her be						
	-	ns and know the value.					
		taff about her feelings.					
	To brush her te	eth.					
	To prepare a m						
	To shower inde						
	To participate i choice	in a leisure activity of her					
	Client C's reco	rd indicated the QIDP did					
	not review clie	nt C's objectives from					
	August 2013 th	rough May 2014.					
	During intervie	ew with QIDP (Qualified					
	Intellectual Dis	sabilities Professional) #1					
	on 9/12/14 at 3	:15 PM, QIDP #2 stated,					
	"The only revie	ews I can find are the ones					
	I did for June a	nd July." The QIDP					
		vas employed with the					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		00	(X3) DATE COMPL	
		15G390	B. WING			09/22	/2014
NAME OF	PROVIDER OR SUPPLIE	ER		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					NDLESON DR		
BENCHI	MARK HUMAN SEI	RVICES		RICHM	OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	^{BE} PRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		2014 and was unable to					
		f reviews prior to her hire					
	_	s QIDPs that worked at the					
	facility.						
	2 The OIDD fe	:1. J to one of £.11 and					
	-	iled to ensure a full and					
	-	inting of client A's and C's					
	W140.	nditures. Please see					
	W 140.						
	2 The OIDD fo	ilad to angura aliant D'a					
	-	iled to ensure client B's					
	-	ehensive Functional					
		CFAs) included an					
		he clients' fine and gross					
		d/or a PT/OT (Physical					
		ational Therapy)					
		ddress the clients'					
		and to ensure client C's					
		ncluded an assessment of					
		y to ambulate over uneven					
	,	es, going up and down					
		g on and off the facility					
	-	failed to ensure the IDT					
	(Interdisciplinat						
		ssed client C's pattern of					
		and seizures and to					
		client A's repeated refusals					
	-	cribed medications and/or					
		medical requests. Please					
	see W210.						
		1. 1					
	-	iled to ensure vocational					
		ere conducted and the					
	clients' present	and future employment					

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) D	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BU	ILDING	00	COMPLETED		
		15G390	B. WI				9/22/2014	
			B. WI		ADDRESS, CITY, STATE, ZIP	CODE		
NAME OF	PROVIDER OR SUPPLIE	R			ENDLESON DR	CODE		
RENCH	MARK HUMAN SEI				OND, IN 47374			
DENCI				TXICI IIV				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	options were re	viewed for clients A, B						
	and C. Please se	ee W225.						
	5 The OIDP fa	iled to ensure client C's						
	ISP/BSP (Indiv							
	· ·							
		Support Plan) addressed						
		ere to supervise/monitor						
		C throughout the day to						
	prevent further	injury from falls and how						
	the staff were to	supervise and monitor						
	client C due to	seizure activity. The						
		ensure client A's ISP/BSP						
	•	the staff were to do when						
		her medications and/or						
	-	bly with medical requests.						
	Please see W24	0.						
	6. The QIDP fa	iled to ensure the staff						
	implemented th	e clients' dining plans and						
	-	l and informal training						
	•	ty existed for clients B,						
	D, E and F. Plea	•						
	D, E and F. Flee	ase see w 249.						
	7. The QIDP fa	iled to ensure the facility's						
	HRC (Human F	Rights Committee)						
		oved and monitored client						
		rictive programs. Please						
	W262.	Programs. Fieuse						
	** 202.							
	8. The QIDP fa	iled to obtain written						
		nt from the clients and/or						
		l representatives for the						
	-	ve programs including the						
	use of behavior	modification medication						

ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	JILDING	TRUCTION 00	C	(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF I	PROVIDER OR SUPPLIE	{		DRESS, CITY, STATE, ZIP C	CODE		
BENCHN	IARK HUMAN SER	RVICES		DLESON DR ID, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL 2 LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
		C and the locking of the e home for client A.					
	use of Sertraline A's BSP (Behav specific plans of eventually elimi	led to ensure client A's was included in client ior Support Plan) with a Freduction to reduce and nate the behaviors for line was to target. Please					
	provided training family style dini informal training and to ensure the packed their own	tiled to ensure the staff g in meal preparation and ng when formal and g opportunities existed e clients prepared and n lunches for the day nts A, B, C, D, E and F. 3.					
	This federal tag #IN00154234.	relates to complaint					
	9-3-3(a)						
V000210	assessments or re	ter admission, the eam must perform accurate eassessments as needed e preliminary evaluation					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOD MEDICADE & MEDICAD SEDVICES

TATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED
		15G390	A. BUILDING		09/22/2014
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		ENDLESON DR	
	IARK HUMAN SEF	N/ICES		IOND, IN 47374	
X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
REFIX TAG		ICY MUST BE PRECEDED BY FULL	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)		Corrective action for resident(s)	
		vation, record review and	W000210	found to have beenaffected	10/17/201
		of 3 sampled clients (A, B		All clients willhave an annual	
		ditional client G, the		Comprehensive Functional	
	facility failed:			Assessment as well as other	
	To ensure clie	ent B's and G's		necessaryassessments such as OT	
	Comprehensive Functional Assessments			and PT. The QIDPwill ensure the	e
	(CFAs) included	an assessment of the		CFAs are completed by	
	clients' fine and	gross motor skills and/or		10-17-14. The LPN will ensure the clients receive OT/PT evaluations	
	a PT/OT (Physi	cal Therapy/Occupational		thatappointments are scheduled b	
		ment to address the		10-17-14.	y
	clients' mobility			The QIDP and LPNwill monitor	
	5	IDT (Interdisciplinary	inary client patter		
		reassessed client C's		medication refusals and will	
	<i>,</i>			reportany patters to the IDT. The	;
	-	sed falls and seizures and		IDT willmeet and document the	
	-	ed refusals to take her		findings from the meeting on an	
	-	cations and/or to comply		meeting notes form.	
	with medical re-	-		How facility will identify other	
	To ensure clie	ent C's PT evaluation		residents potentiallyaffected and	1
	included an asse	essment of client C's		what measures taken	
	ability to ambul	ate over uneven surfaces,		All residentsare affected and	
	inclines, going u	p and down steps and		correctiveaction will address	
	getting on and o	ff the facility van.		theneeds of all clients.	
				Measures or systemic changes	
	Findings include	2:		facility put in place toensure no	
				recurrence	
	1. The facility's	reportable and		The QIDP and LPNwill be retrain	
	investigative records were reviewed on 9/10/14 at 10 AM.			on the need for annual assessmen	
				including but not limited to the CH	FA
				and OT/PT by the RD on	
	The $0/(/14)$ DDI	NS (Durroou of		10-3-14. The QIDP and the LPN secure the assessments are compl	
	The 8/6/14 BDI	•		orappointments scheduled by	
	Developmental Disabilities Services)			10-17-14.	
	-	on 8/6/14 at 7:30 AM		This training willalso include	
		r balance and fell inside		watching for patterns in client fal	ls or
	her home. [Clien	nt G] was taken by		medication refusals tobring to the	;

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 64 of 179

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

PRINTED: 10/24/2014 FORM APPROVED OMB NO. 0938-0391

	R MEDICARE & MEDIC					OMB NO. 0938-039
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLETED
		15G390	B. WING			09/22/2014
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	
					NDLESON DR	
BENCHN	IARK HUMAN SEF	RVICES		RICHM	OND, IN 47374	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	attention of the IDT. TheIDT wi	DATE
		e emergency room due to			meet and will document their	11
-		t hip/leg. [Client G] was			findings on the meeting notes for	m.
	-	ne of hospital] after				
		a fracture to her hip				
	requiring surger			How corrective actions will be		
		lient G] also sustained a			monitored to ensure norecurrent	
	laceration to her			The RD will sign offon the recort training for the QIDP and LPN.		
	more than a ban			RD will conduct quarterly random		
		follow up BDDS report			file reviews to ensure	
	indicated "[Clie	nt G] had a fall that			currentassessments are present for	or
	resulted in a bro	oken hip, hospitalization			each client.	
	and a partial hip	replacement."			A QIDP-d has beenhired to main filing and to conduct monthly file	
					audits. These file audits will be	
	The 5/10/14 I/A	(Incident/Accident)			turned in to the RDfor tracking a	nd
	report and BDD	S report indicated while			compliance.	
	helping client G	with her shower staff				
	noted client G's	right index finger was				
	swollen with a '	'large black and red				
	bruise" at the kr	nuckle. The report				
	indicated client	G did not know how she				
	injured herself a	and was transported to the				
	-	or an evaluation where she				
	-	with a bruise, given pain				
	-	returned to the facility.				
		2				
	The 12/5/13 BE	DDS report indicated on				
		PM while trying to board				
		van, client G fell up the				
		e van and landed on the				
	_	report indicated the staff				
	-	ch client G from landing				
		ent. "She (client G)				
	-	es of scrapes and redness				
	-	ek, right rib area and right				
		en, right no urea and right				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet Page 65 of 179

NTERS FO	R MEDICARE & MEDIC	AID SERVICES				(	OMB NO. 0938-03	
	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. B	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF	PROVIDER OR SUPPLIEI	2			TADDRESS, CITY, STATE, Z	IP CODE		
BENCHI	BENCHMARK HUMAN SERVICES				IENDLESON DR MOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE	
ing	shin." The repor	t indicated client G's the van steps would be						
	9/10/14 at 1 PM Client G's rec	ord indicated an elderly						
	· ·	t not limited to, rittle bones), Urinary						
	Dementia (loss o	igh Blood Pressure, of memory) and Arthritis n of one or more joints).						
	indicated: 10/7/13 "Rt (rig	ng notes, not all inclusive, ht) small finger with dark						
	joint. A pinched	pruise to palm side at first ppears could have been in something."						
	to abd ( alignme	sized deep purple bruise abdomen). Area in ent with counter at house 3 G's home)."						
	10/30/13 "1 (inc aspect o (should	h) oblong bruise to outer of arm between should er) and elbow. Area is						
	towel basis	height to line up with ar in bathroom. [Client G] ne might have bumped it.						
	I'm alrig	n't hurt honey, don't worry, ght.' she stated." m bus steps. No apparent						

	R MEDICARE & MEDI				NOTRIOTION			B NO. 0938-0
с <i>У</i>		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED <b>09/22/2014</b>	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, Z	IP CODE		
RENCHI	IARK HUMAN SE				NDLESON DR DND, IN 47374			
(X4) ID				ID				(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO	ON SHOULD BE		COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENCY			DATE
	12/6/13 "bruisi	ng to rt (right) hip/buttock,						
	rib are	a"						
	1/16/14 "Annua	al Physical Exam some						
		weakness PT (Physical						
	Therap	by) for muscle						
	strengt	hening."						
	1/26/14 "[Clier	it G] got up to go to the						
	bathro	om when she bumped into						
	her bed	l frame. Noted quarter size						
	bruise,	dark blue/purplish in color						
	on upp	er left thigh/peri area."						
	1/30/14 PT Eva	al- Difficulty ascending						
	steps to	o get into van. Difficulty						
	rising	from chair, worsening over						
	past fe	w months.						
	Recom	mendations for PT tx						
	(treatm	nent) for 6 - 8 weeks."						
	2/10/14 "Mami	no (Mammogram)						
	comple	eted Study indicates						
	osteop	orosis, fracture risk is						
	consid	ered high."						
	3/19/14 "was se	een by PT for gait balance						
	and str	engthening. Dischg						
	(Disch	arged) from PT at this time.						
	Recom	mended that staff continue						
	to assis	st patient PRN (as needed)						
	for saf	ety especially in/out of						
	van."							
	5/22/14 "Revie	wed report of injury from						
		4 in which client (G) was						
	reporte	ed to have large black and						
	-	a of discoloration with						
		ng on index finger"						
		ved report of injury that						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĩ,		(X2) MULTIPLE CONSTRUCTION			
		15G390		A. BUILDING			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP C	CODE		
BENCH	MARK HUMAN SE	RVICES			ENDLESON DR OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE	
		G) has a bruise and a scab						
		left arm/elbow. Client (G)						
	-	that she fell out of bed and						
	that is	how she got the bruise."						
		d indicated no assessment						
		regard to client G's fine						
	•	r skills/abilities, client G's						
		and down steps and/or to						
		he facility van. Client G's						
		d no IDT meetings in						
	-	G's ambulatory needs						
	and/or injuries	from falls.						
	Interview with	the facility's LPN on						
	9/11/14 at 1 PM	1 indicated LPN #3						
	terminated emp	loyment with the facility						
	on 12/31/13 and	d LPN #1 filled in for the						
	facility from Ja	nuary through April 2014						
	when the facilit	y hired LPN #4 in April						
	2014. LPN #4 v	worked four months and						
	then LPN #4 te	rminated her employment						
		on August 15, 2014. The						
	5	ve done my best to try to						
		t being here all the time						
		in when they don't have						
		n rough." The LPN						
		ad provided all nursing						
		d notes she was able to						
		t G. The LPN indicated						
		e to locate client G's last						
	PT assessment.	e to locate chefit O 5 last						
	OIDP (Qualifie	d Intellectual Disabilities						

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014
NAME OF	NAME OF PROVIDER OR SUPPLIER		STREE	T ADDRESS, CITY, STATE, ZIP IENDLESON DR	CODE
BENCH	ARK HUMAN SEI	RVICES		MOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE COMPLET
	<ul> <li>The RM and were unable to a client G.</li> <li>The LPN ind Summary was 1 LPN #3 was sti</li> <li>QIDP #1 stat system was beh "or more" and t all of client G's</li> <li>QIDP #1 ind: regard to client or injuries.</li> <li>2. Observations group home on and 7:15 PM and 5:30 AM and 8: observation per on her left lower</li> </ul>	9/12/14 at 3:15 PM. QIDP #1 indicated they locate a PT assessment for icated client G's Risk ast updated 10/1/13 when Il with the facility. ed the facility filing ind six to twelve months hey were unable to find assessments and records. cated no IDT meetings in G's health, mobility and were conducted at the 9/8/14 between 3:30 PM d on 9/10/14 between 35 AM. During both iods client C wore a brace r leg and ambulated vith a forward lean and an			
	unsteady gait. T client C while a AM observation got out of bed a independently t socks on her fee lower leg. After client C walked then back to her	he staff did not supervise mbulating. During the period at 6 AM client C			

_

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CO	DNSTRUCTION 00		ATE SURVEY MPLETED
		15G390	B. WI			- 09	/22/2014
					ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIE	ER		825 ME	NDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHM	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	ambulating.						
	Client C's recor	d was reviewed on					
	9/11/14 at 10 A	M. Client C's record					
	indicated diagn	oses of, but not limited to,					
	-	er and Cerebral Palsy (a					
		ture, muscle tone and					
	-	lting from brain damage).					
		2014 physician's orders					
		C was taking Depakote					
		rams) three times a day,					
	Lamictal 100 m	· · ·					
		600 mg twice a day and					
	-	ce a day for control of					
	seizures.	-					
	Client C's Seizu	are Reports indicated:					
	On 5/3/14 at 4:	34 PM client C was					
	helping	g to set the table and "got					
	stiff an	d began to pee her pants."					
	On 5/29/14 at 6	PM client C "yelped,					
	peed or	n the floor after grabbing					
	her cro	tch and said she was okay."					
	On 6/2/14 at 5:	10 PM client C "Yelped,					
	grabbe	d her crotch, pee'd (sic) and					
	took of	f for the bathroom."					
	On 6/9/14 at 4:	30 PM client C "Yelped,					
	shook,	pee'd (sic) herself and took					
	off for	the bathroom holding her					
	crotch.	"					
	On 6/15/14 at 5	:47 PM client C "Was at					
	the din	ner table eating her dinner					
	and tal	king to staff. Client (C) let					
	out a y	elp or cry, then her whole					

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	( <b>V</b> 2) <b>N</b>		DNSTRUCTION		1B NO. 0938-03
		IDENTIFICATION NUMBER:	(A2) N	IUL HPLE CC		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	15G390	A. BU	ILDING	00		2/2014
		156390	B. WI	NG		09/22	/2014
NAME OF I	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP CODE		
					NDLESON DR		
BENCHN	/IARK HUMAN SE	RVICES		RICHM	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	body s	tiffened, eyes got big and					
	she wa	s holding her private area,					
		e she started peeing."					
		7:51 PM client C "Yelped,					
		d crotch and wet on the					
	•	and immediately got up to					
	-	nge her clothes."					
		:17 PM client C "Yelped,					
		pee'd (sic) on the floor and					
		saying she's sorry."					
	On 6/22/14 at 5	:25 PM client C "Yelled					
	out, whole body stiffened and she						
	grabbe	d her private area because					
		t herself."					
	On 6/28/14 at 4	:10 PM client C "yelled,					
		ly stiffened at first then					
		shaking. Client was also					
		g her private area but didn't					
		g ner private area out ulun t					
	pee."						
		30 PM client C "started					
		g and her head was shaking					
	-	ient C] kept saying I'm					
	-	nd her body shook and was					
	shakin	g."					
	On 7/6/14 5:31	PM client C was eating					
	her din	ner and "grown (sic) and					
		er food. Kept eaten her					
	dinner	-					
		50 PM client C was					
		in a chair and "said a few					
	words,	wet herself and shook."					
		Fall Assessment forms					
	indicated				1		1

	R MEDICARE & MEDI						OMB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3	B) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		COMPLETED
	15G390		B. WIN	G			09/22/2014
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
					NDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHMO	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	E APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		55 AM while at the DP					
		C was walking up the					
		lk incline to the DP and					
	-	oped on her feet and fell.					
		sessment indicated actions					
	-	ent future falls "Direct					
	client t	o point toes forward and					
	plant fo	eet before attempting to					
	walk."						
	On 11/17/13 at	7:50 AM client C was					
	"walki	ng to the bathroom to get					
	some v	vater to take her pills when					
	she lea	ned into a chair and fell on					
	her but	t." The assessment					
	indicat	ed actions to prevent future					
		Try to make sure she is					
		g okay to the whatever it is					
		oing and maybe keep an					
	-	her more when walking					
		without her shoes."					
		20 AM client C rode to					
		(Day Program) on the					
		ous, exited the bus and was					
		g up a slight incline to					
		ne DP and fell.					
		:50 PM client C was					
		lown some steps and was					
		g onto the railing. "After					
		a step and having both feet					
	-						
		ep she lost her balance a					
		t still had her right hand on					
		ing (sic)." The Assessment					
		ed client C was wearing a					
	brace of	on her left ankle and					

	T OF HEALTH AND HU R MEDICARE & MEDIO					ORM APPROVI MB NO. 0938-03
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 09/22/2014	
		15G390	B. WING			
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R	825 M	ENDLESON DR		
BENCH	MARK HUMAN SEI	RVICES	RICHM	10ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	) BE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	indicate	ed immediate actions to				
	prevent	t future falls "Walk in front				
	of clier	t and have someone walk				
	behind	."				
	On 7/13/14 at 5	:45 PM client C was at				
	the gro	up home in the living room				
	and wa	s arguing with a peer.				
	When t	he peer went to hit client				
	C, clier	nt C took a step back and				
	lost her	balance, fell and knocked				
	over a	lamp.				
	On 8/18/14 at 1	:30 PM client C was				
	walkin	g to the break room at the				
	DP and	-				
	Client C's nursi	ng notes indicated				
	5/3/14 "Receive	ed report of seizure in				
	which	client (C) had seizure				
	activity	while assisting with				
	preppir	ng meal. Client had urinary				
	inconti	nence but was able to				
	change	her clothes with assist of				
	-	o injury to report."				
		ved report of injury form				
		/16 (5/16/14) in which it is				
		d that client (C) fell out of				
	-	t in the van when coming				
		rom group home outing.				
		ort no treatment was				
	needed					
		ved report of seizure. Per				
		client (C) was having				
	-	with roommates. She was				
		around with peer and then				
	Joking	around with peer and men	1			

NTERS FO	R MEDICARE & MEDI	CAID SERVICES					OMB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	STRUCTION	<u> </u>	) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00		COMPLETED
		15G390	B. WING			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	P		STREET AI	DDRESS, CITY, STATE, ZIP	CODE	
TWINE OF	I KO VIDEK OK SOITEII				IDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHMO	ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PI	REFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLET
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	grabbe	d herself and was incont					
	(incont	inent) of urine. Per report,					
	client s	stated she wanted to go					
	home b	out did was oriented to self					
	and did	l no show signs of					
	confus	ion (sic)."					
	5/28/14 client 0	C's doctor "is aware that					
	client o	lid not have her Divalproex					
	25 mg	tab at 1 PM on this day."					
	6/2/14 "Received post fall assessment						
	form in	which it is reported that					
	client (	C) fell walking up a slight					
	incline	into the main center					
	buildin	g. No reports of injury					
	noted.'						
	6/3/14 "Review	red report of seizure on					
		in which it is reported that					
		C) had 5 seconds of					
		activity during evening					
		Client ran to bathroom					
		ctivity ceased, no reports					
		ry noted."					
		wed report of seizure					
		5/9/14 in which it is					
		d that client (C) had 10					
	· ·	s of seizure activity with					
		nence. Client has no					
		of injury with this					
	incider						
		ved report of seizure					
		-					
		7 from 6/15/14. Client (C) o have 15-20 seconds of					
	-	7. Client had episodes of					
	inconti	nence during activity."					

	R MEDICARE & MEDI						OMB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	DNSTRUCTION	ì í	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15G390	B. WIN	G		09	/22/2014
NAME OF	PROVIDER OR SUPPLIE	EB		STREET A	ADDRESS, CITY, STATE, ZIP COD	E	
					NDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHM			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	of seizure form received.					
	Approx	x 30 second duration. No					
	injury	reported. Client (C) seem					
	by [nai	me of neurologist] on this					
	date. N	lew orders obtained to					
	begin i	ncrease of Onfi to 20 mg					
	(millig	rams) BID (twice a day)."					
	7/2/14 "Receive	ed report of fall with no					
	injury.	" "Received report of injury					
		ch it is stated that client (C)					
		t of her chair, hit her left					
	-	l fell on buttocks. Client					
	-	ed no medical intervention					
	-	to this incident and has					
		complaints of pain or					
	other."						
		ed report of fall with no					
	injury.	•					
		ed report of seizure form					
		zure lasting 20 seconds					
		o injury to report."					
		wed report of injury for					
		te in which it is stated that					
		(C) landed on her bottom					
		attempting to get off of the					
		er declining assistance					
		taff. Client denies injury.					
		dical intervention was					
	-	ed related to this incident."					
		ved report of seizure for					
		te. Seizure lasted approx 1					
		per this report. Client (C)					
	was no	t injured and returned to					
	her usi	al level of daily activities					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG shortly after seizure ended." 7/21/14 "Received report of fall on 7/13/14 in which it is reported that client (C) fell and knocked over a lamp. Per staff she has a red area on her back." 8/4/14 "Client (C) sent to [name of hospital] ER (Emergency Room) on this date in the early morning for fall in which she stuck (sic) her head and was bleeding. Client was treated in the ER where head lac (laceration) was sutured. She remained at home and was observed by staff per protocol with neuro checks." 8/7/14 "Reviewed report of seizure dated 8/6/14. No injury to report." 8/7/14 "Received to (sic) report of seizure on this date each lasting approx (approximately) 30 seconds. No injury to report." 8/8/14 client C was seen in the ER to have sutures removed. 8/13/14 client C's doctor signed order for client to have a PT (Physical Therapy) evaluation. 8/12/14 "Received three reports of seizure on this client (C) for separate occasions on this date. Clients (sic) seizure each lasted less then (sic) one minute, no injuries have been reported." 8/14/14 client C scheduled for PT FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11 Facility ID: 000904 If continuation sheet Page 76 of 179

PRINTED:

10/24/2014

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			— 09	ate survey Mpleted / <b>22/2014</b>	
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR					
BENCH	ARK HUMAN SEI	K HUMAN SERVICES		RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	evaluat	ion and treatment.						
		C had a seizure lasting 15						
	second							
		(Received) a (sic) injury						
	-	stating that [client C] was						
		g in the break room at the						
		op and lost her balance						
		l landing on her right hip.						
		ssisted her to here (sic) feet e was assessed for injury.						
	None n							
		PM client C had a 30						
		seizure. "Started to shake						
		s incontinent. No injury."						
		PM client C had a seizure						
	while s	itting in a chair that lasted						
		nute. "Hand shaking and						
	was inc	continent. No injury."						
	8/22/14 at 5:40	PM client C had a 30						
		seizure while sitting at the						
		table. No injury.						
		PM client C had a seizure						
		itting on the couch. Client						
		shaking all over and was						
		nent of urine. No injury. I client C had a 30 second						
		. No injury.						
		PM client C had a 30						
		seizure while getting off						
		ility van at church. "Body						
		ed, got goose bumps and						
		'No' during seizure. Also						
		nent of urine. No injury."						

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) DA	ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BI	UILDING	00	COMPLETED		
		15G390		ING		09/22/2014		
					ADDRESS, CITY, STATE, ZIP	, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ĸ		825 ME	ENDLESON DR			
BENCH	MARK HUMAN SEI	RVICES	RICHMOND, IN 47374					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Client C's PT e	valuation dated 8/26/14						
	indicated "Pt (p	atient) is a 40 yo (year						
	old) female wit	h CP and a resident of a						
	group home. Sh	ne (client C) has recently						
	had an increase	d incidence of falls as						
	well as reports	of declining posture which						
	has affected her	balance and safety while						
	eating. She pres	sents today in a left AFO						
	(ankle-foot-orth	notic) with left LE (lower						
	extremity) inter	nally rotated starting at						
	the hip. She has	s decreased strength						
	through left LE	and flexion contracture (a						
	shortening of m	uscle tissue and tendons,						
	which forces a	joint into a flexed						
	position) of left	UE (upper extremity).						
	She has a sever	e forward head with						
	increased thora	cic kyphosis (an excess						
	curvature in the	upper back causing a						
	hump). Berg ba	lance assessment (a test to						
	measure balanc	e) was performed in						
	which she score	ed a 31/56. Any score less						
	than 46 indicate	es an increased risk for						
	falls. This patie	nt would benefit from PT						
	to address abov	e issues to decreased						
	likelihood of fa	lls."						
	The PT asses	sment indicated client C						
		d in regard to transfers						
		to go up and down steps.						
	-	valuation indicated no						
		lient C's ability to get on						
		lity van. Client C's PT						
		te the level of assistance						
		ion required by the staff						
	-	vas at home or at the DP.						

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	СОМ	
		15G390	B. WIN			09/	22/2014
				-	DDRESS, CITY, STATE, ZII	P CODE	
NAME OF	PROVIDER OR SUPPLIE	R		825 MEI	NDLESON DR		
BENCH	MARK HUMAN SEI						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Client C's recor	d indicated no IDT					
		ard to client C's increase					
	number of seizu						
		ares and rans.					
		M and the facility's LPN					
	were interviewe	ed on 9/12/14 at 3:15 PM.					
	The LPN indica	ated she was unable to					
	find all	of client C's records in					
	regard	to the client's visits with					
	her neu	rologist and the client's lab					
	work.	The LPN stated, "I know					
	she sav	wher neurologist recently					
	and her	Onfi medication was					
	increas	ed."					
	QIDP #1 indica	ted she was unable to					
	locate a	any IDT meetings in regard					
	to clien	t C's increased seizures					
	and rec	surring falls. QIDP #1					
	stated,	"I know I haven't had any					
	meeting	gs since I've been here."					
	The LPN stated	, "She [client C] just					
	recently	y went to PT."					
	QIDP #1 indica	ted no changes in client					
	C's car	e, client C's ISP and/or					
	Risk Su	ummary in regard to					
	increas	ed falls, injury with falls					
	and inc	reased seizures.					
	QIDP #1 indica	ted no change in client					
	C's care	e after client C's PT					
	evaluat	tion of 8/26/14. QIDP #1					
	indicat	ed client C's PT evaluation					
	did not	address client C in regards					
		g up and down steps,					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	СО	ATE SURVEY MPLETED	
		15G390	B. WING				- 09/22/2014	
NAME OF	DOVIDED OD SUDDI II	D		STREET A	DDRESS, CITY, STATE, ZI	P CODE		
NAME OF	PROVIDER OR SUPPLIE	ĸ		825 ME	NDLESON DR			
BENCH	HMARK HUMAN SERVICES		RICHMOND, IN 47374					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID		OBBECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	IE AFFROFRIATE	DATE	
	incline	s and/or getting on and off						
	the fac	lity van.						
		2						
	3. Client A's re	cord was reviewed on						
		I. Client A's Medication						
		s (MRRs) indicated:						
	On 9/13/13 at 4	PM client A refused her						
		neds (medications):						
		roex Sodium 500 mg						
	· ·	ram) for mood						
	, <b>,</b>	ation, Gabapentin 200 mg						
		izoaffective Disorder and						
		nadine HCL 180 mg for						
	-	es. The report indicated						
		A was upset about not						
		to have orange juice and						
		her room and wrote. "She						
		multiple times for						
	multipl	e staff."						
	On 9/30/13 clie	nt A refused her 4 PM						
		Divalproex Sodium 500						
		Gabapentin 200 mg. The						
	-	ndicated "Asked 4 times						
	-	er staff tried to talk to her						
		t she would not take						
	them."	i she would not take						
	inem."							
	On 11/11/13 eli	ent A refused her 4 PM						
		Divalproex Sodium 500						
		-						
	-	Gabapentin 200 mg. The						
	-	ndicated "Just refused						
	meds a	nd told staff 'No'."						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	Ĩ,	ULTIPLE CO LDING	NSTRUCTION 00	CO:	ATE SURVEY MPLETED 122/2014
		100000	B. WIN				22/2014
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CC	DDE	
BENCHMARK HUMAN SERVICES					NDLESON DR OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	DULD BE PROPRIATE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	On 11/12/13 at	10:20 AM client A					
	refused	l to go to her dental					
	appoin	tment.					
	On 11/12/13 cli	ent A refused her 4 PM					
	meds:	Divalproex Sodium 500					
	mg and	l Gabapentin 200 mg. The					
	report	ndicated "Client was very					
	upset a	nd refused meds."					
	On 12/27/13 cli	ent A refused her 4 PM					
	meds:	Divalproex Sodium 500					
	mg and	l Gabapentin 200 mg. The					
	report	ndicated "Staff asked her					
		ee times) over the period of					
		nd 5 PM for meds and was					
		at. Staff notified nurse					
	L .	A] never wanted to take					
		The nurse instructed the					
		"Just wait and see if she					
	takes th	nem and fill out a refusal."					
		nt A refused her 7 AM					
		tions: Bupropion and					
		ine for depression, Calcium					
		itamin D, Divalproex					
		n, Gabapentin, Seroquel					
		ipsychotic),					
	-	chlorothiazide (a diuretic),					
		Vitamin and Zovia (for					
		regulation). The report					
		ed "Staff knocked on					
	[client	A's] door, she (client A)	1				

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	( <b>X</b> 2) <b>N</b>	ALLI TIPI E CO	NSTRUCTION	(X3) D/	OMB NO. 0938-03 ATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390		ILDING	CO	MPLETED /22/2014		
NAME OF	PROVIDER OR SUPPLI	FR			ADDRESS, CITY, STATE, ZIF	CODE		
					NDLESON DR			
BENCH	ARK HUMAN SE	RVICES		RICHM	OND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION		(X5)	
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETIC DATE	
1110		d meds. Staff waited 20		mo			DATE	
		es. She (client A) refused						
		Staff waited another 20						
	•	es and she (client A) told						
		o 'leave me alone'."						
	On 2/5/14 clier	nt A refused her 7 AM						
	medica	ations: Bupropion,						
	Sertral	ine, Calcium with Vitamin						
		alproex Sodium,						
	-	entin, Hydrochlorothiazide,						
	-	iel, Multi Vitamin, Zovia						
		evident 5000 Sensitive						
	-	baste. The report indicated						
		sic) 3x's at different times						
		her meds and she (client uldn't even talk to staff. She						
	· · · · ·	A) shook her head no and						
	that wa	· · · · · · · · · · · · · · · · · · ·						
	On 2/12/14 clie	ent A refused all of her 7						
	AM m	edications: Bupropion,						
	Sertral	ine, Calcium with Vitamin						
	D, Div	alproex Sodium,						
	_	entin, Hydrochlorothiazide,						
	-	el, Multi Vitamin and						
		The report indicated "Staff						
		her to come take her meds						
		ne slapped them and cussed						
	them c	out."						
		nt A refused to take her 4						
		valproex Sodium 500 mg						
	tab and	d two Gabapentin 100 mg						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	CO	ATE SURVEY MPLETED / <b>22/2014</b>		
	PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACTI CROSS-REFERENCED TO DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE		
	caps. Tl just kee	ne report indicated "She ps saying will not take drs s) orders."						
		nt A refused her 8 PM to Health mouth wash.						
		nt A refused her 8 PM ro Health mouth wash.						
	medicat Sertralin Calciun Gabape (a diure antipsyc Zovia (i The rep no, refu	nt A refused her 8 AM tions of Bupropion and ne for depression, n, Divalproex Sodium, ntin, Hydrochlorothiazide tic), Seroquel (an chotic), Multi Vitamin and for menses regulation). ort indicated "Kept saying sing to get out of bed, Shut up'."						
		'Please be advised [client sed all morning meds on ."						
	meds: E mg and report in asked h	nt A refused her 4 PM Divalproex Sodium 500 Gabapentin 200 mg. The indicated "I (the staff) er to please take her meds kept telling me (the staff)						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) D	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BU	ILDING	00	CO	OMPLETED
		15G390	B. WI			09/22	
NAME OF		л.			ADDRESS, CITY, STATE, ZIP	P CODE	
NAME OF	PROVIDER OR SUPPLIE	.R		825 ME	ENDLESON DR		
BENCH	MARK HUMAN SEI	RVICES	RICHMOND, IN 47374				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		thly Health Reviews for					
	2014/2013 indi	cated:					
	On 8/1/14 clien	t A refused AM meds and					
	labs or	dered by her PCP.					
	On 8/10/14 clie	nt A refused 7 AM meds.					
	On 8/14/14 clie	nt A refused her 8 PM					
	mouthy	vash.					
	On 12/9/13 refu	ising to see optometrist.					
	Client A's 8/12/	13 BSP (Behavior					
	Support Plan in	dicated client A had a					
	**	or of "Refusals: Refusing					
		ores, refusing available					
	-	wing directions given by					
		rvisors." Client A's BSP					
		refusals of medications,					
		sal to comply with					
	medical request						
	Interview with	staff #5 on 9/10/14 at 7:30					
	AM stated, "Sh	e [client A] refuses all the					
		ked what the staff were to					
	do when she ret	fused, staff #5 stated, "Just					
	ask her to take	t and if she doesn't she					
	doesn't. There's	not much we can do."					
	QIDP #1, the R	M and the facility's LPN					
	were interviewe	ed on 9/12/14 at 3:15 PM.					
	QIDP #1 ind	icated client A's ISP/BSP					
		client A's refusals of					
	medications and	d/or medical requests.					
		the LPN indicated no					
		n regard to client A's					
	-	ications and medical					
		iounono una moutout	1		1		1

AND PLAN	FEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER:         15G390		A. BUII	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			(X3) DATE SURVEY COMPLETED 09/22/2014	
	PROVIDER OR SUPPLIEI			STREET AI 825 MEN RICHMC	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE	
	group home on 9 and 7:15 PM and 5:30 AM and 8: short in stature a slow unsteady g hands together. I long periods in the her hands and w the room. Client B's record 9/10/14 at 3 PM 9/17/13 failed to of client B's fine Client B's record from PT/OT. During interview and the facility's PM, QIDP #1 in if client B's CFA of client B's fine QIDP #1, the RI know if client B assessment. QII indicated the cli organized and o year and they w	were conducted at the 9/8/14 between 3:30 PM d on 9/10/14 between 35 AM. Client B was and ambulated with a ait while holding her Client B would stand for the same place, wringing atching the activities in 4 was reviewed on . Client B's CFA dated o include an assessment and gross motor skills. d indicated no assessment and gross motor skills. d indicated no assessment and gross motor skills. d include an assessment and gross motor skills. d included an assessment and gross motor skills. Mand the LPN did not know A included an assessment and gross motor skills. M and the LPN did not had a PT/OT DP #1 and the RM ents' records had not been r filed for 6 months to a ere unable to find much cords and were in the g to get organized.						

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ENTERS FOF	R MEDICARE & MEDIO	CAID SERVICES			OM	B NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 	
	ROVIDER OR SUPPLIE		825 M	ADDRESS, CITY, STATE, ZIP CODE ENDLESON DR IOND, IN 47374		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſE	(X5) COMPLETION DATE
140		r LSC IDENTIFYING INFORMATION)				DATE
W000225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview for 3 of 3 sample clients (A, B and C), the facility failed to insure vocational assessments were conducted and the clients' present and future employment options were reviewed. Findings include:		W000225	Corrective action for resident(s) found to have beenaffected All clients willhave an annual Vocational Assessment as well as other necessaryassessments. The QIDP will ensure theVAs are completed by 10-17-14. The VAs arecompleted at they da program, either day services or workshop, by the DayPC. The Day PC will turn a copy of theVA into	y ay o the	10/17/2014
	9/10/14 at 2 PM not include an a vocational skill and/or work-rel present and futu	d was reviewed on I. Client A's record did assessment of client A's s, work interests, attitudes ated behaviors and/or are employment options. d indicated no vocational		QIDP for tracking and to place in client's main chart.How facility will identify other residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address theneeds of all clients.		
	9/10/14 at 3 PM include an asses vocational skill and/or work-rel	d was reviewed on I. Client B's record did not ssment of client B's s, work interests, attitudes ated behaviors and/or are employment options.		Measures or systemic changes facility put in place toensure no recurrence The QIDP and LPNwill be retrain on the need for annual assessmen including but not limitedto the VA by the RD on 10-3-14. The QIDPand the LPN will secure the	ts A	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 86 of 179

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	00		
	PROVIDER OR SUPPLIE		825 M	ADDRESS, CITY, STATE, ZIP CODE ENDLESON DR 10ND, IN 47374	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE
	Client B's recor assessment.	d indicated no vocational		assessments are completed or appointments scheduledby 10-		
	9/11/14 at 10 A not include an a vocational skill and/or work-rel present and futu Client C's recor assessment. Interview with Intellectual Dis on 9/12/14 at 33	d was reviewed on M. Client C's record did ssessment of client C's s, work interests, attitudes ated behaviors and/or are employment options. d indicated no vocational QIDP (Qualified abilities Professional) #1 15 PM indicated she did ational assessments had		How corrective actions will be monitored to ensure norecurr The RD will sign offon the rec training for the QIDP and LPN RD will conduct quarterly rand file reviews to ensure currentassessments are present each client. A QIDP-d has beenhired to ma filing and to conduct monthly f audits. These file audits will b turned in to the RDfor tracking compliance.	rence ord of . The lom for intain ile e	
W000240		ogram plan must describe ions to support the				
	Based on obser interview for 2 and C), Client C's IS Support Plan/B failed to addres	vation, record review and of 3 sampled clients (A P/BSP (Individual ehavior Support Plan) s how the staff were to for and assist client C	W000240	Corrective action for resident found to have beenaffected Risk plans, ISPs, and BSPs for consumers are updated annuall as needed when newdiagnoses behaviors present. Thiswill ind patterns of falls, medication rei and seizures. These plans will updated no later than 10-17-14	all y and or clude fusals, be	10/17/201

ГАТЕМЕ	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUI	LDING	00	COMPLETED 09/22/2014	
		156390	B. WING			09/22/2014	
AME OF	ME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR				
ENCH	MARK HUMAN SEF	RVICES		RICHN			
(4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	throughout the	day to prevent further					
	injury from fall	S.			Howfacilitywillidentifyotherre		
	Client C's ISI	P failed to address and			ntspotentiallyaffectedandwhat surestaken	mea	
	how the staff w	ere to supervise and			All residentsare affected and		
	monitor client C	C due to seizure activity.			correctiveaction will address		
	Client A's IS	P/BSP failed to address			theneeds of all clients.		
		vere to do when client A				•••	
	refused medicat	tions and/or refused to			Measuresorsystemicchangesfa	•	
	comply with me				<b>putinplacetoensurenorecurren</b> The RD retrained theGHM, QII		
					and LPN on 10-3-14 on updatin		
	Findings includ	e:			ISP, BSPs and Risk plans as we	-	
	T mangs merua	0.			assending clients for pt/ot		
	1 Observations	were conducted at the			assessments annually and as nee	eded.	
		9/8/14 between 3:30 PM				•.	
	•				Howcorrectiveactionswillbemo redtoensurenorecurrence	onito	
		ouring this observation			The IDT meets quarterly and m	ore	
	<b>^</b>	wore a brace on her left			frequently as needed. At these		
	-	valked with a forward lean			quarterly meetings the team		
	and an unsteady	y gait.			willreview and discuss any new		
					illnesses, risks, or behaviors, red		
		ere conducted at the			meeting noteson the meeting no	tes	
		9/10/14 between 5:30			form, and fill out the Meeting Checklist which will beturned in	nto	
	AM and 8:35 A	M. During this			the RD within 24 hour of each	110	
	· ·	iod client C was out of			meeting.		
	bed at 6 AM an	d ambulated					
	independently w	vearing only socks on her					
feet and no brace on her Client C's gait was unst	e on her left lower leg.						
	Client C's gait v	vas unsteady.					
		1					
	Client C's record was reviewed on 9/11/14 at 10 AM. Client C's record						
indicated diagnoses of, but not Seizure Disorder and Cerebral disorder of posture, muscle ton							
	movement resu	lting from brain damage).					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		00		ATE SURVEY MPLETED
		15G390	B. WING			09/22	
NAME OF I	PROVIDER OR SUPPLIE	D	-	STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	NOVIDER OR SUFFLIE	R		825 ME	NDLESON DR		
BENCH	ARK HUMAN SEI	RVICES		RICHM	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Client C's Seizu	re Reports indicated:					
		34 PM client C was					
		to set the table and "got					
		d began to pee her pants."					
		PM client C "yelped,					
		the floor after grabbing					
	-	tch and said she was okay."					
		10 PM client C "Yelped,					
	grabbe	d her crotch, pee'd (sic) and					
	took of	f for the bathroom."					
	On 6/9/14 at 4:3	30 PM client C "Yelped,					
	shook,	pee'd (sic) herself and took					
	off for	the bathroom holding her					
	crotch.	1					
	On 6/15/14 at 5	:47 PM client C "Was at					
	the din	ner table eating her dinner					
		king to staff. Client (C) let					
		elp or cry, then her whole					
	-	iffened, eyes got big and					
		s holding her private area,					
		e she started peeing."					
		:51 PM client C "Yelped,					
	-	d crotch and wet on the					
		and immediately got up to					
	-	nge her clothes."					
		:17 PM client C "Yelped,					
		pee'd (sic) on the floor and					
		saying she's sorry." :25 PM client C "Yelled					
		ole body stiffened and she					
	-	d her private area because t herself."					
	Un 0/28/14 at 4	:10 PM client C "yelled,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED A. BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG her body stiffened at first then started shaking. Client was also holding her private area but didn't pee." On 7/1/14 at 5:30 PM client C "started shaking and her head was shaking and [client C] kept saying I'm sorry and her body shook and was shaking." On 7/6/14 5:31 PM client C was eating her dinner and "grown (sic) and chew her food. Kept eaten her dinner (sic)." On 8/16/14 at 6:50 PM client C was sitting in a chair and "said a few words, wet herself and shook." Client C's Post Fall Assessment forms indicated On 11/8/13 11:55 AM while at the DP (Day Program) client C was walking up the sidewalk incline to the DP and she tripped on her feet and fell. The assessment indicated actions to prevent future falls "Direct client to point toes forward and plant feet before attempting to walk." On 11/17/13 at 7:50 AM client C was "walking to the bathroom to get some water to take her pills when she leaned into a chair and fell on her butt." The assessment indicated actions to prevent future FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11 Facility ID: 000904 If continuation sheet Page 90 of 179

PRINTED:

10/24/2014

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			— 09	(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP (	CODE		
RENCH	CHMARK HUMAN SERVICES		825 MENDLESON DR					
	-		RICHMOND, IN 47374					
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION S		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE DEFICIENCY	APPROPRIATE	COMPLETIC DATE	
1/10		Try to make sure she is		ind			DAIL	
		g okay to the whatever it is						
		bing and maybe keep an						
	-	her more when walking						
	-	without her shoes."						
		20 AM client C rode to						
		(Day Program) on the						
		bus, exited the bus and was						
		g up a slight incline to						
		the DP and fell.						
		:50 PM client C was						
		lown some steps and was						
		g onto the railing. "After						
		a step and having both feet						
	-	ep she lost her balance a						
		t still had her right hand on						
		ing (sic)." The Assessment						
		ed client C was wearing a						
		on her left ankle and						
		ed immediate actions to						
		t future falls "Walk in front						
	-	and have someone walk						
	behind							
		:45 PM client C was at						
		up home in the living room						
	-	s arguing with a peer.						
		the peer went to hit client						
		nt C took a step back and						
		balance, fell and knocked						
	over a							
		:30 PM client C was						
		g to the break room at the						
	DP and	-						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	ONSTRUCTION 00		ATE SURVEY MPLETED
		15G390	B. WIN			09/22/2014	
NAME OF				STREET A	ADDRESS, CITY, STATE, ZIP C	ODE	
NAME OF	PROVIDER OR SUPPLIE	.R		825 ME	NDLESON DR		
BENCH	ARK HUMAN SERVICES						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF		PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Client C's nursi	ng notes indicated					
	5/3/14 "Receive	ed report of seizure in					
	which	client had seizure activity					
	while a	ssisting with prepping					
	meal. C	Client had urinary					
	inconti	nence but was able to					
	change	her clothes with assist of					
	staff."						
	5/20/14 "Receiv	ved report of injury form					
		/16 (5/16/14) in which it is					
		d that client fell out of her					
	-	the van when coming					
		rom group home outing."					
		ved report of seizure. Per					
		client was having dinner					
	-	om mates. She was joking					
		with peer and then					
		d herself and was incont					
	•	inent) of urine. Per report,					
		tated she wanted to go					
		but did was oriented to self					
		I no show signs of					
		ion (sic)."					
		ed post fall assessment					
		which it is reported that					
		ell walking up a slight					
		into the main center					
	buildin	-					
		red report of seizure on					
		in which it is reported that					
		ad 5 seconds of seizure					
	-	during evening meal."					
		wed report of seizure					
	dated 6	5/9/14 in which it is					

	R MEDICARE & MEDI			(X2) MULTIPLE CONSTRUCTION				<b>B NO. 0938-0</b> 3 Survey	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		ILDING		COMPLETED 09/22/2014			
NAME OF I	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, Z	IP CODE			
BENCH	/ARK HUMAN SE	RVICES			NDLESON DR OND, IN 47374				
(X4) ID		STATEMENT OF DEFICIENCIES		ID				(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION	ON SHOULD BE		COMPLETI	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENCY			DATE	
	reporte	d that client had 10							
	second	s of seizure activity with							
	inconti	nence."							
	6/14/14 "Recei	ved report of seizure							
		y from 6/15/14. Client							
	-	o have 15-20 seconds of							
	activity	<i>.</i>							
	-	of seizure form received.							
	-	x 30 second duration."							
	7/2/14 "Receive	ed report of fall with no							
		" "Received report of injury							
		ch it is stated that client got							
		her chair, hit her left leg							
		l on buttocks."							
	7/5/14 "Receiv	ed report of fall with no							
	injury.								
		ed report of seizure form							
		zure lasting 20 seconds."							
		wed report of injury for							
		te in which it is stated that							
	client l	anded on her bottom while							
	attemp	ting to get off of the van							
	-	eclining assistance from							
	staff."	C							
	7/20/14 "Recei	ved report of seizure for							
		te. Seizure lasted approx 1							
	minute								
	7/21/14 "Recei	ved report of fall on							
		4 in which it is reported							
		ent fell and knocked over a							
		Per staff she has a red area							
	on her								
		(C) sent to [name of							
		al] ER (Emergency Room)							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG on this date in the early morning for fall in which she stuck (sic) her head and was bleeding. Client was treated in the ER where head lac (laceration) was sutured. She remained at home and was observed by staff per protocol with neuro checks." 8/7/14 "Reviewed report of seizure dated 8/6/14. No injury to report." 8/7/14 "Received to (sic) report of seizure on this date each lasting approx (approximately) 30 seconds." 8/12/14 "Received three reports of seizure on this client (C) for separate occasions on this date. Clients (sic) seizure each lasted less then (sic) one minute." 8/16/14 client C had a seizure lasting 15 seconds. 8/19/14 "Rec'd (Received) a (sic) injury report stating that [client C] was walking in the break room at the workshop and lost her balance and fell landing on her right hip. Staff assisted her to here (sic) feet and she was assessed for injury. None noted." 8/19/14 at 6:10 PM client C had a 30 second seizure. "Started to shake and was incontinent." 8/19/14 at 7:45 PM client C had a seizure while sitting in a chair that lasted FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11 Facility ID: 000904 If continuation sheet Page 94 of 179

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10/24/2014

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) I	MULTIPLE CO	NSTRUCTION		ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390		JILDING	00		MPLETED
		12G290	B. WI			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP	CODE	
BENCHI	MARK HUMAN SEI	RVICES			NDLESON DR OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION	SHOULD BE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE
	one mi	nute. "Hand shaking and					
	was inc	continent."					
	8/22/14 at 5:40	PM client C had a 30					
	second	seizure while sitting at the					
	dinner	table.					
	8/22/14 at 7:30	PM client C had a seizure					
	while s	itting on the couch. Client					
		shaking all over and was					
		nent of urine.					
	8/23/14 at 6 PM	I client C had a 30 second					
	seizure						
		PM client C had a 30					
		seizure while getting off					
		ility van at church. "Body					
		ed, got goose bumps and					
		'No' during seizure. Also					
		nent of urine."					
	Client C's PT ev	valuation dated 8/26/14					
	indicated "Pt (p	atient) is a 40 yo (year					
	old) female with	h CP and a resident of a					
	group home. Sh	e (client C) has recently					
	had an increase	d incidence of falls as					
	well as reports	of declining posture which					
	has affected her	balance and safety while					
	eating. She pres	sents today in a left AFO					
	(ankle-foot-orth	notic) with left LE (lower					
		nally rotated starting at					
		decreased strength					
	-	and flexion contracture (a					
	-	uscle tissue and tendons,					
	-	joint into a flexed					
	-	UE (upper extremity).					
		e forward head with					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì.	MULTIPLE CO	DNSTRUCTION 00	СО	ATE SURVEY MPLETED
		15G390	B. WING			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP	CODE	
DENOU					ENDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHM	OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	× ×	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE ()		DATE
		cic kyphosis (an excess					
		upper back causing a					
		lance assessment (a test to					
		e) was performed in					
		ed a 31/56. Any score less					
		es an increased risk for					
	-	nt would benefit from PT					
		e issues to decreased					
		lls." Client C's PT					
		cated no level of staff					
		or supervision client C					
	-	group home and/or the					
		essment indicated no					
		ns to address how the					
		ere to assist and monitor					
		ghout the day to prevent					
	injury from fall	S.					
	Client C's Risk	Summary dated 10/1/13					
	indicated:						
	Client C was a	t risk for falls and had a					
	history	of falls. The Summary					
	indicat	ed "[Client C] has a history					
	of falls	. [Client C] was evaluated					
	to [nan	ne of hospital] physical					
	therapy	/. Most recent PT					
	evaluat	tion was completed 4/15/13					
	and re-	eval 8/1/13 resulting in					
		ge from PT 8/19/13. Pt					
	(patien	t) requires guard assist if					
	walkin	g on uneven ground					
	(grass)	. Independent on level					
	ground	. Staff are to prompt [client					
	C] whe	en walking to point toe					

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION	(X3)	OMB NO. 0938-03 DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING 00 B. WING			COMPLETED 09/22/2014	
			D. WI		DDRESS, CITY, STATE, ZIP COI	DE	
NAME OF P	ROVIDER OR SUPPLII	EK		825 MEN	NDLESON DR		
BENCHN	IARK HUMAN SE	RVICES		RICHMC	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	TION	(X5)	
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETI
TAG		OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d. Staff are to check brace					
	-	o be sure it is on properly.					
		vill assist [client C] in					
	doing	home exercise program 5					
	days a	week scheduled while at					
	the cer	nter Monday thru Friday. If					
	[client	C] falls staff are to assess					
		if treatment is necessary.					
	Staff w	vill notify nurse of fall.					
	Staff w	vill complete injury report					
	along	with post fall assessment					
	and do	cument the fall on the	he fall on the				
	nursing	g notes. Nurse will review					
	nursing	g notes and MAR					
	(Media	cation Administration					
	Record	l) at least monthly."					
	Client C was at	risk due to seizures. The					
	Summ	ary indicated while having					
	a seizu	re the staff were to stay					
	with cl	ient C, to keep her safe, to					
	loosen	her clothing if tight, to					
	remov	e any hard objects and					
	paddin	g/pillow under her head,					
	turn he	er to her side and not to put					
	anythi	ng in her mouth. Client C's					
	risk su	mmary did not indicate					
	how th	e staff were to supervise					
	and mo	onitor client C throughout					
		, including when					
	-	ring, when toileting and					
		n her bedroom.					
		/13 ISP/Risk Summary					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		DNSTRUCTION 00	COM	
		15G390	B. WIN			- 09/	22/2014
NAME OF			-	STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIE	ĸ		825 ME	ENDLESON DR		
BENCHI	IARK HUMAN SERVICES			RICHM	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	failed to indicat	e how the staff were to					
	supervise, moni	tor and assist client C					
	throughout the	day while ambulating to					
	prevent further	injury from falls. The					
	ISP/Risk plan fa	ailed to indicate how the					
	staff were to su	pervise and monitor client					
		e day due to seizures					
	-	in her bedroom and					
	bathroom.						
	OIDP (Oualifie	d Intellectual Disabilities					
		l, the RM (Residential					
		he facility's LPN were					
		9/12/14 at 3:15 PM.					
		w are the staff to					
		tor and assist client C					
	· ·	day to ensure client C's					
	•	to falls, the RM indicated					
	, ,	ited independently and the					
		as needed. QIDP #1					
		anges in client C's care,					
		nd/or Risk Summary in					
	-	sed falls, injury with falls					
		eizures. QIDP #1					
		aff were to follow client					
	C's Risk Summ	ary.					
	2 Observation						
		were conducted at the					
	• •	9/10/14 between 5:30					
		M. At 7:30 AM client A					
		ne to go next door to					
	-	Client A had not					
		A medications prior to					
	leaving the hor	ne. Staff #2 called the					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ê		CONSTRUCTION 00	Č Ź	DATE SURVEY COMPLETED
		15G390	А. В В. W	UILDING ING		09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	ŪR			ADDRESS, CITY, STATE, ZIP	CODE	
BENCH	NCHMARK HUMAN SERVICES				ENDLESON DR /IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID PROVIDER'S F		ORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	SHOULD BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	other facility an	id instructed the staff to					
	ask client A to a	return to the home to get					
	her AM medica	tions. Client A refused at					
	first and then at	fter much prompting from					
	the staff, client	A returned to her home					
	and took her Al	M medications.					
	Client A's recor	d was reviewed on					
	9/10/14 at 2 PM	1. Client A's Medication					
	Refusal Reports	s (MRRs) indicated:					
	On 9/13/13 at 4	PM client A refused her					
	4 PM r	neds (medications):					
	Divalp	roex Sodium 500 mg					
	-	ram) for mood					
		ation, Gabapentin 200 mg					
		izoaffective Disorder and					
		nadine HCL 180 mg for					
		es. The report indicated					
	-	A was upset about not					
		to have orange juice and					
		her room and wrote. "She					
		I multiple times for					
	multipi	e staff."					
	On 9/30/13 clie	nt A refused her 4 PM					
	meds:	Divalproex Sodium 500					
		Gabapentin 200 mg. The					
	-	indicated "Asked 4 times					
	-	her staff tried to talk to her					
		t she would not take					
	them."	i she would not uke					
		ent A refused her 4 PM Divalproex Sodium 500					

	R MEDICARE & MEDI						OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE CO	ONSTRUCTION		ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00		MPLETED
		15G390	B. WI	NG		09	/22/2014
NAME OF I	PROVIDER OR SUPPLIE	ER		STREET A	ADDRESS, CITY, STATE, ZIP CO	DE	
					NDLESON DR		
BENCHN	IARK HUMAN SE	RVICES		RICHM	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRI		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	d Gabapentin 200 mg. The					
	-	indicated "Just refused					
	meds a	and told staff 'No'."					
	On 11/12/13 at	10:20 AM client A					
	refused	l to go to her dental					
	appoin	tment.					
	On 11/12/13 cl	ient A refused her 4 PM					
	meds:	Divalproex Sodium 500					
	mg and	d Gabapentin 200 mg. The					
	-	indicated "Client was very					
	-	ind refused meds."					
	1						
	On 12/27/13 cl	ient A refused her 4 PM					
	meds:	Divalproex Sodium 500					
	-	d Gabapentin 200 mg. The					
	report	indicated "Staff asked her					
	3x (thr	ee times) over the period of					
	4 PM a	and 5 PM for meds and was					
	cursed	at. Staff notified nurse					
	[client	A] never wanted to take					
	them."	The nurse instructed the					
	staff to	"Just wait and see if she					
	takes t	hem and fill out a refusal."					
	On 1/10/14 clie	ent A refused her 7 AM					
		ations: Bupropion and					
		ine for depression, Calcium					
		itamin D, Divalproex					
		n, Gabapentin, Seroquel					
		ipsychotic),					
	-	chlorothiazide (a diuretic),					
		i Vitamin and Zovia (for					
	menses	s regulation). The report	1		1		

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION		OMB NO. 0938-03 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	Ĩ,	ILDING	00	CON	APLETED 22/2014
NAME OF F	PROVIDER OR SUPPLI	ER			ADDRESS, CITY, STATE, ZIP COD	E	
	/ARK HUMAN SE				ENDLESON DR IOND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	LD BE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	DATE
	indicat	ed "Staff knocked on					
	[client	A's] door, she (client A)					
	-	d meds. Staff waited 20					
		es. She (client A) refused					
		Staff waited another 20					
	-	es and she (client A) told					
		b'leave me alone'."					
	On 2/5/14 clier	nt A refused her 7 AM					
	medica	ations: Bupropion,					
		ine, Calcium with Vitamin					
		alproex Sodium,					
		entin, Hydrochlorothiazide,					
	-	iel, Multi Vitamin, Zovia					
	-	evident 5000 Sensitive					
		paste. The report indicated					
	-	sic) 3x's at different times					
		her meds and she (client					
		uldn't even talk to staff. She					
	· · · · ·	A) shook her head no and					
	that wa						
	On 2/12/14 clie	ent A refused all of her 7					
		edications: Bupropion,					
		ine, Calcium with Vitamin					
		alproex Sodium,					
		entin, Hydrochlorothiazide,					
	-	iel, Multi Vitamin and					
	-	The report indicated "Staff					
		her to come take her meds					
		ne slapped them and cussed					
	them of						
	On 6/9/14 clier	nt A refused to take her 4					

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	$(\mathbf{v}_2)$		ONSTRUCTION		OMB NO. 0938-03
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	Ĩ.	ILDING	00	CON	MPLETED 22/2014
NAME OF	PROVIDER OR SUPPLI			-	ADDRESS, CITY, STATE, ZIP C	CODE	
					NDLESON DR		
	MARK HUMAN SE				OND, IN 47374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF	RECTION	(X5)
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC DATE
		valproex Sodium 500 mg					
		two Gabapentin 100 mg					
		The report indicated "She					
	-	eps saying will not take drs					
	-	rs) orders."					
	On 6/12/14 clie	ent A refused her 8 PM					
	Crest I	Pro Health mouth wash.					
	On 6/13/14 clie	ent A refused her 8 PM					
	Crest I	Pro Health mouth wash.					
	On 6/29/14 clie	ent A refused her 8 AM					
	medica	ations of Bupropion and					
	Sertral	ine for depression,					
	Calciu	m, Divalproex Sodium,					
	Gabap	entin, Hydrochlorothiazide					
	(a diur	etic), Seroquel (an					
	antipsy	chotic), Multi Vitamin and					
	Zovia	(for menses regulation).					
	The re	port indicated "Kept saying					
		using to get out of bed,					
	saying	'Shut up'."					
		"Please be advised [client					
		used all morning meds on					
	9/29/1	4."					
		ent A refused her 4 PM					
		Divalproex Sodium 500					
	-	d Gabapentin 200 mg. The					
	-	indicated "I (the staff)					
		her to please take her meds					
	5x she	kept telling me (the staff)					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. BUILDING	Ĵ	STRUCTION 00		DATE SURVEY DMPLETED D/22/2014
NAME OF	PROVIDER OR SUPPLIE	ĒR			DRESS, CITY, STATE, ZIP (	CODE	
BENCH	MARK HUMAN SE	RVICES			DLESON DR ND, IN 47374		
(X4) ID	•	STATEMENT OF DEFICIENCIES	ID		, -		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	G	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	NO!"						
	Client A's Mon	thly Health Reviews for					
	2014/2013 indi	•					
	On 8/1/14 clien	t A refused AM meds and					
	labs or	dered by her PCP.					
	On 8/10/14 clie	ent A refused 7 AM meds.					
	On 8/14/14 clie	ent A refused her 8 PM					
	mouth	wash.					
	On 12/9/13 reft	using to see optometrist.					
	Client A's 8/12/	/13 BSP (Behavior					
	Support Plan in	dicated client A had a					
	targeted behavi	or of "Refusals: Refusing					
	-	ores, refusing available					
		wing directions given by					
	parents or super	rvisors.					
	Client A's BSP	did not include refusals of					
	-	bs and/or refusal to					
		edical requests. Client A's					
		and client A's Updated					
	-	dated 6/26/14 did not					
		s of medications,					
		or refusals of medical					
	-	hat the staff were to do					
	when the client	refused.					
		staff #5 on 9/10/14 at 7:30					
		e [client A] refuses all the					
		ked what the staff were to					
		fused, staff #5 stated, "Just					
		it and if she doesn't she					
	doesn't. There's	not much we can do."					

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	00	x3) date survey completed 09/22/2014
	PROVIDER OR SUPPLIE		825 M	ADDRESS, CITY, STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
W000249	Intellectual Dis the RM (Reside and LPN #2 on QIDP indicated not address clie medication and 9-3-4(a) 483.440(d)(1) PROGRAM IMP As soon as the in formulated a clie each client must treatment progra interventions and number and freq achievement of t the individual pro Based on obser record review f (B) and 3 addit the facility faile implemented th	nterdisciplinary team has ent's individual program plan, receive a continuous active am consisting of needed d services in sufficient juency to support the the objectives identified in ogram plan. vation, interview and for 1 of 3 sample clients ional clients (D, E and F), ed to ensure the staff ne clients' dining plans and al and informal training	W000249	<b>Corrective action for resident(s)</b> <b>found to have beenaffected</b> Staff are to provideactive treatmer both formal and informal at all times. Staff were retrained by the RD at an allstaff meeting on 10-1- and 10-3-14 and the record of training will be placed in the employee HR file.	
				This training willinclude the	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTEDS FOD MEDICADE & MEDICAD SEDVICES

	R MEDICARE & MEDIC NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	(A2) MULTIPLE CO	00	COMPLETED
	of conduction	15G390	A. BUILDING	00	09/22/2014
		156550	B. WING		03/22/2014
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				ENDLESON DR	
	MARK HUMAN SEF	RVICES		IOND, IN 47374	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
	• •	9/8/14 between 3:30 PM		How facility will identify other residents potentially affected an	
		uring this observation		what measures taken	
	-	d, broccoli, tater tots and		All residents areaffected and	
	crushed pineapp	ble were prepared for the		corrective action will address th	e
	evening meal.			needs of all clients.	
	At 3:45 PM s	taff #1 and #2 were in the			
	kitchen starting	the evening snack/meal		Measures or systemic changes	
	while staff #3 b	egan the evening		facility put in place toensure n recurrence	U
	medication pass			One member of management sta	vs in
	At 3:45 PM c	lient B stood watching		the home at least weekly until 7	
		preparing snacks and the		provide on the spottraining. Th	is
		Client E was sitting at the		will include thenecessity for tea	-
	-	ese curls and drinking		staff how to provide active treat	
	-	did not directly supervise		and how to followformal trainin	g
	C C	he ate her snack.		programs. The member ofmanagement will record their	
				observations and any teachable	
		taff #1 prompted clients		moments on the Manager Observ	vation
		lining room table for a		Log.	
		placed a clothing		A member of management will	
	-	ent B and provided clients		conduct random pop in visits no	
		snack of a broken granola		than weekly on varyingdays and	
		a cup of juice. Clients B		shifts to ensure staff are providi active treatment. These random	-
	-	ting immediately.		in visits will be documented nt	
		taff #3 sat down next to		MOL.	
	client E and stat	ed, "Slow down and sit		Also a member of management	
	up straight." Sta	ff #2 sat down next to		(GHM, LPN, Q, Q-d, GHS, or F	RD)
	client D and star	ted, "You need to put		will observe in the home daily	
	your spoon dow	n." Staff #2 got up from		toensure active treatment is beir conducted at all times. These	lg
	the table to get s	something, leaving client		observations will be documente	don
		began coughing. Staff #2		theMOL.	
		D and stated, "Are you			
		k." Staff #2 retrieved		How corrective actions will be	
		the kitchen and then		monitored to ensure norecurre	ence
	returned to sit b			The RD will ensureall staff are	.
				retrained on active treatment and	
	-AL 3.38 PM S	taff #2 sat down beside		formal training programs. The	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 105 of 179

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI ∏	TIPLE CO	ONSTRUCTION	(X3) DATE	B NO. 0938-0 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	l í		00	COMPL	
		15G390	A. BUILD B. WING	DING		09/22/	/2014
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
					ENDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHM	IOND, IN 47374		-
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL		REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLET
TAG		R LSC IDENTIFYING INFORMATION)		TAG	will monitor Provide, the time		DATE
	client B.	nto D. D. and C. had			entryprogram, and the Manager		
		nts B, D and E had			Observation Log, to ensure a		
		hack. Clients B and D			member of management isobser	ving	
	-	led 1:1 (one staff to one			in the home until 7pm at least w	-	
	· •	ion while eating their			and to ensure management staff		
	snack.				providing random pop in visits i		
		client B was asked "Do			less than weekly at varying shift anddays.	.S	
	-	your quarters." Staff #1			A member of management (GHN	Л.	
	opened a zip-lo	ck plastic bag full of fake			LPN, Q, Q-d, GHS, or RD) will		
	coins and dump	bed a few on the table.			observe in the home daily to		
	Client B walke	d slowly over to the table			ensureactive treatment is being		
	reached for a co	oin and then turned and			conducted at all times. These	1	
	walked away fr	om the table. Staff #1 put			observations will be documente theMOL.	1 ON	
	the fake money	away and returned to			unewice.		
	preparing the e	vening meal. Client B					
	stood without e	xpression in the dining					
		titchen and watched the					
	meal preparation	n.					
		staff #2 walked client B to					
		and prompted client B to					
	-	ated, "Here, you want to					
		vision)?" Staff #2 returned					
	· ·	b help with the evening					
		stood for a few seconds					
		the dining room and					
		xpression and wringing					
		her, non verbal and not					
	-	activities. Until time to					
	-	meal, client B continued					
	-						
		the kitchen/dining room					
		red in any activity.					
		intil 5:23 PM client D sat					
	-	om in a recliner, the					
	television on bu	it not actively watching it					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CON	NSTRUCTION	(X3) E	ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			00	· /	OMPLETED
		15G390		.DING		0	9/22/2014
			B. WIN		DDRESS, CITY, STATE, ZII	_	_
NAME OF	PROVIDER OR SUPPLIE	R			NDLESON DR	CODE	
BENCH	MARK HUMAN SEI	RVICES			NDLESON DR ND, IN 47374		
					, in 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY)		COMPLETI
IAU		,		IAU	,		DATE
		y talking to herself.					
		M until 5:23 PM client F					
		room in a recliner, the					
		it not actively watching it.					
		h her eyes closed off and					
	on during this t						
		all clients were prompted					
		ands for the evening meal.					
	Client B slowly	walked to the dining					
	room table and	sat down. Staff #1 placed					
	a clothing prote	ctor on client B and					
	served client B	her evening meal of tater					
	tots, broccoli, tu	ana salad with chopped					
	bread and crush	ed pineapple. Client B					
	immediately be	gan eating at a fast pace,					
	not taking a dri	nk between bites and not					
	-	sil down between bites.					
		also began eating as soon					
		ced in their plates, also					
	-	food and liquids and not					
	-	eir utensils between bites.					
		d E were eating while					
		#3 were serving the					
		e meal to all of the clients.					
		staff #1 asked client B,					
		e ketchup?" Client B had					
		l of her tater tots. Staff #1					
	-	e portion of ketchup onto					
		and client B immediately					
	-	•					
		ketchup and ate it by					
	itself.	toff #1 act down between					
		staff #1 sat down between					
		. Staff #1 got up and down					
	trom the table s	everal times while client					

(EACH DEFICIEN EGULATORY OF te her evenin hout direct su to 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in		B. WIN	STREET A	(EACH CORRECTIV	ATE, ZIP CODE	E	(X5) COMPLETIO DATE
HUMAN SEF SUMMARY S (EACH DEFICIEN EGULATORY OF te her evenin hout direct su At 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	AVICES STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION) Ing meal, leaving client B upervision while eating. Flient D finished her and returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the Flient B finished her for the remainder of the ant B stood watching the e lunch boxes for the next n a recliner near the		825 ME RICHM ID PREFIX	ENDLESON DR OND, IN 47374	LAN OF CORRECTION	E	COMPLETIC
HUMAN SEF SUMMARY S (EACH DEFICIEN EGULATORY OF te her evenin hout direct su At 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	AVICES STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION) Ing meal, leaving client B upervision while eating. Flient D finished her and returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the Flient B finished her for the remainder of the ant B stood watching the e lunch boxes for the next n a recliner near the		ID PREFIX	OND, IN 47374 PROVIDER'S P	E ACTION SHOULD BE	E	COMPLETIC
SUMMARY S (EACH DEFICIEN EGULATORY OF te her evenin hout direct su At 5:45 PM c ning meal an iner in the li and client D self, not active bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ag meal, leaving client B upervision while eating. Flient D finished her ad returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the flient B finished her for the remainder of the at B stood watching the e lunch boxes for the next a recliner near the		ID PREFIX	PROVIDER'S P (EACH CORRECTIV	E ACTION SHOULD BE	E	COMPLETI
(EACH DEFICIEN EGULATORY OF te her evenin hout direct su to 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ag meal, leaving client B upervision while eating. Elient D finished her ad returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the Elient B finished her for the remainder of the at B stood watching the e lunch boxes for the next a recliner near the		PREFIX	(EACH CORRECTIV	E ACTION SHOULD BE	E	COMPLETI
EGULATORY OF te her evenin hout direct su to 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	R LSC IDENTIFYING INFORMATION) ag meal, leaving client B upervision while eating. client D finished her ad returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the client B finished her for the remainder of the at B stood watching the clunch boxes for the next a recliner near the			(EACH CORRECTIV	E ACTION SHOULD BE	E	
te her evenin hout direct su At 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	ng meal, leaving client B upervision while eating. Itent D finished her ad returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the client B finished her for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the		TAG	DEFI	ICIENCY)		DATE
hout direct so At 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	upervision while eating. client D finished her nd returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the client B finished her for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the						
At 5:45 PM c ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	elient D finished her ad returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the elient B finished her for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the						
ning meal ar iner in the li and client D self, not activ bughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	nd returned to sit in a ving room. The TV was sat quietly talking to vely watching the TV remainder of the client B finished her for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the						
iner in the li and client D self, not activ oughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	ving room. The TV was sat quietly talking to vely watching the TV remainder of the client B finished her for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the						
and client D self, not activ oughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	sat quietly talking to vely watching the TV remainder of the client B finished her for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the						
self, not activ oughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	vely watching the TV remainder of the client B finished her for the remainder of the ent B stood watching the e lunch boxes for the next in a recliner near the						
self, not activ oughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat in	vely watching the TV remainder of the client B finished her for the remainder of the ent B stood watching the e lunch boxes for the next in a recliner near the						
oughout the r ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat ir	remainder of the client B finished her for the remainder of the nt B stood watching the lunch boxes for the next n a recliner near the						
ervation. At 5:50 PM c ning meal. F ervation clie f prepare the and/or sat ir	lient B finished her for the remainder of the nt B stood watching the lunch boxes for the next n a recliner near the						
ning meal. F ervation clie f prepare the and/or sat ir	for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the						
ning meal. F ervation clie f prepare the and/or sat ir	for the remainder of the nt B stood watching the e lunch boxes for the next n a recliner near the						
ervation clie f prepare the and/or sat ir	nt B stood watching the e lunch boxes for the next n a recliner near the						
f prepare the and/or sat in	e lunch boxes for the next n a recliner near the						
and/or sat in	n a recliner near the						
ing room wit	mout activity.						
ring this obse	ervation period:						
he staff did	not provide clients B and						
:1 supervisio	on and client E direct						
ervision whi	le eating their snacks and						
als.	-						
The staff did	not prompt clients B, D						
	ir utensils down between						
-							
	_						
	-						
	not offer or provide						
	-						
vines of trail							
	inities existed.			•			
	s, to slow th nate consist id and/or to ughout the s bod. he staff did nts B, D and vities or trai	s, to slow their rate of eating, to nate consistency between food and id and/or to take extra swallows ughout the snack/meal with each bite	s, to slow their rate of eating, to nate consistency between food and id and/or to take extra swallows ughout the snack/meal with each bite ood. he staff did not offer or provide nts B, D and F any leisure time vities or training activities when	s, to slow their rate of eating, to nate consistency between food and id and/or to take extra swallows ughout the snack/meal with each bite ood. he staff did not offer or provide hts B, D and F any leisure time vities or training activities when	s, to slow their rate of eating, to nate consistency between food and id and/or to take extra swallows ughout the snack/meal with each bite bod. he staff did not offer or provide hts B, D and F any leisure time vities or training activities when hing opportunities existed.	s, to slow their rate of eating, to nate consistency between food and id and/or to take extra swallows ughout the snack/meal with each bite ood. he staff did not offer or provide nts B, D and F any leisure time vities or training activities when	s, to slow their rate of eating, to nate consistency between food and id and/or to take extra swallows ughout the snack/meal with each bite bod. he staff did not offer or provide hts B, D and F any leisure time vities or training activities when hing opportunities existed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 9/10/14 at 3 PM. Client B's revised dining plan dated 9/18/13 indicated client B was at "moderate" risk for choking and at risk for aspiration. Client B's dining plan indicated (not all inclusive): "FOOD TEXTURE: Regular. It is appropriate for staff to cut food into 1/4" (inch) to 1/2" pieces due to her tendency to grab foods and put them into her mouth. She does not always chew her food well. EATING/DRINKING STRATEGIES: She is to have 1:1 supervision during meal times. Staff need to encourage her to alternate food/liquid. Food should be cut into 1/4" to 1/2" pieces to prevent choking." Client B's 10/1/13 ISP indicated client B had the following objectives: To identify different coins. To identify the cold water knob. To eat at a slower pace. To put her utensil down between bites. To complete one step of cleaning her bedroom. To brush her teeth for 15 seconds. To complete the steps in making one dinner item. To get into the shower independently. To participate in a leisure item of her choice for 15 minutes. To identify her medications. Client B's ISP indicated "[Client B] is a FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11 Facility ID: 000904 If continuation sheet Page 109 of 179

PRINTED:

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IIII TIPI E COI	NSTRUCTION		OMB NO. 0938-03
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390		ILDING	CON	COMPLETED 09/22/2014	
NAME OF 1	PROVIDER OR SUPPLII	ER			DDRESS, CITY, STATE, Z	IP CODE	
BENCH	/ARK HUMAN SE	RVICES			NDLESON DR DND, IN 47374		
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO	ON SHOULD BE	COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENCY		DATE
	choking risk du	e to eating large bites,					
	eating too quic	kly, and not chewing					
	thoroughly. She	e requires 1:1 monitoring					
	during lunchtin	ne to prevent these issues."					
	Client D's reco	rd was reviewed on					
	9/11/14 at 2 PN	I. Client D's revised					
	dining plan dat	ed 9/18/13 indicated client					
	• •	or choking and aspiration.					
		ng plan indicated (not all					
		TING/DRINKING					
	<i>,</i>	: 1:1 supervision is					
		sips/bites. Must be alert					
	-	ght (90 degrees if					
	possible)."						
	Client D's 10/1	/13 ISP indicated client D					
	had the followi	ng objectives:					
		pace by placing her					
		s down between bites and					
		a drink between bites.					
	To help clean u						
	-	lentify different coins.					
		omplete the basic steps to					
		ng her room.					
		egulate the water					
	temper	•					
	-	hoose and participate in a					
		activity.					
	Client D'e ISP	indicated "[Client D] is at					
		choking due to history,					
	-	d eating too fast. Food					
		ND OVER HAND prior					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	. ,	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BU	ILDING	00	COMPLETED		
		15G390	B. WI				/22/2014	
				STREET	ADDRESS, CITY, STATE, ZIF	P CODE		
NAME OF	PROVIDER OR SUPPLIE	R		825 ME	ENDLESON DR			
BENCH	MARK HUMAN SEI	RVICES		RICHM	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE AFFROFRIATE	DATE	
	to her eating. N	eeds constant prompting						
	-	Staff are to be sitting next						
		ile she is eating to prompt						
	her and ensure							
	nor und ensure	survey.						
	Client E's recor	d was reviewed on						
		PM. Client E's revised						
		ed 7/24/14 indicated client						
	01	r choking and aspiration.						
		• •						
		g plan indicated (not all						
	· · · · ·	TING/DRINKING						
		Must sit upright with						
		position. Supervision						
	·	ing and drinking. Prompt						
		tes/sips, slowing rate,						
	-	sistencies and to use extra						
	swallows Spe	ecific skills to						
	maintain/acquir	e: Place sppon (sic) down						
	between bites to	o slow eating pace."						
	Client F's recor	d was reviewed on						
	9/11/14 at 3 PM	1. Client F's 10/1/13 ISP						
	indicated client	F had the following						
	objectives:	-						
	e e	gulate the water						
	temper	-						
	-	ensil down between bites						
	-	and take a drink of liquid.						
		ms and swab her moth						
	-	outhwash.						
	To identify diff							
		he preparation of one						
	dinner							
	To participate i	n a leisure activity of her						

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DU		00	CO	MPLETED	
		15G390		ILDING			/22/2014	
			B. WI		ADDREGG CITY OT ATE 71			
NAME OF I	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR					
DENIQUE								
BENCHI	IARK HUMAN SEI	RVICES		RICHM	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	/	DATE	
	choice.							
		social skills by repeating						
		mple words after staff.						
	To repeat the na	ames of her medications.						
	-	w with QIDP (Qualified						
		abilities Professional) #1						
	and the RM (Re	esidential Manager) on						
	9/12/14 at 3:15	PM, QIDP #2 stated the						
	staff were to pr	ovide the clients with						
	-	rmal training at every						
		l "no one should be just						
		-						
		periods of time." The RM						
	indicated the sta	aff were to follow the						
	clients' dining p	lans whenever the clients						
	were eating the	ir snacks and/or their						
	-	indicated clients B and D						
		ided 1:1 staff supervision						
	-	-						
	-	d the staff were not to						
	leave clients B							
	unsupervised w	hile serving the meal						
	and/or to get up	from the table to retrieve						
	something.							
	e							
	9-3-4(a)							
	$\mathcal{F} \mathcal{F} = \mathcal{F}(\mathfrak{a})$							
V000262	483.440(f)(3)(i)							
1000202		ITORING & CHANGE						
		hould review, approve, and						
		I programs designed to						
		priate behavior and other						
		the opinion of the			1		1	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG committee, involve risks to client protection and rights. W000262 Correctiveactionforresident(s)foun 10/17/2014 Based on observation, record review and dtohavebeenaffected interview for 2 of 3 sampled clients (A The LPN is responsible for seeking and C), the facility's HRC (Human Rights HRC approval for a new or changed Committee) failed to review, approve and psychotropic medicationorder. Once monitor client A's and C's restrictive guardian or client approvalis programs. received, the LPN will seek HRC approval and will update the BC who will update the BSP. The QIDPwill Findings include: ensure the BSPis complete and accurate. The QIDP will seek HRC Observations were conducted at the approval forrestrictive programs integrated into the BSP. The QIDP facility on 9/8/14 between 3:30 PM and will seek guardian and or client 7:15 PM. During this observation period approval and then will forwardto while preparing the evening meal staff #1 HRC for approval. used a pair of sharp scissors to cut the Staff will betrained on allnew or vegetables. At 5:10 PM staff #1 rinsed updated BSPsby the BC ora Q or supervisor trainedby the BC. the scissors, dried them off and placed them in an unlocked cabinet above the Howfacilitywillidentifyotherreside kitchen stove. ntspotentiallyaffectedandwhatmea surestaken Client A's record was reviewed on All residentsreceiving psychotropicmedications are 9/10/14 at 2 PM. Client A's 8/13/14 affectedand corrective action physician's orders indicated client A was willaddress the needsof all clients. taking Wellbutrin SR 200 mg (milligrams) and Sertraline 50 mg qd Measuresorsystemicchangesfacility (every day) for depression, Depakote 500 putinplacetoensurenorecurrence Monitoring the BSPand physician mg bid (twice a day) for mood orders willbe added to themeeting stabilization, Seroquel 300 mg qd for checklist. The team including the BC, impulse control and depression and QIDP, andLPN will compare Neurontin 200 mg bid for Schizoaffective thephysician orders to he BSP at eachquarterly to ensurecompliance, disorder (a mental condition that causes HRC approval, and guardian both a loss of contact with reality and approval. The QIDPis responsible mood problems). Client A's record did forthe meeting agenda.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y60

Y6CM11 Facility I

Facility ID: 000904

If continuation sheet

Page 113 of 179

PRINTED:

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DAT	TE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		00	COM	PLETED	
		15G390	A. BUIL B. WINC			09/2	2/2014	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF 1	PROVIDER OR SUPPLIE	R			NDLESON DR			
BENCH	ARK HUMAN SEF	RVICES			OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)	
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	) BE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	not indicate HR	C review and/or approval				•.		
	for the use of ps	sychotropic medications.			Howcorrectiveactionswillbe redtoensurenorecurrence	monito		
	Client A's recor	d did not indicate HRC			The QIDP willupdate all BS	D _S		
	review and/or a	pproval of the facility			andensure all staff aretrained			
	locking the kniv	ves and sharp objects.			newor updated plans.			
					The Regional Directorwill be			
	Client C's recor	d was reviewed on			the meetingchecklist following	•		
		M. Client C's Physicians			consumermeeting by theQID	P to		
		13/14 indicated client C			ensure compliance.			
		pirone HCL 10 mg qd for						
		speridone 2.5 mg qd for						
	-	. Client C's record did not						
		eview and/or approval for						
		notropic medications.						
	the use of psych	iotropic medications.						
	Interview with s	staff #3 on 9/8/14 at 5:50						
	PM indicated th	e knives and sharps						
	(including sciss	ors) were locked inside						
	the medication	cabinet in the staff office.						
	Staff #3 stated t	he sharp scissors above						
		ld have been locked up."						
		ed the sharps were locked						
		A had threatened harm						
		more than one occasion.						
		w long the sharps had						
		, staff #3 stated, "I think a						
	couple of month							
	Interview with	QIDP (Qualified						
	Intellectual Dis	abilities Professional) #2						
		15 PM indicated she was						
		ity as of May 2013. QIDP						
		e did not know if the						
		d reviewed and/or						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y6CM11 Facility ID: 000904

If continuation sheet Page 114 of 179

ENTERS FOR	R MEDICARE & MEDI	CAID SERVICES				0	MB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390		LDING	00	(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF F	PROVIDER OR SUPPLIE	R .			ADDRESS, CITY, STATE, ZIP CODE		
					NDLESON DR		
	IARK HUMAN SE				OND, IN 47374		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETIO
TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	DATE
	BSPs (Behavio included the us medications an group home. Q waiting on HRQ addendum to he locking of the k client A's threa stated, "We are in the medication the time being the move them to the indicated the kar locked in the fat asked why it wa	A's and C's restrictive r Support Plans) that e of psychotropic d restrictions within the IDP #2 indicated she was C approval of client A's er BSP that included the envices in the garage due to tening behaviors. QIDP #2 locking them (the sharps) on cabinet in the office for until I can get approval to he garage." QIDP #2 nives/sharps had been cility since July. When as taking so long to obtain HRC, QIDP #2 stated, "I					
W000263	The committee s programs are co written informed parents (if the cli guardian. Based on obser record review f (A and C) with	NITORING & CHANGE hould insure that these nducted only with the consent of the client, ent is a minor) or legal vation, interview and for 2 of 3 sampled clients restrictive programs, the p obtain written informed	WO	00263	<b>Correctiveactionforresident(s</b> <b>dtohavebeenaffected</b> The LPN is responsiblefor seek HRC approval for a new or cha psychotropic medicationorder. guardian or client approvalis	ting Inged	10/17/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	00	DATE SURVEY COMPLETED 09/22/2014
	PROVIDER OR SUPPLIEI		825 ME	ADDRESS, CITY, STATE, ZIP CODE ENDLESON DR	
	MARK HUMAN SEF	RVICES		10ND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
TAG	clients' legal rep clients' restrictiv use of behavior and the locking home. Findings include Observations we facility on 9/8/1 7:15 PM. During while preparing used a pair of sh vegetables. At 5 the scissors, drie them in an unlock kitchen stove. A indicated the kn (including scisso the medication of Staff #3 stated th the stove "shoul Staff #3 indicated because client A with a knife on the When asked how been locked up, couple of month Client A's record 9/10/14 at 2 PM Client A's rev (Behavior Support	resentatives for the re programs including the modification medication of the sharps within the e: ere conducted at the 4 between 3:30 PM and g this observation period the evening meal staff #1 arp scissors to cut the :10 PM staff #1 rinsed ed them off and placed eked cabinet above the t 5:50 PM staff #3 ives and sharps ors) were locked inside eabinet in the staff office. the sharp scissors above d have been locked up." ed the sharps were locked had threatened harm more than one occasion. w long the sharps had staff #3 stated, "I think a is."		received, the LPN will seek HRC approval and will update the BC who will update the BSP. The QIDPwill ensure the BSP is complete and accurate. Staff will betrained on allnew or updated BSPsby the BC ora Q or supervisor trainedby the BC. <b>Howfacilitywillidentifyotherreside</b> <b>ntspotentiallyaffectedandwhatmea</b> <b>surestaken</b> All residentsreceiving psychotropicmedications are affectedand corrective action willaddress the needsof all clients. <b>Measuresorsystemicchangesfacility</b> <b>putinplacetoensurenorecurrence</b> Monitoring the BSPand physician orders willbe added to themeeting checklist. The team includingthe BC, QIDP, andLPN will compare thephysician orders to the BSP at eachquarterly to ensurecompliance, HRC approval, and guardian approval. The QIDP is responsible for the meeting agenda. <b>Howcorrectiveactionswillbemonito</b> <b>redtoensurenorecurrence</b> The QIDP willfollow up to ensure the BC updates allBSPs and all staffare trained on newor updated plans. The Regional Directorwill be sent the meetingchecklist following each consumermeeting by theQIDP to ensure compliance.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Facility ID: 000904 Y6CM11

If continuation sheet

Page 116 of 179

PRINTED: 10/24/2014 FORM APPROVED

# DEPAR VICES

RTMENT	OF HEALTH AND HUMAN SERV
RS FOR	MEDICARE & MEDICAID SERVI

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ]	MULTIPLE CO	ONSTRUCTION		DATE SURVEY OMPLETED	
AND FLAN	OF CORRECTION	15G390	A. BUILDING B. WING			09/22/2014		
NAME OF	PROVIDER OR SUPPLIE	R.	STREET ADDRESS, CITY, STATE, ZIP CODE					
					ENDLESON DR			
BENCH	MARK HUMAN SEI	RVICES		RICHM	IOND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE	
		(every day) for						
		pakote 500 mg bid (twice						
		l stabilization, Seroquel						
	• •	mpulse control and						
	-	Neurontin 200 mg bid for						
		disorder (a mental						
		auses both a loss of						
		ality and mood problems).						
		13/14 physician's orders						
		A was also taking						
		ntidepressant) 50 mg qd.						
		was not included in client						
	A's BSP.							
		cord indicated client A						
	<u>^</u>	by a legal guardian.						
		cord indicated the facility						
		d written informed						
	consent from cl	-						
	-	or the restrictive BSP that e of Wellbutrin, Depakote,						
		eurontin and/or for the						
	•	ed consent for the use of						
	Sertraline.	a consent for the use of						
		cord indicated no written						
		nt to lock the sharps in the						
	home in regard	-						
	Client C's recor	d was reviewed on						
		M. Client C's updated						
		dicated client C was						
		ne 10 mg qd for anxiety						
		e 2.5 mg for mood						
	-	C's record indicated						
		presented by a legal						

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĩ.	ULTIPLE CO LDING	00	· /	SURVEY LETED
		15G390	B. WING			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					NDLESON DR		
BENCH	MARK HUMAN SEI	RVICES		RICHM	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE PRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	Client C's record indicated					
	-	not obtained written					
		nt from client C and/or					
	e e	representative for the					
		that included the use of					
	Buspirone and	Risperidone.					
	During intervie	w with QIDP (Qualified					
	Intellectual Dis	abilities Professional) #2					
	on 9/12/14 at 3:	15 PM, QIDP #2					
	indicated she w	as unable to locate client					
	A's and C's writ	tten informed consents for					
	their restrictive	BSPs including the use of					
	the clients' beha	vior modification					
	medications. Q	IDP #2 indicated client					
	A's legal guardi	an had given approval					
	over the telepho	one in July to lock the					
	knives. QIDP #	2 indicated an addendum					
	to client A's pla	n was written in August					
	to include the lo	ocking of the knives.					
	QIDP #2 indica	ted she had not obtained					
	written informe	d consent from client A's					
	guardian for the	e BSP that included the					
	locking of the k	nives and/or for the use of					
	Sertraline.						
	An email dated	9/15/14 at 9:29 AM was					
		QIDP #2 and reviewed on					
		AM. The email indicated					
		to client A's BSP. The					
		ed 8/14 indicated:					
		had a history of self					
		us behaviors and injuries					
	-	to these attempts. In order					
	Icialeu	to mose attempts. In order	1				1

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	R MEDICARE & MEDI						OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CON	ISTRUCTION	r í	DATE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPLETED	
		15G390	B. WING			0	9/22/2014
			<u> </u>	STREET AI	DDRESS, CITY, STATE, ZIP COD	E	
NAME OF 1	PROVIDER OR SUPPLIE	2R		825 MEN	NDLESON DR		
BENCHN	ARK HUMAN SE	RVICES		RICHMC	ND, IN 47374		
(X4) ID	SUMMADY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	p	REFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		COMPLETION
TAG		RET MOST BETREEEDED DT FOEL R LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
1110				1710			DATE
	-	[client A] and her					
		nates safe restrictive					
	measur	res have needed to be					
	placed	within the home.					
	Restric	tions: [Client A] will not					
	be perr						
	not acc						
	0 0	will be kept locked at all					
		ind the sharps (the knife,					
		s, and pizza cutter) will be					
		there as well as other					
	sharp u	itensils as determined by					
	the ID	Γ. This restriction is in					
	place to	place to maintain control over					
	-	in order to keep [client A]					
	-	r housemates safe. Review:					
		A's] IDT will review these					
	-						
		ions at least on a quarterly					
		f the team decides at any					
	time to	reduce restrictions, it can					
	be imp	lemented immediately. A					
	team m	nember will simply need to					
	cross o	out the restriction in the					
	book a	late the change, and					
		itial. All new restrictions					
	-						
	need H	IRC approval."					
	9-3-4(a)						
	- (*)						
14/000010	492 450(-)(0)						
W000312	483.450(e)(2) DRUG USAGE						
	Drugs used for c						1

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. W000312 Correctiveactionforresident(s)foun 10/17/2014 Based on record review and interview for dtohavebeenaffected 1 of 2 sampled clients receiving The BC will update the BSP to medications to control behaviors (A), the include a titration plan orplan of facility failed to ensure client A's use of reduction for any consumer Sertraline was included in client A's BSP prescribed a psychotropic (Behavior Support Plan) with a specific medication. The BC or supervisor trained by the BC willtrain all staff plans of reduction to reduce and on the updated BSP. eventually eliminate the behaviors for which the Sertraline was to target. Howfacilitywillidentifyotherreside ntspotentiallyaffectedandwhatmea surestaken Findings include: All residentscould be affected and corrective action planwill be put Client A's record was reviewed on inplace to protect allconsumers. 9/10/14 at 2 PM. Client A's 8/13/14 physician's orders indicated client A was Measuresorsystemicchangesfacility putinplacetoensurenorecurrence taking Sertraline (an antidepressant) 50 A pharmacist comes to the group milligrams a day. The use of Sertraline homesquarterly to check medications was not included in Client A's revised and discuss titration plans. These BSP dated 10/17/13. titration plans will be included in theBSP by the BC. The QIDP is responsible for ensuring the BSPs are Interview with QIDP (Qualified updated and complete. The QIDP Intellectual Disabilities Professional) #2 will seek guardian, client, and HRC on 9/12/14 at 3:15 PM indicated she was approval for any new orupdated not aware client A had been started on BSP. Sertraline. QIDP #2 indicated her Howcorrectiveactionswillbemonito employment began with the facility in redtoensurenorecurrence May 2014 as the behavior specialist and Monitoring the BSPand physician she was still getting to know the clients orders willbe added to the quarterly and had not had time to update and/or meeting checklist. The team including the BC, QIDP, and LPN will revise all of the clients' BSPs.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y6C

Y6CM11 Facility I

Facility ID: 000904

If continuation sheet

Page 120 of 179

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	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(V2) M		NSTRUCTION		MB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		00	(X3) DATE SURVEY COMPLETED	
		15G390	B. WIN			09/22	2/2014
NAME OF F	PROVIDER OR SUPPLIE	ĒR			DDRESS, CITY, STATE, ZIP CODE	3	
BENCHM	IARK HUMAN SEI	RVICES			NDLESON DR DND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	9-3-5(a)				compare thephysician orders BSP at eachquarterly meetin toensure compliance, HRC a	g	
					and guardian/clientapproval. TheQIDP is responsible for the meeting agenda.	ne	
				The Regional Directorwill be the meetingchecklist followi	ng each		
					consumermeeting by theQID ensure compliance.	P to	
W000318	483.460 HEALTH CARE S The facility must	SERVICES ensure that specific health					
	care services requirements are met. Based on observation, interview and record review, the facility failed to meet			00318	See W322, W323,W327, V W336, W352, W362, and	W331,	10/17/201
	the Condition of Participation: Health Care Services for 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, E, F and G). The facility nursing services failed to develop and implement a specific plan of care that included how the staff were to monitor and assist client C throughout the day inside and outside of the home in				W368.		
	-	C's frequent falls and ure client C's PT (Physical					
		sment addressed client C's l fine/gross motor skills					
	(the use of steps						
	the facility van) and to ensure client C's pharmacy recommendations were						
	addressed. The facility r	nursing services failed to					
		se client G's Risk gard to client G's injuries					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ION IDENTIFICATION NUMBER:		IULTIPLE CO	00	(X3) DAT COMI	
		15G390	B. WI			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
					NDLESON DR		
BENCHI	MARK HUMAN SE	RVICES		RICHM	OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)		COMPLETIC DATE
IAU		,		IAU			DATE
		sure an assessment from al Therapy/Occupational					
	· ·	a assess and monitor client					
		kin integrity and					
	-	breakdown of her					
		breakdown of her					
	buttocks.						
	The facility nu	sing services failed to:					
	-	implement a specific plan					
		ess client A's refusals of					
		d medical requests.					
		edications were labeled					
		s name, medication,					
		ime to be given and all					
	-	nmendations for client B.					
		al physical examinations					
		eening for early detection					
	of cancer for cl	<b>C</b>					
		al hearing, vision and					
		ons for clients A, B and C.					
		al TB (Tuberculosis)					
		creening for clients B and					
	C.	creening for chemis D and					
		erly nursing/health					
		clients A, B and C.					
		harmacist conducted					
		ws of the clients' drug					
		ients A, B and C.					
	-	ugs were administered in					
		h the each clients'					
	-	ers for clients B, C, D, E,					
	F and G.						
	Findings includ	<u>ه</u> .					

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE CO	ONSTRUCTION	(X3) D	OMB NO. 0938-03 ATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	Č,	ILDING	00	COMPLETED 09/22/2014	
	PROVIDER OR SUPPLI	ED		STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
					NDLESON DR		
BENCH	MARK HUMAN SE	RVICES		RICHM	OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)		COMPLETI
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
	1 Nursing serv	vices failed to ensure					
	-	were provided annual					
		nations and routine annual					
		arly detection of cancer.					
	Please see W32	•					
		22.					
	2. Nursing serv	vices failed to ensure the					
	clients' hearing	and vision were evaluated					
	annually for cli	ients A, B and C. Please					
	see W323.						
	3. Nursing serv	vices failed to ensure					
	•	received an annual TB					
	(Tuberculosis)	testing and/or screening.					
	Please see W32						
	4. Nursing serv	vices failed to develop and					
	implement a sp	becific plan of care that					
	included how t	he staff were to monitor					
	and assist clien	t C throughout the day					
	inside and outs	ide of the home in regard					
	to client C's fre	equent falls and seizures, to					
	ensure client C	's PT (Physical Therapy)					
	assessment add	lressed client C's					
	ambulatory and	l fine/gross motor skills					
	(the use of step	s and getting on and off					
	the facility van	) and to ensure client C's					
	pharmacy reco	mmendations were					
	addressed. Nur	sing services failed to					
		ise client G's Risk					
	Summary in re	gard to client G's injuries					
		sure an assessment from					
		al Therapy/Occupational					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I	MULTIPLE C	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014			
	or conduction	15G390	A. BU B. WI	ILDING NG					
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP	CODE			
	MARK HUMAN SEI				ENDLESON DR 10ND, IN 47374				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	1			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION	SHOULD BE		COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE		DATE	
	Therapy) and to	assess and monitor client							
		kin integrity and							
	-	breakdown of her							
		ng services failed to							
		plement a specific plan of							
	-	client A's refusals of							
		d medical requests, to							
		cations were labeled with							
the client's na		e, medication, dosage,							
		e given and all pharmacy							
	· · · · · · · · · · · · · · · · · · ·	ins for client B, to ensure							
		examinations and routine							
		arly detection of cancer for							
	-	, to ensure annual hearing,							
		al evaluations for clients							
		ensure annual TB							
		testing and/or screening							
		d C, to ensure quarterly							
		assessments for clients A,							
		ure the pharmacist							
	-	terly reviews of the							
		gimens for clients A, B							
		sure all medications were							
		compliance with the each							
		ans' orders for clients B, C,							
	D, E, F and $G$ .	Please see W331.							
	5 Nursing serv	ices failed to ensure							
	-	d C were provided							
		ng/health assessments.							
	Please see W33	-							
		ices failed to ensure xaminations for clients B							

	MEDICARE & MEDIC	_				OMB NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULI A. BUILDI B. WING	IPLE CONSTRUCTION NG 00	CO	TE SURVEY MPLETED 122/2014
NAME OF P	ROVIDER OR SUPPLIEF	λ.		TREET ADDRESS, CITY, 25 MENDLESON D		
BENCHM	IARK HUMAN SER	VICES		RICHMOND, IN 473		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	]	D PROVIDE	ER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		EFIX (EACH CORRE CROSS-REFER	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	COMPLETIO
TAG	and C. Please se	e W352.	1	AG	DEFICIENCY)	DATE
	facility pharmac reviews of the cl clients A, B and 8. Nursing servi- medications wer compliance with orders for clients Please see W368	ces failed to ensure the ist conducted quarterly lients' drug regimens for C. Please see W362. ces failed to ensure all re administered in a each clients' physicians' s B, C, D, E, F and G. 3. relates to complaint				
V000322	and general media Based on record 2 of 3 sampled of facility failed to provided annual and routine annu- detection of cano Findings include	provide or obtain preventive cal care. review and interview for clients (B and C), the ensure the clients were physical examinations nal screening for early cer.	W000	dtohavebeen The LPN wa 10-3-14 that annual physic screenings at medical file. have a physic consumers w in their medi	ctionforresident(s)foun naffected s retrained by the RD on allconsumers must have cals including pre cancer ble to belocated in their Allconsumers must cal annually. All vill have annual physicals cal chart by 10-17-14. willidentifyotherreside lyaffectedandwhatmea	10/17/201

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

PRINTED: 10/24/2014 FORM APPROVED OMB NO. 0938-0391

NTERS FOR MEDICARE & ME				OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES		(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
	15G390	B. WING		09/22/2014		
NAME OF PROVIDER OR SUPP	JER	STREET	ADDRESS, CITY, STATE, ZIP CODE	-		
TABLE OF TROVIDER OR SUFF.			ENDLESON DR			
BENCHMARK HUMAN S	ERVICES	RICHM	10ND, IN 47374			
(X4) ID SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)		
PREFIX (EACH DEFIC	TENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD ) CROSS-REFERENCED TO THE APPROF	BE COMPLETION		
TAG REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
indicated no a	nnual physical by the		surestaken			
client's physic	cian. Client B's record		All residentscould be affected			
indicated clie	nt B was over the age of 20.		andcorrective action planwill inplace to protect allconsumer			
Client B's rec	ord indicated no		inplace to protect anconsumer	5.		
preventative 1	Pap screening for early		Measuresorsystemicchanges	facility		
detection of c	ancer.		putinplacetoensurenorecurre			
			The LPN has included on the			
Client C's rec	ord was reviewed on		monthlynursing summary the			
	AM. Client C's record		each client's last physical. This ensure the dates are reviewedr			
	innual physical by the		to ensure compliance. Also	nonuny		
	cian. Client C's record		thesedates will be included on	the		
	nt C was over the age of 40.		quarterly meeting checklist that	at will		
	ord indicate no preventative		be reviewedat each quarterly r	neeting		
	Pap screening and/or a mammogram for		and signed off on by the RD.			
early detectio			Howcorrectiveactionswillben	aonito		
	if of calleer.		redtoensurenorecurrence	iointo		
During intern	ion with OIDD (Qualified		The LPN's monthly nursing su	immary		
•	iew with QIDP (Qualified		is sent to the QIDPmonthly to			
	isabilities Professional) #1,		include in the QIDP's monthly			
	dential Manager), LPN #1		programming summary. Thes			
	on 9/12/14 at 3:15 PM,		will be viewed monthly by the to ensure compliance. The	QIDP		
	cated the clients' records		monthlyprogramming summar	rv is		
	filed for "Six to twelve		sent to the AWS compliance	5		
	haybe longer" and "We are		department.			
	locate things." LPN #1		The dates will also be included			
	clients were to have an		reviewed on the quarterlymeet	-		
annual physic	al and were to be provided		checklist. This checklist willb to the RD after each meeting t			
	ing for cancer. LPN #1		reviewed and signed off on.			
indicated she	was unable to locate all of					
the clients' cu	rrent medical records.					
9-3-6(a)						
1		1	I	1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y6C

Y6CM11 Facility ID: 000904

904 If con

If continuation sheet

Page 126 of 179

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. BUILDING B. WING	CONSTRUCTION 00	COMP	e survey pleted 2/2014
	ROVIDER OR SUPPLIE		825 N	T ADDRESS, CITY, STATE, ZIP CODE		
BENCHN	ARK HUMAN SEI	RVICES	RICH	MOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
W000323	483.460(a)(3)(i) PHYSICIAN SEF The facility must physical examina minimum include and hearing. Based on record 3 of 3 sampled facility failed to hearing and vis annually. Findings includ Client A's recor 9/10/14 at 2 PM indicated client evaluation was Client A's phys A's hearing. Cli no hearing eval indicated client evaluated annua Client B's recor 9/10/14 at 3 PM indicated no he B's most curren 9/8/12. Client E B's hearing and annually.	AVICES provide or obtain annual ations of each client that at a s an evaluation of vision d review and interview for clients (A, B and C), the o ensure the clients' ion were evaluated e: e: e: e: d was reviewed on f. Client A's record A's most recent physical conducted on 1/28/14. ical did not address client ent A's record indicated uation. Client A's record A's hearing was not	W000323	Correctiveactionforresident dtohavebeenaffected The LPN was retrained by the 10-3-14 that allconsumers mu annual vision and hearing appointments able to be locat their medical file. All consumersmust have a physic annually. Allconsumers will annual physicals in their med chart by 10-17-14. Howfacilitywillidentifyother ntspotentiallyaffectedandwh surestaken All residentscould be affected andcorrective action planwill inplace to protect allconsume Measuresorsystemicchanges putinplacetoensurenorecurr The LPN has included on the monthlynursing summary the each client's last physical. The ensure the dates are reviewed to ensure compliance. Also thesedates will be included on quarterly meeting checklist th be reviewedat each quarterly and signed off on by the RD. Howcorrectiveactionswillber redtoensurenorecurrence The LPN's monthly nursing s is sent to the QIDPmonthly to	e RD on list have edin ral have ical reside atmea l be put rs. facility ence dates of lis will monthly n the lat will meeting monito ummary	10/17/201

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15G390	A. BUILDING B. WING		09/22/2014
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
BENCHN	IARK HUMAN SEF	RVICES		ENDLESON DR //OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	record indicated vision evaluation 7/7/13. Client C C's hearing and annually. Interview with the 9/12/14 at 3:15 was unable to be and C's hearing The LPN indicat the facility had	evaluation. Client C's I Client C's most recent n was conducted on I's record indicated client vision were not evaluated the facility's LPN on PM indicated the LPN boate all of client A's, B's and vision evaluations. ted the clients' records for not been filed for 6 to 12 was unable to find all of rds.		include in the QIDP's monthly programming summary. These will be viewed monthly by theQ to ensure compliance. The monthlyprogramming summary sent to the AWS compliance department. The dates will also be included a reviewed on thequarterly meetin checklist. This checklistwill be to the RD after each meeting to reviewed and signed offon.	IDP is und g sent
W000327	physical examina minimum include appropriate to the accordance with the American Co the section on dis American Acades Based on record 2 of 3 sampled facility failed to	provide or obtain annual tions of each client that at a s tuberculosis control, e facility's population, and in the recommendations of lege of Chest Physicians or seases of the chest of the ny of Pediatrics, or both. I review and interview for clients (B and C), the ensure the clients ual TB (Tuberculosis) creening.	W000327	<b>Correctiveactionforresident(s)</b> <b>dtohavebeenaffected</b> All consumers must have a phys annually which includes aTB tes The LPN was retrained by the R 10-3-14 that all consumers must an annual TD test and that must belocated in the medical file. Allconsumers will have a TB tes	ical st. Don have

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG the main file or an appointment scheduled by10-17-14. Client B's record was reviewed on 9/10/14 at 3 PM. Client B's June 2014 Howfacilitywillidentifyotherreside nursing Monthly Health Review ntspotentiallyaffectedandwhatmea indicated client B received a TB test on surestaken All residentscould be affected 3/10/14. Client B's record indicated no and corrective action planwill be put results for the TB test. inplace to protect allconsumers. Client C's record was reviewed on Measuresorsystemicchangesfacility 9/11/14 at 10 AM. Client C's June 2014 putinplacetoensurenorecurrence The LPN has included on the nursing Monthly Health Review monthlynursing summary the dates of indicated client C received a TB test on each client's last physical and TB 3/10/14. Client C's record indicated no test. This will ensure the dates are results for the TB test. reviewedmonthly to ensure compliance. Thesedates will be included on the meeting checklist Interview with the facility's LPN on that will be reviewed at eachquarterly 9/12/14 at 3:15 PM indicated the clients' meeting and signed off on by the records had not been filed for 6 to 12 Regional Director. months and she was unable to locate the results of the TB tests and/or verify the Howcorrectiveactionswillbemonito redtoensurenorecurrence tests were given for clients B and C. The LPN's monthly nursing summary is sent to the QIDPmonthly to 9-3-6(a) include in the QIDP's monthly programming summary. These dates will be viewed monthly by theQIDP to ensure compliance. The monthlyprogramming summary is sent to the RD and the AWS compliance department. The dates will also be included and reviewed on the meetingchecklist. This will be sent to the Regional Director after each quarterly meeting to be reviewed and signed offon. W000331 483.460(c) FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11 Facility ID: 000904 If continuation sheet Page 129 of 179

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	R MEDICARE & MEDIC	-				IB NO. 0938-0391	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	00 	(X3) DATE SURVEY COMPLETED 09/22/2014		
	PROVIDER OR SUPPLIE MARK HUMAN SEF		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	The facility must services in accord Based on observ- interview for 3 and C) and 3 ad F), the facility r Develop and of care in regard falls and seizure staff were to more throughout the of home, in her be while outside of the facility van. services failed t (Physical Thera all of client C's to client C's find going up and do and off the facili Ensure client	provide clients with nursing dance with their needs. vation, record review and of 3 sampled clients (A, B ditional clients (D, E and nursing services failed to: implement a specific plan d to client C's frequent es that included how the onitor and assist client C day while inside the droom and bathroom, f the home and while on The facility nursing o ensure client C's PT py) assessment addressed mobility needs in regard e and gross motor skills, own steps and getting on	W000331	IN addition tobelow, please see W322, W323, W327, W336, W3 W363, and W368. Correctiveactionforresident(s)f dtohavebeenaffected QIDP and LPN were retrained or 10-3-14 for updating careplans including ISPs, BSPs and Risk Plans. This includes to monitor f patterns such as falls, seizures, andmedication refusals. ISPs, BSPs, and Risk Plans will updated by 10-17-14 to includea necessary information on each client. Howfacilitywillidentifyotherres ntspotentiallyaffected and correctiveaction will address theneeds of all clients.	foun n for be ny	10/17/201	

Review and revise client G's Risk Summary in regard to client G's history of falls and frequent injuries and to ensure an assessment from PT/OT (Physical Therapy/Occupational Therapy) to include client G's fine and gross motor skills and ambulatory needs. Assess and monitor client G in regard to skin integrity and client G's identified skin breakdown of her buttocks.

Develop and implement a specific plan

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:

Y6CM11

Facility ID: 000904

behavior.

Measuresorsystemicchangesfacility

Howcorrectiveactionswillbemonito

meeting checklist to ensure the team

is discussing all pertinentinformation

for each client at the meetings. The

QIDP and the LPN will monitor for

patterns and call IDT meetingswhen a client is displaying a new illness or

One member of management will be

redtoensurenorecurrence The RD will be sentthe quarterly

putinplacetoensurenorecurrence

If continuation sheet

Page 130 of 179

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG in the home at least until 7pm at least of care to address client A's refusals of weekly. One member of medications and medical requests. management will conduct Ensure all medications were labeled randompop in visits at least weekly with the client's name, medication, on varying shifts and days to ensure dosage, route, time to be given and all staff areproviding active treatment and following treatment plans. pharmacy recommendations for client B. Ensure annual physical examinations and routine screening for early detection of cancer for clients B and C. Ensure annual hearing, vision and dental evaluations for clients A, B and C. Ensure annual TB (Tuberculosis) testing and/or screening for clients B and С. Ensure quarterly nursing/health assessments for clients A, B and C. Ensure the pharmacist conducted quarterly reviews of the clients' drug regimens for clients A, B and C. Ensure all drugs were administered in compliance with the each clients' physicians' orders for clients B, C, D, E, F and G Findings include: 1. Observations were conducted at the group home on 9/8/14 between 3:30 PM and 7:15 PM. During this observation period client C wore a brace on her left lower leg and walked with a forward lean and an unsteady gait. Observations were conducted at the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11 Facility ID: 000904 If continuation sheet Page 131 of 179

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	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CON	ISTRUCTION	(X3)	OMB NO. 0938-03 DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390		LDING	00	C	COMPLETED 		
		136390	B. WIN				19/22/2014		
NAME OF I	PROVIDER OR SUPPLI	ER			DRESS, CITY, STATE,	, ZIP CODE			
BENCH	ARK HUMAN SE	RVICES			ND, IN 47374				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLETI		
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIEN		DATE		
	group home on	9/10/14 between 5:30							
	AM and 8:35 A	M. During this							
	observation per	riod client C was out of							
	bed at 6 AM ar	id ambulated							
	independently	wearing only socks on her							
	feet and no bra	ce on her left lower leg.							
	Client C's gait	was unsteady.							
	The facility's re	portable records were							
	reviewed on 9/	10/14 at 10 AM.							
	The 5/26/14 BI	DDS report indicated							
		C did not receive her 1 PM							
dose		f Divalproex 250 mg							
		rams) for seizure control							
	on 5/26/14.								
	The 6/16/14 BI	DDS report indicated							
	client	C did not receive her 7 AM							
	dose o	f Divalproex 250 mg on							
	6/14/1	4.							
	Client C's recor	rd was reviewed on							
	9/11/14 at 10 A	M. Client C's record							
	indicated diagn	oses of, but not limited to,							
	Seizure Disord	er and Cerebral Palsy (a							
	disorder of pos	ture, muscle tone and							
	movement resu	lting from brain damage).							
	Client C's Seiz	ure Reports indicated:							
		34 PM client C was							
	helpin	g to set the table and "got							
	-	id began to pee her pants."							
		5 PM client C "yelped,							
		n the floor after grabbing							

### **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG her crotch and said she was okay." On 6/2/14 at 5:10 PM client C "Yelped, grabbed her crotch, pee'd (sic) and took off for the bathroom." On 6/9/14 at 4:30 PM client C "Yelped, shook, pee'd (sic) herself and took off for the bathroom holding her crotch." On 6/15/14 at 5:47 PM client C "Was at the dinner table eating her dinner and talking to staff. Client (C) let out a yelp or cry, then her whole body stiffened, eyes got big and she was holding her private area, because she started peeing." On 6/16/14 at 7:51 PM client C "Yelped, grabbed crotch and wet on the couch and immediately got up to go change her clothes." On 6/17/14 at 6:17 PM client C "Yelped, shook, pee'd (sic) on the floor and started saying she's sorry." On 6/22/14 at 5:25 PM client C "Yelled out, whole body stiffened and she grabbed her private area because she wet herself." On 6/28/14 at 4:10 PM client C "yelled, her body stiffened at first then started shaking. Client was also holding her private area but didn't

DEPARTMENT OF HEALTH AND HUMAN SERVICES

pee." On 7/1/14 at 5:30 PM client C "started shaking and her head was shaking and [client C] kept saying I'm FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Y6CM11

Facility ID: 000904

If continuation sheet

Page 133 of 179

PRINTED:

FORM APPROVED

	R MEDICARE & MEDI							B NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CON		(X3) DATE SURVEY COMPLETED		
		15G390	B. WIN			-	09/22/	2014
NAME OF	PROVIDER OR SUPPLI	ER	_		DDRESS, CITY, STATE, ZIP CO	DE		
BENCHI	MARK HUMAN SE	RVICES			NDLESON DR DND, IN 47374			
(X4) ID		STATEMENT OF DEFICIENCIES		ID		0		(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	ULD BE	F	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	PROPRIAT	E	DATE
	sorry a	nd her body shook and was						
	shakin	g."						
	On 7/6/14 5:31	PM client C was eating						
	her dir	ner and "grown (sic) and						
	chew h	ner food. Kept eaten her						
	dinner	(sic)."						
	On 8/16/14 at 6	5:50 PM client C was						
	sitting	in a chair and "said a few						
	words,	wet herself and shook."						
	Client C's Post	Fall Assessment forms						
	indicated							
	On 11/8/13 at 11:55 AM while at the DP							
	client	C was walking up the						
	sidewa	lk incline to the DP and						
	she trij	oped on her feet and fell.						
	The as	sessment indicated actions						
	to prev	ent future falls "Direct						
	client t	to point toes forward and						
	plant f	eet before attempting to						
	walk."							
	On 11/17/13 at	7:50 AM client C was						
	"walki	ng to the bathroom to get						
	some v	vater to take her pills when						
		ned into a chair and fell on						
	her but	tt." The assessment						
		ed actions to prevent future						
		Fry to make sure she is						
	walkin	g okay to the whatever it is						
	she's g	oing and maybe keep an						
	-	her more when walking						
	around	without her shoes."						
	On 6/2/14 at 8:	20 AM client C rode to						
	the DP	(Day Program) on the						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 00 COMPLETED A. BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND, IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG house bus, exited the bus and was walking up a slight incline to enter the DP and fell. On 7/5/14 at 12:50 PM client C was going down some steps and was holding onto the railing. "After taking a step and having both feet on a step she lost her balance a feel but still had her right hand on the railing (sic)." The Assessment indicated client C was wearing a brace on her left ankle and indicated immediate actions to prevent future falls "Walk in front of client and have someone walk behind." On 7/13/14 at 5:45 PM client C was at the group home in the living room and was arguing with a peer. When the peer went to hit client C, client C took a step back and lost her balance, fell and knocked over a lamp. On 8/18/14 at 1:30 PM client C was walking to the break room at the DP and fell. Client C's nursing notes indicated 5/3/14 "Received report of seizure in which client had seizure activity while assisting with prepping meal. Client had urinary incontinence but was able to change her clothes with assist of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Ye

Y6CM11 Facility ID: 000904

000904 If

If continuation sheet Page '

Page 135 of 179

PRINTED:

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	C	OMPLETED	
		15G390	B. WI			09/2		
NUME OF				STREET	ADDRESS, CITY, STATE, ZIP	CODE		
NAME OF	PROVIDER OR SUPPLIE	ĸ		825 ME	ENDLESON DR			
BENCH	MARK HUMAN SEI	RVICES		RICHM	IOND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	staff. N	lo injury to report."						
	5/20/14 "Receiv	ved report of injury form						
	from 5/	/16 (5/16/14) in which it is						
	reporte	d that client fell out of her						
	seat in	the van when coming						
	home f	rom group home outing.						
	Per rep	ort no treatment was						
	needed							
	5/24/14 "Receiv	ved report of seizure. Per						
		client was having dinner						
	-	ommates. She was joking						
		with peer and then						
		d herself and was incont						
	-	inent) of urine. Per report,						
		tated she wanted to go						
	home b							
		l no show signs of ion (sic)."						
		C's doctor "is aware that						
		lid not have her Divalproex						
		tab at 1 PM on this day."						
	-	•						
		ed post fall assessment						
		which it is reported that ell walking up a slight						
		into the main center						
		g. No reports of injury						
	noted."							
		d report of seizure on						
		in which it is reported that						
		ad 5 seconds of seizure						
	-	during evening meal.						
		ran to bathroom when						
	-	ceased, no reports of						
	injury 1	noted."						

	(EACH DEFICIEN REGULATORY OF 6/10/14 Review 6/9/14 i client h activity		P	825 MEN	DDRESS, CITY, STATE, ZI DDLESON DR ND, IN 47374 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	CORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
(X4) ID PREFIX	SUMMARY S (EACH DEFICIEN REGULATORY OF 6/10/14 Review 6/9/14 i client h activity has no p	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ed report of seizure dated in which it is reported that ad 10 seconds of seizure with incontinence. Client	P	RICHMO ID REFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETI
PREFIX	(EACH DEFICIEN REGULATORY OF 6/10/14 Review 6/9/14 i client h activity has no p	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ed report of seizure dated in which it is reported that ad 10 seconds of seizure with incontinence. Client	P	REFIX	(EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETI
	regulatory of 6/10/14 Review 6/9/14 i client h activity has no p	R LSC IDENTIFYING INFORMATION) ed report of seizure dated in which it is reported that ad 10 seconds of seizure with incontinence. Client			(EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE	
TAG	6/10/14 Review 6/9/14 i client h activity has no	ed report of seizure dated in which it is reported that ad 10 seconds of seizure with incontinence. Client		TAG	DEFICIENCY)		DATE
	6/9/14 i client h activity has no p	in which it is reported that ad 10 seconds of seizure with incontinence. Client					
	client h activity has no p	ad 10 seconds of seizure with incontinence. Client					
	activity has no 1	with incontinence. Client					
	has no i						
		reports of injury with this					
		1 55					
	6/14/14 "Receiv	ved report of seizure					
		from 6/15/14. Client					
	-	b have 15-20 seconds of					
	activity	. Client had episodes of					
		nence during activity."					
		of seizure form received.					
	-	30 second duration. No					
		eported. Client (C) seen by					
		of neurologist] on this					
	-	ew orders obtained to					
		ncrease of Onfi to 20 mg					
	-	ams) BID (twice a day)."					
		ed report of fall with no					
		"Received report of injury					
		h it is stated that client got					
		her chair, hit her left leg					
		on buttocks. Client					
		d no medical intervention					
	-	to this incident and has					
	had no	complaints of pain or					
	other."						
	7/5/14 "Receive	ed report of fall with no					
	injury."	-					
		ed report of seizure form					
		ure lasting 20 seconds					
		injury to report."					
		wed report of injury for					
		e in which it is stated that					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. BUILDING B. WING	3	00	-	DATE SURVEY COMPLETED 09/22/2014
NAME OF	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP CO IDLESON DR	DE	
BENCHI	MARK HUMAN SE	RVICES	82 Ri				
(X4) ID		STATEMENT OF DEFICIENCIES	ID				(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	G	CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	DATE
	client l	anded on her bottom while					
	attemp	ting to get off of the van					
	after de	eclining assistance from					
	staff. C	Client denies injury. No					
	medica	al intervention was required					
	related	to this incident."					
	7/20/14 "Receiv	ved report of seizure for					
	this da	te. Seizure lasted approx 1					
	minute	per this report. Client was					
	not inj	ured and returned to her					
	usual l	evel of daily activities					
	shortly	after seizure ended."					
	7/21/14 "Receiv	ved report of fall on					
	7/13/14	4 in which it is reported					
	that cli	ent fell and knocked over a					
	lamp. I	Per staff she has a red area					
	on her	back."					
	8/4/14 "Client (	(C) sent to [name of					
	hospita	al] ER (Emergency Room)					
	on this	date in the early morning					
	for fall	in which she stuck (sic)					
	her hea	ad and was bleeding. Client					
	was tre	eated in the ER where head					
	lac (lac	ceration) was sutured. She					
	remain	ed at home and was					
		ed by staff per protocol					
	with no	euro checks."					
		ved report of seizure dated					
	8/6/14.	No injury to report."					
		ed to (sic) report of					
		e on this date each lasting					
	approx	(approximately) 30					
		s. No injury to report."					
	8/8/14 client C	was seen in the ER to					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	C	OMPLETED	
		15G390	A. BUILDING B. WING				9/22/2014	
			5. WI		ADDRESS, CITY, STATE, ZIF	P CODE		
NAME OF	PROVIDER OR SUPPLIE	ER			ENDLESON DR			
BENCH	MARK HUMAN SEI	RVICES			IOND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	1		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	DATE	
	have su	itures removed.						
	8/13/14 client C	I's doctor signed order for						
		o have a PT (Physical						
		y) evaluation.						
	· ·	ved three reports of						
		on this client (C) for						
		e occasions on this date.						
	-	(sic) seizure each lasted						
		en (sic) one minute, no						
	5	s have been reported."						
		C scheduled for PT						
		tion and treatment.						
		C had a seizure lasting 15						
	second							
		(Received) a (sic) injury						
	-	stating that [client C] was						
		g in the break room at the						
		op and lost her balance						
	and fel	l landing on her right hip.						
	Staff as	ssisted her to here (sic) feet						
	and she	e was assessed for injury.						
	None n	oted."						
	8/19/14 at 6:10	PM client C had a 30						
	second	seizure. "Started to shake						
	and wa	s incontinent. No injury."						
	8/19/14 at 7:45	PM client C had a seizure						
	while s	itting in a chair that lasted						
		nute. "Hand shaking and						
		continent. No injury."						
		PM client C had a 30						
		seizure while sitting at the						
		table. No injury.						
		PM client C had a seizure						
		itting on the couch. Client						
	wine s	nung on me couch. Cheft						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	15G390	A. BUILDING UU		00	09/22/2	
NAME OF	PROVIDER OR SUPPLIE	ĒR			DDRESS, CITY, STATE, ZIP C	ODE	
					IDLESON DR		
	MARK HUMAN SEI				ond, in 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID EFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC DATE
		shaking all over and was					
		nent of urine. No injury.					
		1 client C had a 30 second					
		. No injury.					
		PM client C had a 30					
		seizure while getting off					
	the fac						
		ed, got goose bumps and					
		'No' during seizure. Also					
		nent of urine. No injury."					
		5 5					
	Client C's nursi	ng notes indicated no					
	visual assessme	ents of client C by the					
	facility nurse af	fter falls and/or seizures.					
	Client C's PT e	valuation dated 8/26/14					
	indicated "Pt (p	atient) is a 40 yo (year					
	old) female wit	h CP and a resident of a					
	group home. Sh	ne (client C) has recently					
	had an increase	d incidence of falls as					
	well as reports	of declining posture which					
		r balance and safety while					
		sents today in a left AFO					
		notic) with left LE (lower					
		mally rotated starting at					
	-	s decreased strength					
	-	and flexion contracture (a					
	-	nuscle tissue and tendons,					
	-	joint into a flexed					
	- ·	UE (upper extremity).					
		e forward head with					
		cic kyphosis (an excess					
		upper back causing a					
	hump). Berg ba	lance assessment (a test to					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DA	ATE SURVEY		
ND PLAN	OF CORRECTION	N IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
		15G390	R. BUIL B. WINC		- 09	09/22/2014			
					DDRESS, CITY, STATE, ZIP C	ODE			
NAME OF I	PROVIDER OR SUPPLIE	R	825 MENDLESON DR						
BENCHN	/IARK HUMAN SEI	RVICES		RICHMO	OND, IN 47374				
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
		e) was performed in							
		ed a 31/56. Any score less							
	than 46 indicate	es an increased risk for							
	falls. This patie	nt would benefit from PT							
	to address abov	e issues to decreased							
	likelihood of fa	lls."							
	The PT asses	sment indicated client C							
	was not assesse	d in regard to transfers							
	and was not ass	essed for her ability to go							
	up and down th	e steps. Client C's PT							
	evaluation indic	cated no assessment of							
	client C's ability	y to get on and off the							
	facility van. Cli	ent C's PT assessment							
	indicated no lev	el of assistance and/or							
	supervision clie	ent C required at the group							
	home and/or the	e DP. The PT assessment							
	indicated no rec	commendations to address							
	how the facility	staff were to assist and							
	monitor the clie	ent throughout the day to							
	prevent injury f	rom falls.							
	Client C's Risk	Summary dated 10/1/13							
		C was at risk for falls and							
		falls. The Summary							
		ent C] has a history of							
		was evaluated to [name							
		sical therapy. Most recent							
		vas completed 4/15/13							
		13 resulting in discharge							
		3. Pt (patient) requires							
		valking on uneven ground							
	•	ident on level ground.							
		mpt [client C] when							
	-	t toe forward. Staff are to							

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			· · ·	(X3) DATE SURVEY COMPLETED	
		15G390				- 09/22/2014		
NAME OF			ST	REET AI	DDRESS, CITY, STATE, ZIP C	CODE		
NAME OF	PROVIDER OR SUPPLIE	2R	82	25 MEN	IDLESON DR			
BENCH	MARK HUMAN SE	RVICES	R	СНМО	ND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	)	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TA	G	DEFICIENCY)		DATE	
	check brace dai	ly to be sure it is on						
	properly. Staff	will assist [client C] in						
	doing home exe	ercise program 5 days a						
	week scheduled	l while at the center						
	Monday thru Fi	riday. If [client C] falls						
	-	ss to see if treatment is						
	necessary. Staf	f will notify nurse of fall.						
		lete injury report along						
	-	ssessment and document						
	-	ursing notes. Nurse will						
		notes and MAR						
	-	lministration Record) at						
	least monthly."	initiation Record) at						
	least montiny.							
	Client C's recor	d indicated no IDT						
	(Interdisciplina	ry Team) meetings in						
		C's increased number of						
		ls. Client C's ISP/Risk						
	Summary failed	to indicate how the staff						
	-	se, monitor and assist						
	-	hout the day while						
	Ũ	prevent further injury from						
		Risk plan failed to indicate						
		ere to supervise and						
		C throughout the day due						
	to seizures.	e unoughout the day due						
	Client C's Cons	ultation Report dated						
		e pharmacist indicated:						
		eives an anticonvulsant						
		lium DR 250 mg						
	-	-						
		d (twice a day);						
	-	600 mg bid and						
	Lamotrigine 10	0 mg bid for epilepsy.						

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	R MEDICARE & MEDI						OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	DNSTRUCTION		ATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BI	JILDING	00		OMPLETED	
		15G390	B. WING			09/22/2014		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP	CODE		
			825 MENDLESON DR					
BENCH	MARK HUMAN SE	RVICES		RICHM	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	SHOULD BE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		treatment for epilepsy can						
	cause varying l	ab results for individual						
	AED (antiepile	ptic drugs) agents. In						
	addition, Oxcar	bazepine can cause						
	hyponatremia (	low blood sodium levels).						
	Recommendati	ons: Please consider						
	monitoring the	following (blood tests): 1)						
	Valproic acid le	evel q (every) 6 months. 2)						
	-	) and ALT q 6 months						
	· · · · · · · · · · · · · · · · · · ·	trolytes q 6 months						
		e)." Client C's record						
	· ·	utine lab work and/or						
		alproex) or Valproic acid						
	· ·	to client C's increased						
	seizure activity							
	seizure activity							
	QIDP (Qualifie	d Intellectual Disabilities						
	Professional) #	1, the RM (Residential						
	Manager) and t	he facility's LPN were						
	interviewed on	9/12/14 at 3:15 PM.						
	The LPN indica	ated she was unable to						
	find all	of client C's records in						
	regard	to the client's visits with						
	-	rologist and the client's lab						
		The LPN stated, "I know						
		w her neurologist recently						
		r medication was						
	increas							
		ited she was unable to						
	-	any IDT meetings in regard						
		nt C's increased seizures						
		curring falls. QIDP #1						
		-						
		"I know I haven't had any						
	meetin	gs since I've been here."						

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G390		(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 09/22/2014	
	PROVIDER OR SUPPLIEI		825 M	IP CODE			
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	MOND, IN 47374 PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TI DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
	recently When asked how supervise client C ensure of to falls, ambulat staff ass QIDP #1 indicat C's care Risk Su increase and incre QIDP #1 indicat PT ther C's need DP. QIDP #1 indicat follow of QIDP #1 and the new to the and wet	"She [client C] just went to PT." ware the staff to se, monitor and assist throughout the day to client C's safety in regard the RM indicated client C ted independently and the sist her as needed. The dist her as needed. T					
	9/10/14 at 2 PM						
	(MRRs) indicate	PM client A refused her					

	<b>MEDICARE &amp; MEDI</b>	X1) PROVIDER/SUPPLIER/CLIA	(V2) M		NSTRUCTION		OMB NO. 0938-03
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390		LDING	CO	COMPLETED 09/22/2014	
NAME OF P	AME OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIF	P CODE	
BENCHM	IARK HUMAN SE	RVICES			NDLESON DR OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO TH DEFICIENCY)		DATE
	Divalp	roex Sodium 500 mg					
	(millig	ram) for mood					
	stabiliz	zation, Gabapentin 200 mg					
	for Scł	nizoaffective Disorder and					
	Fexofe	madine HCL 180 mg for					
	allergi	es. The report indicated					
	client A	A was upset about not					
	getting	to have orange juice and					
	went to	her room and wrote. "She					
	refused	l multiple times for					
	multip	le staff."					
	On 9/30/13 clie	ent A refused her 4 PM					
	meds:	Divalproex Sodium 500					
	mg and	d Gabapentin 200 mg. The					
	report	indicated "Asked 4 times					
	and oth	ner staff tried to talk to her					
	also bu	it she would not take					
	them."						
	On 11/11/13 cl	ient A refused her 4 PM					
	meds:	Divalproex Sodium 500					
	mg and	d Gabapentin 200 mg. The					
	report	indicated "Just refused					
	meds a	nd told staff 'No'.					
	On 11/12/13 at	10:20 AM client A					
		l to go to her dental					
	appoin	-					
	On 11/12/13 cl	ient A refused her 4 PM					
		Divalproex Sodium 500					
		d Gabapentin 200 mg. The					
	-	indicated "Client was very					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULT A. BUILDIN B. WING		COM	te survey Mpleted 22/2014		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR RICHMOND, IN 47374					
(X4) ID		TATEMENT OF DEFICIENCIES			ND, IN 47374		(X5)	
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	EFIX AG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	COMPLETIC	
	upset ar	id refused meds."						
	meds: E mg and report in 3x (thre 4 PM an cursed a [client A them." 7 staff to	ent A refused her 4 PM Divalproex Sodium 500 Gabapentin 200 mg. The indicated "Staff asked her e times) over the period of ind 5 PM for meds and was it. Staff notified nurse A] never wanted to take The nurse instructed the "Just wait and see if she em and fill out a refusal."						
	medicat Sertralin with Vi Sodium (an antij Hydroch a Multi menses indicate [client A refused minutes again. S minutes	at A refused her 7 AM ions: Bupropion and he for depression, Calcium tamin D, Divalproex , Gabapentin, Seroquel psychotic), hlorothiazide (a diuretic), Vitamin and Zovia (for regulation). The report d "Staff knocked on A's] door, she (client A) meds. Staff waited 20 . She (client A) refused taff waited another 20 and she (client A) told 'leave me alone'."						
	medicat	A refused her 7 AM ions: Bupropion, ne, Calcium with Vitamin						

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(V2) N		NSTRUCTION		OMB NO. 0938-03 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	Ì.	ILDING	COM	COMPLETED 09/22/2014	
NAME OF F	E OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIF	P CODE	
BENCHM	IARK HUMAN SE	RVICES		825 ME RICHM			
(X4) ID						(X5)	
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI			COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		alproex Sodium,					
		entin, Hydrochlorothiazide,					
	-	el, Multi Vitamin, Zovia					
		evident 5000 Sensitive					
	-	aste. The report indicated					
		sic) 3x's at different times					
		her meds and she (client					
	· · · · · ·	aldn't even talk to staff. She A) shook her head no and					
	that wa						
	On 2/12/14 clie	ent A refused all of her 7					
	AM m	edications: Bupropion,					
	Sertral	ine, Calcium with Vitamin					
	D, Div	alproex Sodium,					
	Gabap	entin, Hydrochlorothiazide,					
	-	el, Multi Vitamin and					
		The report indicated "Staff					
		her to come take her meds					
		ne slapped them and cussed					
	them o	ut."					
	On 6/9/14 clier	t A refused to take her 4					
		valproex Sodium 500 mg					
		l two Gabapentin 100 mg					
		The report indicated "She					
	-	eps saying will not take drs					
	(doctor	rs) orders."					
		ent A refused her 8 PM					
	Crest I	Pro Health mouth wash.					
	On 6/13/14 clie	ent A refused her 8 PM					
		Pro Health mouth wash.					

	R MEDICARE & MEDIC	-					MB NO. 0938-0	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CON	ISTRUCTION		E SURVEY PLETED	
AND FLAN	OF CORRECTION	15G390	A. BUILI	DING	00		2/2014	
		196990	B. WING			_		
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD IDLESON DR	ЭЕ		
BENCHI	MARK HUMAN SEF	RVICES		RICHMC				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	I	ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI	LD BE	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	On 6/20/14 align	nt A refused her 8 AM						
		tions of Bupropion and ne for depression,						
		n, Divalproex Sodium,						
		n, Divarproex Sourum, entin, Hydrochlorothiazide						
	_	etic), Seroquel (an						
		chotic), Multi Vitamin and						
		for menses regulation).						
		ort indicated "Kept saying						
	_	using to get out of bed,						
		Shut up'."						
	Suying	Shut up.						
	On 6/30/14 fax	"Please be advised [client						
	A] refu	sed all morning meds on						
	9/29/14	."						
	On 8/16/14 clier	nt A refused her 4 PM						
	meds: I	Divalproex Sodium 500						
		Gabapentin 200 mg. The						
	report in	ndicated "I (the staff)						
	asked h	er to please take her meds						
	5x she l	kept telling me (the staff)						
	NO!"							
	Client A's Mont	hly Health Reviews for						
	2014/2013 indic	-						
		t A refused AM meds and						
	labs or	lered by her PCP.						
		nt A refused 7 AM meds.						
		nt A refused her 8 PM						
	mouthw	vash.						
	On 12/9/13 refu	sing to see optometrist.						
							1	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SU	RVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLET	ΈD		
		15G390	A. BUILDING B. WING		- 09/22/2014			
				ADDRESS CITY STATE ZIP C	ODE	E		
NAME OF	PROVIDER OR SUPPLIE	ER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 825 MENDLESON DR				
BENCH	MARK HUMAN SE	RVICES		IOND, IN 47374				
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
	Client A's 8/12/	/13 BSP (Behavior						
	Support Plan in	dicated client A had a						
	targeted behavi	or of "Refusals: Refusing						
	to complete cho	pres, refusing available						
	work, not follow	wing directions given by						
	parents or super	rvisors.						
	Client A's BSP	did not include refusals of						
	medications, la	bs and/or refusal to						
		edical requests. Client A's						
		and client A's Updated						
		dated 6/26/14 did not						
		s of medications,						
		or refusals of medical						
		hat the staff were to do						
	-	refused. Client A's record						
		ng failed to address client						
		medication and medical						
		incurcation and incurcat						
	requests.							
	Interview with	staff #5 on 9/10/14 at 7:30						
	AM stated, "Sh	e [client A] refuses all the						
	time." When as	ked what the staff were to						
	do when she re	fused, staff #5 stated, "Just						
	ask her to take	it and if she doesn't she						
	doesn't. There's	not much we can do."						
	During intervie	w with QIDP (Qualified						
	-	abilities Professional) #1,						
		ential Manager), LPN #1						
		:15 PM, the QIDP						
		A's ISP/BSP did not						
		A's refusals for medication						
	and/or medical	requests. QIDP #2 and	1					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	AULTIPLE CO	DNSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING 00 B. WING				/22/2014	
NAME OF	OF PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COI	DE		
					ENDLESON DR			
BENCH	MARK HUMAN SE	RVICES		RICHM	OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
	LPN #1 indicat							
		ry Team) meetings in						
	regard to client							
	medications an	d medical requests.						
	3. The facility's	reportable and						
	investigative re	cords were reviewed on						
	9/10/14 at 10 A	M. The 8/6/14 BDDS						
	(Bureau of Dev	elopmental Disabilities						
	Services) repor	t indicated on 8/6/14 at						
	7:30 AM client	G "lost her balance and						
	fell inside her h	ome. [Client G] was						
	taken by ambul	ance to the emergency						
	room due to pa	in in her right hip/leg.						
	[Client G] was	admitted to [name of						
	hospital] after 2	X-rays showed a fracture						
	to her hip requi	ring surgery for a partial						
	hip replacemen	t. [Client G] also						
	sustained a lace	eration to her left elbow,						
	not requiring m	ore than a bandage."						
	The 8/13/14	follow up BDDS report						
	indicated "[Clie	ent G] had a fall that						
	resulted in a bro	oken hip, hospitalization						
	and a partial hi	p replacement."						
	The 5/10/14 I/A (Incident/Accident)							
		DS report indicated while						
	-	G with her shower staff						
		right index finger was						
		"large black and red						
		nuckle. The report						
		G did not know how she						
		and was transported to the						
	-	or an evaluation where she						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE CO LDING	NSTRUCTION 00	СС	ATE SURVEY
		15G390	B. WIN	IG	09	- 09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	P		STREET A	ADDRESS, CITY, STATE, ZII	P CODE	
NAME OF	I KO VIDEK OK SOTTELE	IX			NDLESON DR		
BENCH	MARK HUMAN SEI	RVICES		RICHM	OND, IN 47374		
(X4) ID				ID	PROVIDER'S PLAN OF C	OPPECTION	(X5)
PREFIX			PREFIX (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH		N SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	with a bruise, given pain returned to the facility.					
		DDS report indicated on					
	12/5/13 at 3:10	PM while trying to board					
		van, client G fell up the					
	three steps of th	e van and landed on the					
	van steps. The	report indicated the staff					
	were able to cat	ch client G from landing					
	onto the pavem	ent. "She (client G)					
	sustained injuri	es of scrapes and redness					
	on her right che	ek, right rib area and right					
	shin." The repo	rt indicated client G's					
	ability to climb	the van steps would be					
	assessed.						
		d was reviewed on					
	9/10/14 at 1 PM						
		cord indicated an elderly					
		years of age and					
		at not limited to,					
	· ·	rittle bones), Urinary					
		ligh Blood Pressure,					
	· ·	of memory) and Arthritis					
	V	on of one or more joints).					
	Client G's nursi indicated:	ng notes, not all inclusive,					
	10/7/13 "Rt (rig	tht) small finger with dark					
	purple	bruise to palm side at first					
	joint. A	ppears could have been					
	-	d in something."					
	10/23/13 "dime	sized deep purple bruise (abdomen). Area in					
		audullicii). Aica III	1				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, j	ULTIPLE CO	NSTRUCTION 00		X3) DATE COMPL	
		15G390	B. WIN			-	- 09/22/2014	
NAMEOE	PROVIDER OR SUPPLIE	2D		STREET A	DDRESS, CITY, STATE, ZIP C	CODE		
NAME OF	FROVIDER OR SUFFEII				NDLESON DR			
BENCH	MARK HUMAN SERVICES		RICHMOND, IN 47374					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COF	ORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIAT	E	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)			DATE
	-	ent with counter at house 3						
		G's home)."						
		ch) oblong bruise to outer						
	-	of arm between should						
		der) and elbow. Area is						
		height to line up with						
		par in bathroom. [Client G]						
		she might have bumped it.						
		sn't hurt honey, don't worry,						
		ight.' she stated."						
		om bus steps. No apparent						
	injury.							
		ng to rt (right) hip/buttock,						
	rib area							
		al Physical Exam some						
		weakness PT (Physical						
		y) for muscle						
	e e	hening."						
	-	t G] got up to go to the						
		om when she bumped into						
		l frame. Noted quarter size						
		dark blue/purplish in color						
		er left thigh/peri area."						
		al-Difficulty ascending						
	-	b get into van. Difficulty						
	-	from chair, worsening over						
	-	w months.						
		mendations for PT tx						
		nent) for 6 - 8 weeks."						
		no (Mammogram)						
	-	eted Study indicates						
	-	orosis, fracture risk is						
		ered high."						
	3/19/14 "was se	een by PT for gait balance						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MI A. BUII B. WIN	LDING G	00		(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, Z	IP CODE		
BENCH	MARK HUMAN SEI	RVICES			NDLESON DR ND, IN 47374			
						(275)		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO		(X5) COMPLETIO	
TAG	-	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENCY	HE APPROPRIATE	DATE	
		engthening. Dischg						
		arged) from PT at this time.						
		mended that staff continue						
		st patient PRN (as needed)						
		ety especially in/out of						
	van."	specially infour of						
		wed report of injury from						
		4 in which client (G) was						
		d to have large black and						
	-	a of discoloration with						
		g on index finger"						
		ved health care concern						
		which it is reported that						
		G) has redness on her						
		from frequent loose stools						
		ne day prior. Instructed staff						
		y the Desitin cream client						
		lered for redness to peri						
		d report back if the area						
		is or does not show signs of						
	healing	•						
		wed report of injury that						
		G) has a bruise and a scab						
		left arm/elbow. Client (G)						
		that she fell out of bed and						
	-	how she got the bruise."						
		ved and reviewed health						
		oncern form dated for						
		4 which discusses client						
		reas of concerns on left and						
		uttocks. These areas have						
	-	ddressed and are slowly						
		g. Record of training on						
	-	re and toileting developed						
	1	0					1	

	T OF HEALTH AND H R MEDICARE & MEDI						ORM APPROVI MB NO. 0938-03
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CON	STRUCTION	(X3) DATE	E SURVEY
AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER:			NG	00	COMP	LETED
		15G390	A. BUILDING			09/22	2/2014
			5	TREET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	ER	8	325 MEN	IDLESON DR		
BENCH	MARK HUMAN SE	RVICES	F	RICHMC	ND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	1	ID		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	1	AG	DEFICIENCY)		DATE
	and ser	nt to the group home					
	manag	er and the day service					
	coordi	nator for training." Client					
	G's rec	ord indicated no further					
	nursing	g notes after the note of					
	7/24/14	4. Client G's nursing notes					
	indicat	ed nursing services did not					
	assess	and/or monitor client G's					
	buttocks and/or skin issues.						
	Client G's Risk	Summary dated 10/1/13	0/1/13				
		G was at risk for					
		nd had a history of falls.					
	-	ndicated client G was					
	-	xercise program to help					
	-	lower extremities. The					
	-	indicated the staff were to					
	-	reach of client G at all					
		ent G was ambulating in					
		and provide hands on assist					
		alating on uneven or					
		ces. The Risk Summary					
		e how the staff were to					
		tor client G in regard to					
		off the facility van, while					
		her bedroom to ensure					
		ty from falls. Client G's					
		d no update to client G's					
		in regard to client G's					
	· ·	•					
	continued falls	and injuncs.					
	Client G's recor	rd indicated:					
		g for bone density and/or					
	routine annual	iao testing.		1			1

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ì.		ONSTRUCTION 00		ATE SURVEY MPLETED
		15G390	A. BU B. WI	ILDING NG		/22/2014	
NAME OF	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CO	ODE	
BENCHI	MARK HUMAN SE	RVICES			NDLESON DR OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		ent from PT/OT					
		Therapy) in regard to					
		and gross motor					
		ability to go up and down					
	-	get on and off the facility					
	van.						
	、	erdisciplinary Team) notes					
	-	s in regard to client G's					
	-	eds and/or injuries.					
		n assessments by the staff					
		e in regard to skin					
	breakdown on client	client G's buttocks.					
	Interview						
		n 9/10/14 at 6 AM					
		as working the morning of					
		ent G was injured. Staff					
		ere were three staff in the					
		ing of client G's injury,					
		kitchen, one staff in the					
		m and one staff in the					
		ing another client with a					
		5 indicated she (staff #5)					
	-	isted client G with her					
		ent G had returned to her					
	(client G's) bed	room when all the staff					
		nd found client G on the					
	floor in the hall	way outside of client G's					
		#5 stated, "She (client G)					
	said she was ok	, denied hurting anywhere					
	-	l to get up. When she tried					
	to get up she co	ouldn't. We had to get the					
		air and lift her up into the					
	chair. We knew	something was wrong					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) D	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING 00				MPLETED /22/2014
			D. W		ADDRESS, CITY, STATE, ZIP C	ODE	
NAME OF	PROVIDER OR SUPPLIE	ËR			ENDLESON DR		
BENCH	CHMARK HUMAN SERVICES				IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX	[×]	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A		COMPLETIC
TAG	-	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		we called 911." Staff #5					
	indicated client	G was elderly and had					
	issues with mer	nory loss and did not					
	always rememb	er how she was injured.					
	Staff #5 indicat	ed no staff were with					
	client G at the t	ime of her last fall. Staff					
	#5 stated, "It ge	ts kinda crazy at times					
		f) aren't always right with					
	her when she's	, i i i i i i i i i i i i i i i i i i i					
	Interview with	the facility's LPN on					
		I indicated LPN #3					
		loyment with the facility					
	-	LPN #1 filled in for the					
		nuary through April 2014					
	-	y hired LPN #4 in April					
		vorked four months and					
		rminated her employment					
		on August 15, 2014. The					
		e done my best to try to					
	1 17	t being here all the time					
		in when they don't have					
	-	n rough." The LPN					
		ad provided all nursing					
		d notes she was able to					
		G. The LPN indicated					
		e to locate client G's last					
	PT assessment	and/or lab results.					
	QIDP (Qualifie	d Intellectual Disabilities					
	Professional) #	l, the RM (Residential					
	Manager) and t	he facility's LPN were					
	interviewed on	9/12/14 at 3:15 PM.					
	The RM and	QIDP #1 indicated they					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	Č,	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP	CODE		
BENCH	MARK HUMAN SEI	RVICES			NDLESON DR OND, IN 47374			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	were unable to	locate a PT assessment for						
	client G.							
	The LPN ind	icated client G's Risk						
	Summary was 1	ast updated 10/1/13 when						
		ll with the facility.						
	The LPN ind	icated she had provided						
	all of the clients	s' nursing notes for review.						
	QIDP #1 stat	ed the facility filing						
	system was beh	ind six to twelve months						
	"or more" and t	hey were unable to find all						
	of client G's ass	essments and records.						
	QIDP #1 indi	icated no IDT meetings in						
		G's health, mobility and						
	or injuries.							
	4. Observation	of the medication pass						
	was conducted	on 9/10/14 between 6:30						
	AM and 7:50 A	M. At 6:35 AM staff #3						
	applied an over	the counter cleansing						
	lotion to client	B's skin and an over the						
	counter peri wa	sh to client B's perineal						
	area (the area b	etween the anus and						
	vulva). The bot	tle of lotion and the bottle						
	of peri-wash die	d not have a pharmacy						
	label to indicate	the client's name,						
	medication, tim	e of administration,						
	dosage and/or w	where to apply.						
	Interview with	staff #5 on 9/10/14 at 7						
	AM indicated th	ne lotions and peri wash						
		om an outside company.						
	Interview with a 9/12/14 at 3:15	the facility's LPN on PM indicated all						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPI A. BUILDING B. WING	e construction 00	COM	(X3) DATE SURVEY COMPLETED 09/22/2014	
	PROVIDER OR SUPPLIE		825	EET ADDRESS, CITY, ST			
	MARK HUMAN SEF			HMOND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCE	PLAN OF CORRECTION IVE ACTION SHOULD BE CED TO THE APPROPRIATE SFICIENCY)	(X5) COMPLETIC DATE	
	medications, we pharmacy label medication, dos	luding over the counter re to be labeled with a with the client's name, age, route, time to be ther special instructions.					
	C were provided examinations an	I to ensure clients B and I annual physical d routine annual rly detection of cancer. 2.					
	hearing and visi	d to ensure the clients' on were evaluated nts A, B and C. Please					
	C received an ar	d to ensure clients B and mual TB (Tuberculosis) reening. Please see					
	and C were prov	d to ensure clients A, B rided quarterly ssessments. Please see					
	•	d to ensure annual dental r clients B and C. Please					
	pharmacist cond	ed to ensure the facility lucted quarterly reviews ug regimens for clients A,					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED - 09/22/2014	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ENDLESON DR		
BENCHN	IARK HUMAN SEI	RVICES		10ND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	B and C. Please	see W362.				
	drugs were adm with each client clients B, C, D, W368.	vices failed to ensure all inistered in compliance s' physicians' orders for E, F and G. Please see relates to complaint				
W000336	clients certified a care plan, a revie which must be or frequent basis de Based on record 3 of 3 sample c facility failed to quarterly nursin	must include, for those s not needing a medical ew of their health status n a quarterly or more epending on client need. d review and interview for lients (A, B and C), the p provide evidence of ng/health assessments.	W000336	<b>Corrective action for resident(s)</b> <b>found to have beenaffected</b> All clients are tohave a quarterly nursing summary completed and of file in their medicalchart. The LP was retrained on this requirement	on PN	
	9/10/14 at 2 PM indicated client medical care pl indicated diagn	e: d was reviewed on I. Client A's record A did not require a an. Client A's record oses of, but not limited to, Hypertension. Client A's		the RD on 10-3-14. <b>How facility will identify other</b> residents potentiallyaffected and what measures taken All residentsare affected and correctiveaction will address theneeds of all clients. Measures or systemic changes		

	R MEDICARE & MEDI		(376) 3 55				NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	- 09/22/2014	
		15G390	B. WINC			09/22/2	014
AME OF	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP CODE		
					ENDLESON DR		
BENCH	MARK HUMAN SEI	RVICES		RICHM	IOND, IN 47374		
K4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	updated Risk Su	ummary of 6/26/14			facility put in place toensure r	0	
	indicated client	A was at risk for			recurrence	11 1	
	constipation, irr	egular menses and			Quarterly nursing summaries with turned into the QIDP quarterly		
	increased bleed	ing due to the use of			include in the monthlysummary		
	Sertraline (for d	lepression) use with the			Summaries will also be turnedi		
		n and Ibuprofen for pain.			the Manager of Health Services		
	-	d indicated no quarterly			oversight and to ensurecomplia	nce.	
		ients for the first quarter					
	of 2014.	ients for the first quarter			How corrective actions will be		
	01 2014.				monitored to ensure norecurr	ence	
					The RD will conduct quarterly random file audits to ensure quarterly	ortorly	
		d was reviewed on			nursing summaries and up toda		
		I. Client B's record			present in the medical file. The		
		B did not require a			will ensure the LPN's retraining		
	medical care pla	an. Client B's record			completing quarterly		
	indicated diagn	oses of, but not limited to,			nursingsummaries is placed in	he	
	Epilepsy (a brai	n disorder in which a			LPN's employee file.		
	person has repe	ated seizures over time),			A QIDP-d has beenhired to ma		
		ture of the spine),			client files and will conduct mo		
		onstipation. Client B's			file audits to ensureall necessar components of a file are presen		
	•	l no quarterly nursing			updated.	t and	
		the first quarter of 2014.			up unit un		
		the first quarter of 2014.					
	Client Cla recor	d was reviewed on					
		M. Client C's record					
		C did not require a					
	-	an. Client C's record					
	e e	oses of, but not limited to,					
	Seizure disorde	r, Cerebral Palsy (a					
	disorder of post	ure, muscle tone and					
	movement result	lting from brain damage),					
	Hypothyroidisn	n (low levels of					
		mones resulting in low					
		m in the blood system),					
		nd Vulgaris (skin					
	Acine Rusacea a	ina vuigaris (skill					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014
	PROVIDER OR SUPPLIEI		825 N	I ADDRESS, CITY, STATE, ZIP CODE IENDLESON DR MOND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC DATE
	quarterly nursin quarter of 2014. During interview Intellectual Disa and LPN #1 on QIDP #1 stated not been filed for and maybe long trying to locate	at C's record indicated no g assessments for the first w with QIDP (Qualified bilities Professional) #1 9/12/14 at 3:15 PM, the clients' records had r "Six to twelve months er" and "We are still hings." LPN #1 indicated to have quarterly nursing			
W000352	SERVICE Comprehensive d include periodic e performed at leas Based on record 2 of 3 sampled of facility failed to provided an ann Findings include Client B's record	review and interview for lients (B and C), the ensure the clients were ual dental examination. e: I was reviewed on . Client B's Monthly	W000352	<b>Correctiveactionforresident(s)f</b> <b>dtohavebeenaffected</b> All consumers must have a denta exam annually. The LPN was retrained by the RD on 10-3-14th all consumers must have an annu dental exam and that must be loc inthe medical file. All consumer willhave an annual dental exam is the main file or an appointment scheduled by10-17-14.	al nat nal sated s

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG ntspotentiallyaffectedandwhatmea indicated client B's most current dental surestaken exam was 3/29/13. Client B's record All residentscould be affected indicated no dental evaluations. and corrective action planwill be put inplace to protect allconsumers. Client C's record was reviewed on Measuresorsystemicchangesfacility 9/11/14 at 10 AM. Client C's Monthly putinplacetoensurenorecurrence Health Review dated June 2014 indicated The LPN has included on the client C's had a dental exam on 2/1/14. monthlynursing summary the dates of Client C's record indicated no dental each client's last physical and TB evaluation of 2/1/14. test. This will ensure the dates are reviewedmonthly to ensure compliance. Thesedates will be Interview with the facility's LPN on included on the meeting checklist 9/11/14 at 2 PM indicated the clients' that will be reviewed at eachquarterly records had not been filed for 6 to 12 meeting and signed off on by the months and she was unable to locate any Regional Director. dental records for clients B and C. Howcorrectiveactionswillbemonito redtoensurenorecurrence 9-3-6(a) The LPN's monthly nursing summary is sent to the QIDPmonthly to include in the QIDP's monthly programming summary. These dates will be viewed monthly by theQIDP to ensure compliance. The monthlyprogramming summary is sent to the RD and the AWS compliance department. The dates will also be included and reviewed on the meetingchecklist. This will be sent to the Regional Director after each quarterly meeting to be reviewed and signed offon. W000362 483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least guarterly.

Event ID: Y6CM11

Facility ID: 000904

If continuation sheet

Page 162 of 179

PRINTED:

10/24/2014

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG W000362 **Corrective action for resident(s)** 10/17/2014 Based on record review and interview for found to have beenaffected 3 of 3 sample clients (A, B and C), the All clients willhave a quarterly facility failed to ensure the facility pharmacy review. Thepharmacist pharmacist conducted quarterly reviews will work with the LPN to schedule of the clients' drug regimens. and complete these quarterlyreviews. The LPN will track thesereviews and ensure all Findings include: recommendations are taken to the client's IDT. Client A's record was reviewed on The LPN wasretrained by the RD on 9/10/14 at 2 PM. Client A's August 2014 10-3-14 about the need for quarterly pharmacy reviews tobe completed quarterly physician's orders indicated and filed. client A received routine medications which consisted of Bupropion, Seroquel, How facility will identify other Sertraline, Neurontin and Depakote for residents potentially affected and behavior modification, HCTZ what measures taken All residentsare affected and (Hydrochlorothiazide) for blood pressure correctiveaction will address control, Zovia for menses control, theneeds of all clients. Enulose for constipation, Calcium with Vitamin D for dietary supplementation Measures or systemic changes and Crest Pro-Health dental rinse and facility put in place toensure no recurrence Prevident 5000 Sensitive tooth paste for The LPN will track the quarterly oral health. Client A's record did not pharmacy reviews and bring that indicate quarterly reviews of client A's information to the quarterlymeeting. drug regimen by the pharmacist for The LPN will mark on thequarterly 2013/2014. meeting checklist the date the pharmacy review was completed thatquarter. Client B's record was reviewed on 9/10/14 at 3 PM. Client B's August 2014 How corrective actions will be quarterly physician's orders indicated monitored to ensure norecurrence The QIDP will fillout the quarterly client B received routine medications meeting checklist and ensure all which consisted of Calcium with Vitamin information is complete and accurate D for bone health, Cetirizine for allergies, and will turn it into the RD after the Colace for constipation, Fludrocortisone meeting for tracking and compliance. for adrenal insufficiency, Folic Acid for The RD will ensure he record of

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y6

Y6CM11 Facility

Facility ID: 000904

If continuation sheet

Page 163 of 179

PRINTED:

10/24/2014

NTERS FO	R MEDICARE & MEDIC	AID SERVICES				L L	OMB NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. B	MULTIPLE	construction 00	COM	TE SURVEY IPLETED 22/2014
NAME OF	PROVIDER OR SUPPLIE	{			T ADDRESS, CITY, STATE, ZI	IP CODE	
BENCH	MARK HUMAN SER	VICES			IENDLESON DR MOND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	COMPLETIC
TAG		LSC IDENTIFYING INFORMATION)	$\rightarrow$	TAG	DEFICIENCY		DATE
	-	t, Phenobarbital and			training for the LPN v the LPNs employeefil	-	
		ure control, Anusol			the Er ivs employeeme.		
	cream (an anesth	•					
	medication), Spi	•					
	, .	nonium Lactate lotion for					
		stop for fungal infections.					
		l did not indicate					
		rs of client B's drug					
	regimen by the p	onarmacist for					
	2013/2014.						
		d was reviewed on					
	9/11/14 at 10 AI	M. Client C's August					
		hysician's orders					
	indicated client	C received routine					
	medications whi	ch consisted of					
		lonase nasal spray for					
		ote, Oxcarbazepine,					
		nfi for seizure control,					
		ipation, Levothyroxine					
		lism), Minocycline (an					
		eridone for mood					
		in D3 and a multi					
		ry supplementation,					
	-	d Desonide lotion for					
		solution for dry scalp.					
		l did not indicate					
		s of client C's drug					
	regimen by the p	pharmacist for					
	2013/2014.						
	Interview with the	he facility's LPN on					
	9/9/14 at 1 PM i	ndicated the clients'					
	mananda for the f	acility had not been filed					1

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 00	X3) DATE SURVEY COMPLETED
		15G390	B. WING		09/22/2014
NAME OF F	ROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				ENDLESON DR	
BENCHN	IARK HUMAN SEI	RVICES	RICHM	10ND, IN 47374	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ths and she was unable to			
		quarterly pharmacy			
	reviews for each	h of the clients.			
	9-3-6(a)				
W000368		TRATION rug administration must ugs are administered in			
	compliance with	the physician's orders.			
		l review and interview for	W000368	Correctiveactionforresident(s)for	un 10/17/20
	2 of 3 sampled clients (B and C) and 4			dtohavebeenaffected All staff willbe retrained on	
		ts (D, E, F and G), the		MedicationAdministration in a	
	-	iled to ensure all drugs		refreshercourse taught by theGrou	р
	were administer	red in compliance with the		Home LPN on 10-3-14. This	
	each clients' ph	ysicians' orders.		medicationadministration training willinclude the appropriateway to	
	Findings includ	e:		pass medicationand the appropriateway to measure	
	The facility's re	portable records, staff		liquidmedication. This will also include following physician order:	5
		and personal records		and looking at allmedication label	
	were reviewed	on 9/10/14 at 10 AM.		The Team Leaderswill observe on medicationpass for each staffmont	
	A 4/25/14 BDD	S (Bureau of		and the LPN will observe one medication pass for each	
		Disabilities Services)		TLmonthly.	
	-	client F did not receive			
	-	mg (milligrams) for a		Howfacilitywillidentifyotherresid	
		time on $4/23/14$ . The		ntspotentiallyaffectedandwhatm	ea
	-	the staff responsible for		surestaken All residentsare affected and	
	-	receive a disciplinary		correctiveaction will address	
	and error would	receive a anserprinary		theneeds of all clients.	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. BUII	LDING	00	СОМ	(X3) DATE SURVEY COMPLETED <b>09/22/2014</b>	
	PROVIDER OR SUPPLIE		B. WIN	STREET 825 M	ADDRESS, CITY, STATE, ZIP			
BENCH	MARK HUMAN SEI	RVICES		RICHM	10ND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE	
	action. A 4/21/14 BDD 4/20/14 client F doses of Wellbu (anti-depressant loss), Pepcid (a control blood su for an overactiv behavior modif cholesterol cont supplements; T. Vitamin D. "It v p.m. med (medi check of the M. Administration to ensure all me indicated for the that none of the given the morni medications had on the MAR, bu present in the m team needs to in happened and v facility records and no further a F's missed med A 5/5/14 BDDS 5/2/14 "[Client URI (Upper Re prescribed Amo	DS report indicated on T did not receive her 7 AM atrin and Sertraline ts), Evista (to reduce bone n antacid), Metformin (to agar levels), Oxybutynin re bladder, Risperdal for fication, Simvastatin for trol and dietary hera-tab, Calcium and was discovered during the fication) buddy check (a ARs - Medication Records) after a med pass edications were given as at med pass) on 4/21/14 se medications had been ing of 4/20/14. The d been signed for as given at all of the pills were still hed packs [Client F's] nvestigate how this who is responsible." The indicated no investigation actions in regards to client			Measuresorsystemicch: putinplacetoensurenor: The Team Leaderswill of medicationpass for each staffmonthly. This will of are continuallypassing m trained in CoreA Core E will observe one medica foreach TL monthly. Th medication passobserva turned into the GHM for to ensure compliance. Howcorrectiveactionsw redtoensurenorecurren The Team Leaderswill s medication observations itinto the LPN andGroup Manager monthlyto ensu aredoing all required medicationobservations The RD ensured all Gro staffreceived this retrain 10-3-14 and will sign of Record ofTrainings. If s attend, theywill be remo schedule until they recei retraining.	ecurrence observe one ensurestaff nedicationsas 3. The LPN ation pass hese tions will be r tracking and willbemonito nce sign off ona sheet and turn p Home ure they monthly. up Home ating on ff on all staff fail to oved from the		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION 00	C	DATE SURVEY COMPLETED
		15G390	B. WING			09/22/2014	
NAME OF	PROVIDER OR SUPPLIE	2D	S	FREET A	DDRESS, CITY, STATE, ZIP	CODE	
NAME OF	FROVIDER OR SUFFLIE		8	25 MEN	NDLESON DR		
BENCH	MARK HUMAN SEI	RVICES	R		OND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	П	D	PROVIDER'S PLAN OF CO	PRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
	failed to admini	ister the dose on 5/21/14					
	at 2 pm and it w	vas discovered on 5/3/14					
	during a medica	ation audit. The staff					
	discovering the	medication error wrote a					
	medications err	or report and notified the					
	nurse on call bu	it failed to notify a					
	manager to repo	ort the medication error.					
	<b>U</b> 1	C' on the MAR					
		the medications would be					
	•	nter' but [client G] was					
	-	ne and the staff working					
		e medication had not					
		ne center as the MAR					
	-	e report indicated all staff					
		uld be retrained.					
	A 5/18/14 BDE	S report indicated on					
		G did not get her weekly					
		onate Sodium 70 mg for					
		report indicated the staff					
		the medication error					
	-	ned and disciplinary					
	action would be	1 5					
	A 5/26/14 BDD	S report indicated client					
		ve her 1 PM dose of					
		mg for seizure control on					
	-	port indicated the staff					
		the medication error					
	-	ned and disciplinary					
	action would be						
		- takuli.					
		OS report indicated client					
		ve her 6 AM dose of					
		ve ner o Aivi dose or					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĩ,	MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014	
		15G390	A. BU B. WI				
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZII	P CODE	
BENCH	MARK HUMAN SE	RVICES			ENDLESON DR OND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETIC DATE
	Levothyroxine	(a hormone replacement)					
	75 mcg on 6/14	/14. The report indicated					
	the staff respon	sible for the medication					
	error would be	retrained and disciplinary					
	action would be	e taken.					
	A 6/14/14 BDD	OS report indicated on					
		A client C was given a					
		her Levothyroxine 50					
	mcg. The repor	t indicated the staff					
	responsible for	the medication error					
	would be retrain	ned and disciplinary					
	action would be	e taken.					
	A 6/16/14 BDE	OS report indicated client					
		ve her 7 AM dose of					
	Divalproex 250	mg on 6/14/14. The					
	report indicated	I the staff responsible for					
	the medication	error would be retrained					
	and disciplinary	y action would be taken.					
	A 6/25/14 BDE	OS report indicated for the					
		2014 client C received					
	three tablets of	Vitamin D3 daily at 7					
	AM. The report	t indicated client C was to					
	have only one t	ablet of Vitamin D3 daily.					
	-	cated no training was					
	provided in reg	ard to this error.					
	A 7/22/14 BDE	OS report indicated client					
		one of her two AM doses					
		mg for constipation on					
		port indicated the staff					
		the medication error					

ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES					OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	Č,	ILDING NG	NSTRUCTION 00	СОМ 09/2	te survey 1pleted 22/2014
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP	P CODE	
BENCHN	/IARK HUMAN SEF	RVICES			NDLESON DR OND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	would be retrain	ned.					
	B did not receiv mg for allergies	S report indicated client e her 8 PM Cetirizine 10 on 7/29/14. The report ff will be retrained.					
	B did not receiv Calcium 500 mg supplement on 7	S report indicated client e her 4 PM dose of g with Vitamin D 7/29/14. The report off would be retrained.					
	F did not receive (a Z-pack antibi report indicated	DS report indicated client e her 4 PM Azithromycin otic) on 8/18/14. The the staff responsible for error would be retrained					
	3:15 PM indicat	LPN #2 on 9/12/14 at red all clients were to dications as ordered by					
	9-3-6(a)						
V000426	where clients who	DOMS in areas of the facility b have not been trained to mperature are exposed to					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, í		00	ì í	PLETED	
		15G390	A. BUIL			09/22	09/22/2014	
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		-	
NAME OF	PROVIDER OR SUPPLIE	ER			ENDLESON DR			
RENCHI	MARK HUMAN SEI	RVICES			IOND, IN 47374			
_								
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	I	(X5)	
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	BEIGERCIT		DATE	
		e that the temperature of the xceed 110 degrees						
	Based on obser	vation and interview for 1	W00	0426	Corrective action for resident	(s)	10/17/2014	
		ients (B) and 3 additional		found to have beenaffected			10/17/201	
	-	d F), the facility failed to			Bader Mechanical wascontacted			
		r temperatures within the			came to the home on 10-1-14 t			
		exceed 110 degrees.			adjust water temperatures. Wa temperature is now below	ter		
	facility did not	execcu 110 degrees.			110degrees. A new water			
	Eindings includ				temperaturetracking sheet is in	the		
	Findings includ	e.			home and water temps will be			
		1 / 1 / 1			daily. Also a digital water			
		ere conducted at the			thermometer has beenpurchase			
	-	4 between 3:30 PM and			ensure consistency for staff tes	ting		
		50 PM staff #3 was			the water temperature.			
	running water in			How facility will identify othe	r			
		preparing the evening meal. Steam was			residents potentiallyaffected a			
	visible rising fr			what measures taken				
	standing nearby	tanding nearby the kitchen sink			All consumers couldpotentially			
	watching and st	ated, "Hot." The water			affected and corrective action j			
	temperature wa	s tested in the kitchen sink			will address the needs of all clie	ents.		
	and was found	to be 123.8 degrees			Measures or systemic change	2		
	Fahrenheit. The	e water temperature was			facility put in place toensure			
	then tested in th	ne shower/bathroom and			recurrence			
		2.8 degrees Fahrenheit in			Staff will be trained and will fi			
		1.1 degrees Fahrenheit in			a record of trainingaddressing	the		
	the shower.				need to take and record water			
	the shower.				temperatures daily. If a temper			
	Interview with	staff #3 on 9/8/14 at 5 PM			is above 110 degrees staffwill trained to contact their			
		aff in the home did not			supervisor. This record of train	ing		
		ter temperatures. Staff #3			will be placed in the employee	-		
		•			file as proof of training.			
		ter has been hot lately."						
		ed clients B, D, E and F			How corrective actions will be			
	were unable to	•			<b>monitored to ensure norecurr</b> The GHM, Supervisors, and Q			
	temperatures in	dependently.			will monitor for all healthand s			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility ID: 000904

If continuation sheet

Page 170 of 179

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/22/2014	
		15G390	A. BUILDING B. WING			
NAME OF F	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP CODE		
BENCHM	IARK HUMAN SEI	RVICES		/ENDLESON DR MOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETIC RIATE DATE	
				issues including water temperat the weekly and daily visits.One		
		d Intellectual Disabilities		member of management stays i		
	· · · · · ·	and the RM (Residential		homeweekly until 7pm to provi		
	U U	interviewed on 9/8/14 at		the spot training. This will incl		
	5:15 PM.			the necessity for teachingstaff h		
		cated clients B, D, E and		monitor health and safety of the		
		o regulate water		clients. The member of manage will record theirobservations an		
	<u>^</u>	dependently and required		teachable moments on the Man	-	
		and clients A and C were		Observation Log.	-	
	able to adjust the			Also a member of management	will	
	temperatures. T	he RM indicated the RM		conduct random pop invisits at		
	monitored the v	vater temperatures		varying times on different shift: days at least weekly.	s and	
	monthly.			A member of management staff	f will	
	QIDP #1 ind	icated the water		conduct observations in the hom		
	temperatures w	ere not to exceed 110		daily to provide on the spot trai		
	degrees Fahren	heit. QIDP #1 indicated		and ensure the completion ofac	tive	
	she did not kno	w if there was a regulator		treatment both formal and	b	
	on the water he	ater to ensure the water		informal. The managers will re- their observations and visits on		
	temperatures di	d not go above 110		MOL.		
	degrees Fahren	heit.				
	9-3-7(a)					
W000454	483.470(I)(1) INFECTION CON	NTROL				
		provide a sanitary				
	environment to a	void sources and				
	transmission of ir					
		vation, record review, and	W000454	Corrective action for resident	(s) 10/17/20	
		of 3 sampled clients (B)		found to have beenaffected All consumer toothbrushes show	uld be	
		onal clients (E and H), the		covered to ensure health and sa		
	-	implement and follow		and proper hygiene. The GHM	-	
	Universal Preca	utions to prevent the		purchase tooth brush covers for		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15G390 09/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 825 MENDLESON DR BENCHMARK HUMAN SERVICES RICHMOND. IN 47374 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG client and ensure they are placed no spread of infection in regard to the later than 10/13/14. clients' toothbrushes. How facility will identify other Findings include: residents potentiallyaffected and what measures taken All consumers couldpotentially be Observations were conducted at the affected and corrective action plans group home on 9/10/14 between 5:30 will address the needs of all clients. AM and 8:35 AM. Client B's E's, H's rectangular plastic hygiene boxes were Measures or systemic changes observed in the hall closet outside of the facility put in place toensure no recurrence medication room. The boxes were not Staff will be retrained and fill out a clean and had particles of dirt and dust record of trainingaddressing proper along the bottom of the boxes. Client B's, hygiene and the need for tooth E's and H's tooth brushes were uncovered brushes to be covered. This record and laying in their hygiene boxes along of training will be placed in theemployee HR file as proof of with bottles of body wash, shampoo and training. lotion. How corrective actions will be Interview with staff #5 on 9/10/14 at 7 monitored to ensure norecurrence AM stated all the clients "used to have a The GHM, Supervisors, and QIDP will monitor for all healthand safety cover for their toothbrushes, but I don't issues including tooth brushes know what happened to them. They (the covered at the weekly and toothbrushes) should be covered." dailyvisits.One member of management stays n the home QIDP (Qualified Intellectual Disabilities weekly until 7pm to provide on the spot training. This will include the Professional) #1 and the RM (Residential necessity for teachingstaff how to Manager) were interviewed on 9/12/14 at monitor health and safety of the 3:15 PM. The RM stated, "They (the clients. The member of management clients' toothbrushes) don't have covers will record theirobservations and any teachable moments on the Manager on them? They should have." QIDP #1 Observation Log. stated, "That's unsanitary" and indicated Also a member of management will the clients would be provided covers for conduct random pop invisits at their toothbrushes. varying times on different shifts and days at least weekly.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

Y6CM11 Facility II

Facility ID: 000904

If continuation sheet

Page 172 of 179

PRINTED:

10/24/2014

	T OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	II TIPLE CO	ONSTRUCTION	-	<b>AB NO. 0938-039</b> E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G390		A. BUILDING 00			COMPLETED 09/22/2014		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
BENCHM	IARK HUMAN SEI	RVICES			ENDLESON DR IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE
	9-3-7(a)				A member of management staff conduct observations in the hom daily to provide on the spot train and ensure the completion of act treatment both formal and informal. The managers will rec their observations and visits on MOL.	e ning ive ord	
W000488	in a manner considevelopmental le Based on obser of 6 clients livin B, C, D, E and ensure the staff preparation and formal and info opportunities ex- clients prepared lunches for the Findings includ Observations w group home on and 7:15 PM. D period tuna sala crushed pineapp evening meal. At 3:45 PM of	assure that each client eats istent with his or her vel. vation and interview for 6 ng in the home (clients A, F), the facility failed to provided training in meal family style dining when rmal training tisted and to ensure the and packed their own day program.	wo	00488	Corrective action for resident( found to have beenaffected Staff are to provideactive treatm both formal and informal at all times. This includes at meal tim Staff will assist consumers to pa theirlunches and not pack their lunches for them. Staff will also assist clients with meal preparat and not prepare themeal for their facilitate family style dining. So were retrained by the RD at an allstaff meeting on 10-3-14 and record of training will be placed theemployee HR file. How facility will identify other residents potentiallyaffected and what measures taken All residents areaffected and corrective action will address th needs of all clients. Measures or systemic changes	ent, nes. ck ion n and aff the in	10/17/201
	-	Clients A, C and E were in itchen during meal			facility put in place toensure n recurrence One member ofmanagement sta		

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

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. BUIL B. WINC	DING	00	(X3) DATE SURV COMPLETEI 09/22/201	)
	PROVIDER OR SUPPLIEF MARK HUMAN SER			825 ME	ADDRESS, CITY, STATE, ZIP CODE ENDLESON DR IOND, IN 47374		
X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE CO	(X5) MPLETION DATE
	preparation. Click assist with the m At 3:53 PM click eating cheese cu provided her. The snack for clients delivered it to the clients. Staff #1 preparation the tuna salad w watched her. Wh staff #1 held a sp said to client B, it?" Staff #1 smin must think I'm n making the tuna At 4:45 PM st to sprinkle spice #1 finished the t bowl and placed Staff #1 opend and then prompt cans of pineappl covered the bow refrigerator. At 5:10 PM st broccoli off the st it into small piece #2 placed 10 slice At 5:17 PM st into cups for ever prepared client I by adding thicket	ents D and F did not leal preparation. Lient E sat at the table rls and juice the staff had be staff then prepared a B, C, D and F and e table for each of the red cut up the eggs for hile clients B and C hile preparing the salad bice container out and "Here, you want to do led and stated, "No, you uts," and continued			the home weekly until 7pm to provide on the spottraining. This will include thenecessity for teac staff how to provide active treatm and how to followformal training programs as well as providing informal training. The member of management will record theirobservations and any teacha moments on the Manager Observation Log. Also a member of management w conduct random pop invisits at varying times on different shifts days at least weekly. A member of management staff w conduct observations inthe home daily to provide on the spot train and ensure the completion ofacti treatment both formal and informal. The managers will reco their observations and visits on the MOL. How corrective actions will be monitored to ensure norecurrent The RD will ensureall staff are retrained on active treatment and formal training programsincludint meal preparation, family style dia and packing lunches. The RD w monitor Provide, the time entryprogram, and the Manager Observation Log, to ensure a member of management isobserv in the home until 7pm at least we conducting observations andproviding on the spot training	shing nent g of ble vill and will ing ve ord ne nce nce ng ning ill	DATE

Y6CM11 Facility ID: 000904

If continuation sheet Page 174 of 179

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	NSTRUCTION	(X3) DA	ATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BU	ILDING	00	CO	COMPLETED	
		15G390	B. WI		- 09	09/22/2014		
				STREET A	DDRESS, CITY, STATE, ZIP (	CODE		
AME OF	AME OF PROVIDER OR SUPPLIER			825 ME				
BENCHI	MARK HUMAN SEF	RVICES		RICHMO	OND, IN 47374			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COI	RRECTION	(X5)	
REFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	-	#1 got the bowl of tuna						
		owl of pineapple from the						
	-	placed them on the table.						
		slices of bread and then						
	_	the table with the clients'						
	plates.							
		Ill clients were prompted						
		inds and come to the						
		sking or saying anything						
		f #1 placed a clothing						
	<u>^</u>	ent B. Staff filled client						
	-	ne food. Staff #2 cut client						
	-	her. Staff went around the						
	table with the b							
		at a fast pace and took						
	-	er finishing her food, the						
	-	B another large scoop of						
		nt B was not prompted to						
	-	ake smaller bites, to put						
		vn between bites at every						
	opportunity.	eaning forward and her						
		ughout the entire meal.						
		client C to sit up straight						
		did not look up and/or sit						
	up straight.	and not look up and/or sit						
		neal was done, the staff						
		g the table and cleaned up						
		f #1 then got out all of the						
		small Styrofoam bowls						
		g the bowls with the						
	-	he evening meal and						
		Is into the lunch boxes.						
		"I'll help you. Wait a						

Event ID: Y6CM11 Facility ID: 000904

ITERS FC	R MEDICARE & MEDIC	AID SERVICES				, i i i i i i i i i i i i i i i i i i i	OMB NO. 0938-03	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP (	CODE		
BENCH	MARK HUMAN SER	VICES			NDLESON DR ND, IN 47374			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	minute, I have to Client C went to #1 continued pre- When client C c bathroom staff # out the drink." S bottles from the out the kool-aid opened the pack one per water bot then placed the w clients' lunch bo During this obse The staff faile with formal and preparation and/ when opportunit The staff faile with formal and preparing their c During interview (Residential Mat (Qualified Intell Professionals) # QIDP #1 indicat provide the clients much as possible staff were to act	b go to the bathroom." the bathroom and staff eparing the lunch boxes. ame back from the 1 stated, "You can pick taff #1 got six water garage. Client C picked flavor. Staff #1 then ets of flavor and added ttle, shook the bottle and water bottles into the xes. rvation period: d to provide the clients informal training in meal or family style dining y existed. d to provide the clients informal training in wn lunch boxes.						

	R MEDICARE & MEDIC						MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G390		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/22/2014	
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE	•	
	IARK HUMAN SEF				ENDLESON DR IOND, IN 47374		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	COMPLETIO DATE
	as needed durin indicated the cli their own lunch lunchbox for th	hand over hand assistance g meal time. The RM ents were to be preparing es and packing their own e day program everyday re not to be doing it for					
W009999	State Findings		W0	09999	Correctiveactionforresident(	s)foun	10/17/201
	Facilities for Pe Developmental met. 460 IAC 9-3-1 ( b) The resident the following ci division by telep first business da summaries as re An emergency i individual resul a. a physical s b. a medical o c. any other ev	Disabilities rule was not Governing Body tial provider shall report rcumstances to the phone no later than the phone no later than the ty followed by written equested by division. 11. ntervention for the ting from: ymptom. r psychiatric condition.			dtohavebeenaffected RD retrained allgroup home s staff meetings on 10-1-14 and 10-3-14 on the AWSAbuse/N Policy as well as the Incident Reporting Policy. This will in what is abuse, neglect,exploita and injuries of unknown origi incidents are reportable,and th mandate for immediate report the QIDP. The RD will pass of Incident Report cardsthat prov- reminder of what incidents are reportable. Also the RD will reminder of whatincidents are reportable on the Staff Communication Board in the medicationroom. RD retrained theQIDP, LPN a GHM on 10-3-14 on necessar components of all relevant indiv-	eglect aclude ation, n, what re ing to but vide a e place a nd the y This gh	

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		00	COMPLETED	
		15G390	A. BUILDING B. WING		09/22/2014	
				ADDRESS, CITY, STATE, ZIP CODE		
AME OF	PROVIDER OR SUPPLIE	R		ENDLESON DR		
BENCH	MARK HUMAN SEF	RVICES		10ND, IN 47374		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	by:			within 24 hours.		
		1 . 1		Howfacilitywillidentifyotherres	ide	
		I review and interview for		ntspotentiallyaffectedandwhatn		
		ent (F), the facility failed		surestaken		
	to notify the Bu	reau of Developmental		All residentsare affected and		
	Disabilities Ser	vices (BDDS) within 24		correctiveaction will address		
	hours in accorda	ance with state law		theneeds of all clients.		
	regarding an inc	cident requiring		Measuresorsystemicchangesfac	ility	
	emergency serv	ices.		putinplacetoensurenorecurrence		
				RD retrained allgroup home staff		
	Findings includ	e:		staff meetings on 10-1-14 and		
	. <u>O</u>			10-3-14 on the AWSAbuse/Negl	ect	
	The facility's re	portable records were		Policy as well as the Incident		
		0/14 at 10 AM. The		Reporting Policy. This will inclu-		
	9/10/14 BDDS			what is abuse/neglect, whatincide are reportable and the mandate for		
		Disabilities Services)		immediate reporting to theQIDP.		
	-	· · · · · · · · · · · · · · · · · · ·		The AWS Reportable Incident		
	-	on 9/8/14 at 6:30 PM		Policystates that any unknown		
		a bowel movement while		injuries over 3 inches in size in a		
	-	cliner and would not get		way or indicative of abuse are to		
	-	l up with any amount of		reported. This is the policy that t staff will be trained on. The RD		
		[Client F] refused and		pass out Incident Report cards th		
		e that she was in pain by		provide a reminder of what incide		
		nt F] was very resistant to		are reportable. Also theRD will		
		rom anyone. The nurse		place a reminder of what inciden	ts	
	was called and	he nurse advised staff to		are reportable on the		
	call 9-1-1." The	report indicated client F		StaffCommunication Board in th		
	was to have a fo	bllow up on 9/11/14 to see		medication room. Any current gr	-	
	a surgeon to have	ve her gall-bladder		home staff not attending one of t meetings will beremoved from th		
	-	acility records did not		schedule until they receive this		
		dent requiring emergency		training from the RD or adesignation	ited	
		ent F was reported to		representative. The RD willsign		
	<u>^</u>	4 hours following the		on these trainings and will give		
	incident.	i nouis ionowing me		copies to HR to be placed in		
	incluent.			eachemployee's HR file.	N	
				The RD retrain theQIDP, the LP	N,	

	R MEDICARE & MEDIO NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER: 15G390	A. BUILDING B. WING	00	COMPLETED 09/22/2014	
	PROVIDER OR SUPPLIE MARK HUMAN SEF		825 ME	ADDRESS, CITY, STATE, ZIP CODE ENDLESON DR 10ND, IN 47374	•	
BENCHI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE) REGULATORY O During interview Intellectual Diss on 9/10/14 at 1 she had forgotte for client F and	RVICES STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) w with QIDP (Qualified abilities Professional) #1 PM, the QIDP indicated en to file the BDDS report stated, "I've just have so I completely forgot."		AOND, IN 47374  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  and the GHM on 10-3-14 on necessary components ofinvestigations. This included conductingthorough interviews of relevant individuals, and immed reporting. The RD will sign off these trainings andwill give cop HR to be placed in each employ HR file. Each client will also be asked about theirhome and livin environment in their quarterly meetings. This will be documer on the meeting notesand saved i their main chart in the office.  Howcorrectiveactionswillbemo redtoensurenorecurrence Incidents are to bereported to th immediately. The RDwill write email to document the date and notified to be included withthe investigation packet. Theinvestigation packet is then a to the RD for original signature. RD sends the original investigationpacket to the Vice President for original signature. Vice President sends the	of all liate fon ies to ee's e g nted n onito e RD an time sent The The	
				Vice President sends the originalinvestigation packet to the Director of Compliance for orig signature. Once all signatures a obtained, theDirector of Compli- scans the investigation packet to RD to file. The RD will review 100% of incident reports.	inal re ance	

Y6CM11 Facility ID: 000904

If continuation sheet

Page 179 of 179

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10/24/2014