STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G766	A. BUILDING 00 B. WING	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	10036 CROWN POINT FORT WAYNE, IN 46804

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaints #IN00430139 and #IN00422547. Complaint #IN00430139: Federal/state deficiencies related to the allegation(s) are cited at W149 and W154. Complaint #IN00422547: No deficiencies related to the allegation(s) are cited. Survey Dates: April 2, 3, 4, 5, 8, and 9, 2024. Facility Number: 012402 Provider Number: 15G766 AIMS Number: 200993410 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/22/24.	W 0000		
W 0136 Bldg. 00	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to ensure clients had the opportunity to participate in community outings. Findings include:	W 0136	W0136 All staff was retrained 5/3/24 on continuous active treatment and ensuring that all plans are implemented as written. All staff received retraining and completed	05/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Eldridge	Residential Director	05/07/2024

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	A record review of the group home's monthly activity calendars dated January 2024 - February 2024 was completed on 4/3/24 at 3:12 PM. The activity calendars indicated clients A, B and C had 14 activities that were done in the home, and 2 van rides were completed but no destinations or purposes were indicated for those rides. The March 2024 activity calendar indicated the only outing for client C was an opportunity to go home. January 2024 1/3/24 - play games 1/8/24 - coloring 1/11/24 - cookies 1/23/24 - movies 1/25/24 - music February 2024 2/8/24 - van ride 2/11/24 - bake oatmeal cookies 2/13/24 - play with exercise ball 2/23/24 - movie night 2/28/24 - board games March 2024 3/2/24 - visit home with mom (client C) 3/5/24 - cookies 3/9/24 - watched television. 3/10/24 - watched Gestures show 3/12/24 - van ride 3/16/24 - watched TV 3/20/24 - movie night. A record review of the Group Home client logs dated January 2024-March 2024 was completed on 4/3/24 at 3:12 PM and indicated no documentation for the activities or outings that occurred. There was no documentation to indicate the purpose of the van ride or to show the van rides took place.		a post test on active treatment. All staff were retrained on properly documenting activity calendars for all individuals within the home. Making sure that the home is providing more community integration for all individuals served. Also, the importance of documenting the destination or purpose of working toward a goal, through the actual van ride. The indicated outings should occur 1-2 times per week. This will be documented on the specific individual's activity calendar. To ensure that the training was effective, management will monitor the activity calendars and outings and turn them in monthly to the director for compliance. This monitoring will take place (2) times weekly for 1 month. Then (1) time a week for a month ongoing.	

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	An interview with the Resident Director (RD) was completed on 4/4/24 at 4:15 PM and indicated an outing should occur 1-2 times per week or as much as the group home can manage. The RD stated, "A van ride is only an acceptable outing if there is a destination or purpose of working toward a goal." The RD indicated outings such as going to science central or a park, shopping or for a client with a counting goal - how many animals can we find on this trip and count the animals seen while riding in the van. The RD indicated when an outing is completed, the staff document that on the activity calendar and update the calendar daily with what activity was completed. The RD indicated the daily notes should reflect the activities being completed by the staff with the clients. An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM. The QIDP indicated he had completed training for outings recently with the staff as most have been there less than 6 months. The QIDP indicated the group home should have an organized outing for the entire house one time per month and every day a different client should be leaving the house for a 1:1 outing. The QIDP indicated each client should be out once per week. The QIDP indicated an outing using a van ride should have a purpose or a destination depending on the goals for each client. The QIDP indicated the staff should be documenting the outings daily on the activity calendar the day the outings took place, and those should be reflected in the communication log. 9-3-2(a)			

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 sampled clients (A and B), plus 1 additional client (former client G), the facility failed to implement their policy and procedure to prevent an incident of substantiated physical abuse of former client G and failed to conduct thorough investigations regarding the substantiated physical abuse of former client G, client B's fractured leg, and client A's fractured sternum. Findings include: 1. The facility's BDS (Bureau of Disability Services) reports and investigations were reviewed on 4/2/24 at 6:30 PM. The 3/7/24 BDS report indicated, " ... [Former client G] became physically aggressive with a staff person and that the staff engaged in physical aggression toward [former client G] in response ...." The facility's investigative report summary dated 3/9/24 for former client G was reviewed on 4/4/24 at 4:15 PM and indicated, "On 3/6/24 it was reported to the Residential Manager that [former client G] became physically aggressive with a staff person and that the staff engaged in physical aggression toward [former client G] in response. [Former client G] was assessed through telehealth on 3/5/24. The report indicated no obvious injury to the nose and that [former client G] was at baseline. [Former client G] was then assessed by the [facility] nurse on 3/7/24. The assessment indicates that [former client G] presents with two 3 inch scratches on the right side of her neck, a ¼ inch scratch on her left nostril and ½ inch bruise	W 0149	W0149 The investigative summary report did not include any corrective measures and dates to be completed. For corrective measures for client G, all staff will be retrained 5/3/24 on Honoring the rights of Individuals served and Reporting suspected Abuse, Neglect and Exploitation Policy. A posttest will be completed for both trainings, to verify their understanding of the policy and specifically their responsibility to report and prevent ANE from occurring. All staff was retrained and completed a posttest 5/3/24 on the Health Issue Note / Change in Individual Condition Reporting. To verify their understanding of the importance of this form. Additional management oversight will be conducted. Management will monitor Health Issue Note/ Change of Condition form as staff complete them and turn them in. The managers and the director will monitor for compliance ongoing. Both client A and B had significant injuries and the BDDS reports were completed. Client A, IR	05/03/2024

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	across the ridge of her nose which appeared to cause bruising under the right eye. 2 inch bruising below the back right shoulder. The alleged staff person was suspended immediately pending the results of the investigation. [Former client G] was given emotional support from staff and management .... The investigation was completed and abuse was substantiated. Statements indicate that [former client G] and the staff person ended up on the floor during the behavioral incident. The alleged staff indicated that she put her hands up toward [former client G] to block and protect herself from the aggression. However, the witness and [former client G] both indicated that the staff hit [former client G] in the face. The alleged staff stated (sic) that she put her arms out to push [former client G] off of her and this could be the cause of the scratches to the neck (sic). It was determined that the scratches were likely inadvertent contact. There were control issues identified prior to the aggression which is an indicator of the staff's mindset during that time. The staff person did not use Mandt (self-management program for positive communication) approved techniques and resorted to aggression. [Former client G] was offered emotional support. He (sic) The IDT (interdisciplinary team) Team (sic) will cont (sic) to meet and review [former client G's] BSP (Behavioral Support Plan). The team will continue to make adjustments as needed and continue to provide support for [former client G]. The investigatory question was answered." The investigative summary report did not include any corrective measures, dates corrective measures were completed and signatures of the investigator, director, vice president, and compliance officer. The Residential Director (RD) was interviewed on		dated (12/27/22) and client B, IR dated (6/14/23). Both IR's documented that an investigation was completed. At the time of survey, the investigation could not be found. Residential Directors will be retrained on the Incident Reporting and Investigation Policy to ensure that Investigations are completed as per policy.	

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	4/4/24 at 4:15 PM and indicated he completed the investigation involving former client G, the group home staff were retrained on MANDT and de-escalation techniques, and the staff involved was terminated. An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM and indicated the staff had been retrained on MANDT and power struggles training. Documentation of the training was not available. 2. The facility's BDS report for client B was reviewed on 4/4/24 at 3:01 PM and indicated, " ...On 6/14/23 [client B] had gotten out of the group home van in the garage. [Client B] got out of the van without incident. [Client B] then the (sic) staff noticed his hands started to shake and he fell straight forward. The staff noticed blood and ran inside to call 911. EMS (Emergency medical services) arrived and transported [client B] to [area hospital] ER (emergency room). He was diagnosed with an open displaced fracture of the Tibia (lower leg bone) (sic). [Client B] had surgery on 6/15/23 to repair the fracture which was fixed with screws and plates. Surgery was successful and [client B] is resting well. An internal investigation has been initiated due to the seriousness of the injury." The facility's BDS report dated 6/21/23 indicated, " ...On 6/19/23 [client B] was transferred from [area hospital] post-surgery for an open -displaced fracture of the tibia to [area rehabilitation center] for recovery. On 6/21/23 (sic) 2 pm, [facility] was informed that [client B] had pulled off his soft cast and two of his staples and has been hitting staff. The [area hospital] informed [facility] that [client B] would be transferred back to [area hospital]			

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	due to safety concerns." The facility's Incident follow-up report for client B dated 8/7/23 indicated, " ...Update 8/7/23: [client B] remains hospitalized at [area hospital] where he is receiving physical therapy. [Client B] is scheduled for repeat RLE (right lower extremity) x-rays on 8/10/23. Once orthopedics advances his weight-bearing status to full weight he will be discharged to the group home." Client B's record was reviewed on 4/4/24 at 3:01 PM. Client B's hospital history and physical dated 6/14/23 indicated, " ...Patient has an open fracture of the right distal one third tibia shaft ....plan to go to the operating room tomorrow." Client B's x-ray report dated 6/14/23 indicated, "Impression: Open, comminuted fractures of the distal tibia and fibula (lower leg bone). Nondisplaced fracture of the proximal fibula." Client B's hospital ER consult dated 6/14/23 indicated, "Chief complaint: brought in by medics for a fall, obvious deformity from a group home ...Reason for consultation: R (right) Grade 3 open fracture of the distal tib-fib (tibia-fibula - leg bones in the lower leg) with gross deformity (sic) History of Present Illness: History by caregivers, present at bedside ...he had a fall supposedly in the garage. Open frx (fracture) ...Musculoskeletal: ...RLE (right lower extremity): there is a large laceration with exposed tibia to the right distal lower leg ....There is obvious rotation laterally of the right ankle .... Assessment/Plan: Closed fracture of fibula, proximal right ... ground-level fall ...open fracture of right fibula and tibia ...Will need definitive fixation in the future."			

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	An interview with the Residential Director (RD) was completed on 4/3/24 at 1:45 PM. The RD indicated the fall in the garage resulted in a tib/fib fracture that required surgery with screws/plates. The RD indicated an investigation was conducted because the fall resulted in a significant injury. The RD indicated his duties included completing investigations. The RD stated, "another RD completed this investigation prior to my taking the position. The VP (vice president) is out of the office today and returns tomorrow and can ask her at that time if she has any paperwork in the hanging files (agency medical book for client) from the previous RD." There was no documentation the facility completed an investigation of the incident available at the time of this interview. An interview with the Vice President (VP) was completed on 4/4/24 at 11:30 AM and indicated the previous RD completed the investigation and the compliance department should have a copy. The VP indicated the RD could access the investigation and provide the needed copy. An interview with the RD was completed on 4/4/24 at 4:15 PM, and he stated "compliance doesn't have a copy of the investigation and there is not a way to get a copy as the RD who would have completed the investigation is no longer here." An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM. The QIDP indicated there was a fall in the garage at the group home. Client B was hospitalized. The QIDP indicated a BDS report had been completed but she had not seen			

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	the investigation paperwork. The QIDP stated, "at the end of the investigation, we were not in trouble because it was an accident." No documentation of the investigation of the incident was available and provided for review. 3. The facility's BDS report for client A dated 12/28/22 was reviewed on 4/3/24 at 2:18 PM and indicated, " ...On 12/27/22 staff noticed that [client A] was acting strangely and like he was in pain. The decision was made to have him transported to [area hospital] ER (emergency room) for further evaluation. The hospital took a CT (computed tomography) scan and found that [client A] had a fractured sternum. They prescribed [medication] for pain and did not do any tests. [Client A] was discharged and transported home by staff. On 12/28/22 the residential manager transported [client A] to [another area hospital] ER for a 2nd evaluation, since [area hospital] didn't run labs. A full evaluation was completed including EKG (electrocardiogram), labwork (sic), and urine analysis. No other issues were found other than the fractured sternum. [Client A] was discharged with a prescription for [med] for pain and instructions to follow up with his PCP (primary care physician) as soon as possible. " The facility's investigative report summary for client A dated 1/3/23 was reviewed 4/3/24 at 1:45 PM and indicated, " ...On 12/27/22, [client A] was taken to [area hospital] ER due to acting like he was in pain. CT scan revealed a fractured sternum ... Analysis and Findings ...On 12/17/22 [client A] was observed by staff to trip and fall straight into the side of the coffee table in the living room then landing (sic) on his side on the floor. At the time he was checked for injuries and none found (sic). However, no incident/injury report was			

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	completed. The staff immediately moved the coffee table from his path and reported the incident to the residential manager. [Client A] has had no other falls since this incident per staff statements. Therefore, this fall is most likely the cause of his injury." Client A's record was reviewed on 4/4/24 at 9:50 AM. Client A's emergency documentation dated 12/27/22 indicated, "[Client A] was seen and evaluated. Medical screening examination was performed ....CT imaging evidence of a nondisplaced renal fracture (sic). [MD] discussed with the aide. She is uncertain of any falls however it is likely that he did fall ... Impression and Plan - Diagnosis: Sternal fracture." Client A's office/clinic note dated 1/15/23 indicated, "chief complaint: [Client A] here for follow up on fractured sternum. Still some pain and is unable to sleep at night. Would like [med] for pain at HS (hour of sleep). History of Present Illness: He has been on (sic) pain with sternal fracture, (sic) He has been agitation, (sic) HE (sic) was given [pain med] has relief (sic). He has had a fall, (sic) He has noted worsening agitation .... Assessment/Plan: 1. Sternal Fracture." An interview with staff #7 was completed on 4/2/24 at 5:00 PM. Staff #7 stated, "[client A] was on a medication that wasn't "setting well" and had him off balance. Staff #7 indicated client A had multiple falls and the nurse was called to assess him after the falls. Staff #7 indicated multiple incident reports had been filled out after client A's falls. Staff #7 indicated client A had no bruising or complaints of pain but she stated, "I knew he had an issue going on because of abnormal vital			

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	signs - his pulse rate was very high (no # given)." Staff #7 indicated client A was taken to the ER and was diagnosed with a fractured sternum. An interview with the Residential Director (RD) was completed on 4/3/24 at 1:45 PM. The RD indicated he was responsible for completing the investigation. The RD indicated an investigation should have been thorough and complete. The RD indicated he did not have staff statements or corrective action paperwork available. The RD was interviewed regarding staff reports of multiple falls by client A with incident report documentation being completed and the nurse assessment form/documentation being completed, and the RD stated, "I don't have any of those forms. I don't know where they would be as they should have been in the hanging files (the medical books given by the agency)." An interview with the Licensed Practical Nurse (LPN) on 4/5/24 at 8:30 AM indicated she had no further documentation for the investigation that was completed. The LPN indicated she was not a part of the investigation process. The LPN indicated she did not have any fall risk assessment forms or injury forms for post fall of 12/17/22 or 12/20/22. An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM. The QIDP stated, "it was a result of an unknown fall, and no investigation was completed because nothing bad happened." The QIDP indicated he had not seen the completed documentation for the investigation and did not have a copy of the investigation available. The facility's ANE (Abuse Neglect and			

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	Exploitation) policy dated 2/26/24 was reviewed on 4/3/24 at 10:20 AM and indicated, "Abuse, neglect and exploitation are defined as follows: A. Abuse includes but is not limited to: ...Intentional or willful infliction of physical injury ... should the charges be substantiated, disciplinary action will be taken which may include termination .... B. Neglect includes but is not limited to, failure to: 1. Provide appropriate supervision, 2. Train, 3. Provide and maintain a clean ...environment ...to a participant as indicated in the Person-Centered Individualized Support Plan (PCISP)." This federal tag relates to complaint #IN00430139. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 2 sampled clients (A and B), plus 1 additional client (former client G), the facility failed to conduct thorough investigations regarding the substantiated physical abuse of former client G, client B's fractured leg, and client A's fractured sternum. Findings include: 1. The facility's BDS (Bureau of Disability Services) reports and investigations were reviewed on 4/2/24 at 6:30 PM. The 3/7/24 BDS report indicated, " ... [Former client G] became physically aggressive with a staff person and that the staff engaged in physical aggression toward [former client G] in response ...."	W 0154	W0154 The investigative summary report did not include any corrective measures and dates to be completed. For corrective measures for client G, all staff will be retrained 5/10/24 on Honoring the rights of Individuals served and Reporting suspected Abuse, Neglect and Exploitation Policy. A posttest will be completed for both trainings, to verify their understanding of the policy and specifically their responsibility to report and prevent ANE from occurring.	05/03/2024

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	The facility's investigative report summary dated 3/9/24 for former client G was reviewed on 4/4/24 at 4:15 PM and indicated, "On 3/6/24 it was reported to the Residential Manager that [former client G] became physically aggressive with a staff person and that the staff engaged in physical aggression toward [former client G] in response. [Former client G] was assessed through telehealth on 3/5/24. The report indicated no obvious injury to the nose and that [former client G] was at baseline. [Former client G] was then assessed by the [facility] nurse on 3/7/24. The assessment indicates that [former client G] presents with two 3 inch scratches on the right side of her neck, a ¼ inch scratch on her left nostril and ½ inch bruise across the ridge of her nose which appeared to cause bruising under the right eye. 2 inch bruising below the back right shoulder. The alleged staff person was suspended immediately pending the results of the investigation. [Former client G] was given emotional support from staff and management .... The investigation was completed and abuse was substantiated. Statements indicate that [former client G] and the staff person ended up on the floor during the behavioral incident. The alleged staff indicated that she put her hands up toward [former client G] to block and protect herself from the aggression. However, the witness and [former client G] both indicated that the staff hit [former client G] in the face. The alleged staff stated (sic) that she put her arms out to push [former client G] off of her and this could be the cause of the scratches to the neck (sic). It was determined that the scratches were likely inadvertent contact. There were control issues identified prior to the aggression which is an indicator of the staff's mindset during that time. The staff person did not use Mandt (self-management program for positive		All staff was retrained and completed a posttest 5/3/24 on the Health Issue Note / Change in Individual Condition Reporting. To verify their understanding of the importance of this form. We want DSP's understand that it is important that they noticed and did something about it- Quality Care. It provides a timeline of events and details if needed. Change in condition is often the first sign that something is not right. Additional management oversight will be conducted. Documentation of those visits will be done 3 times weekly for 30 days or until compliance can be verified. Documentation will be done on a home visit form by the managers and the director will monitor for compliance. Both client A and B had significant injuries and completed incident reports documented and submitted to the state. Client A, IR date(12/27/22) and client B, IR date (6/14/23). Both IR's have documented that an investigation was completed. At the time of survey those documents could not be found.	

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	communication) approved techniques and resorted to aggression. [Former client G] was offered emotional support. He (sic) The IDT (interdisciplinary team) Team (sic) will cont (sic) to meet and review [former client G's] BSP (Behavioral Support Plan). The team will continue to make adjustments as needed and continue to provide support for [former client G]. The investigatory question was answered." The investigative summary report did not include corrective measures, dates corrective measures were completed and signatures of the investigator, director, vice president, and compliance officer. A review of the investigation was not thorough due to no recommendations to prevent recurrence being included in the investigation. The Residential Director (RD) was interviewed on 4/4/24 at 4:15 PM and indicated he completed the investigation involving former client G, the group home staff were retrained on MANDT and de-escalation techniques, and the staff involved was terminated. An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM and indicated the staff had been retrained on MANDT and power struggles training. Documentation of the training was not available. 2. The facility's BDS report for client B dated 6/14/23 was reviewed on 4/4/24 at 3:01 PM and indicated, " ...On 6/14/23 [client B] had gotten out of the group home van in the garage. [Client B] got out of the van without incident. [Client B] then the (sic) staff noticed his hands started to shake and he fell straight forward. The staff			

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	noticed blood and ran inside to call 911. EMS (Emergency medical services) arrived and transported [client B] to [area hospital] ER (emergency room). He was diagnosed with an open displaced fracture of the Tibia (lower leg bone) (sic). [Client B] had surgery on 6/15/23 to repair the fracture which was fixed with screws and plates. Surgery was successful and [client B] is resting well. An internal investigation has been initiated due to the seriousness of the injury." The facility's BDS report dated 6/21/23 indicated, " ...On 6/19/23 [client B] was transferred from [area hospital] post-surgery for an open -displaced fracture of the tibia to [area rehabilitation center] for recovery. On 6/21/23 (sic) 2 pm, [facility] was informed that [client B] had pulled off his soft cast and two of his staples and has been hitting staff. The [area hospital] informed [facility] that [client B] would be transferred back to [area hospital] due to safety concerns." The facility's Incident follow-up report for client B dated 8/7/23 indicated, " ...Update 8/7/23: [client B] remains hospitalized at [area hospital] where he is receiving physical therapy. [Client B] is scheduled for repeat RLE (right lower extremity) x-rays on 8/10/23. Once orthopedics advances his weight-bearing status to full weight he will be discharged to the group home." There was no documentation indicating the facility conducted an investigation. Client B's record was reviewed on 4/4/24 at 3:01 PM. Client B's hospital history and physical dated 6/14/23 indicated, "...Patient has an open fracture of the right distal one third tibia shaft ....plan to go			

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	to the operating room tomorrow." Client B's x-ray report dated 6/14/23 indicated, "Impression: Open, comminuted fractures of the distal tibia and fibula (lower leg bone). Nondisplaced fracture of the proximal fibula." Client B's hospital ER consult dated 6/14/23 indicated, "Chief complaint: brought in by medics for a fall, obvious deformity from a group home ...Reason for consultation: R (right) Grade 3 open fracture of the distal tib-fib (tibia-fibula - leg bones in the lower leg) with gross deformity (sic) History of Present Illness: History by caregivers, present at bedside ...he had a fall supposedly in the garage. Open frx (fracture) ...Musculoskeletal: ...RLE (right lower extremity): there is a large laceration with exposed tibia to the right distal lower leg ....There is obvious rotation laterally of the right ankle .... Assessment/Plan: Closed fracture of fibula, proximal right ... ground-level fall ...open fracture of right fibula and tibia ...Will need definitive fixation in the future." An interview with the Residential Director (RD) was completed on 4/3/24 at 1:45 PM. The RD indicated the fall in the garage resulted in a tib/fib fracture that required surgery with screws/plates. The RD indicated an investigation was conducted because the fall resulted in a significant injury. The RD indicated his duties included completing investigations. The RD stated, "another RD completed this investigation prior to my taking the position. The VP (vice president) is out of the office today and returns tomorrow and can ask her at that time if she has any paperwork in the hanging files (agency medical book for client) from the previous RD." There was no documentation the facility			

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	completed an investigation of the incident available at the time of this interview. An interview with the Vice President (VP) was completed on 4/4/24 at 11:30 AM and indicated the previous RD completed the investigation and the compliance department should have a copy. The VP indicated the RD could access the investigation and provide the needed copy. An interview with the RD was completed 4/4/24 at 4:15 PM, and he stated "compliance doesn't have a copy of the investigation and there is not a way to get a copy as the RD who would have completed the investigation is no longer here." An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM. The QIDP indicated there was a fall in the garage at the group home. Client B was hospitalized. The QIDP indicated a BDS report had been completed but he had not seen the investigation paperwork. The QIDP stated, "at the end of the investigation, we were not in trouble because it was an accident." No documentation of the investigation of the incident was available. 3. The facility's BDS report for client A dated 12/28/22 was reviewed on 4/3/24 at 2:18 PM and indicated, " ...On 12/27/22 staff noticed that [client A] was acting strangely and like he was in pain. The decision was made to have him transported to [area hospital] ER (emergency room) for further evaluation. The hospital took a CT (computed tomography) scan and found that [client A] had a fractured sternum. They prescribed [medication] for pain and did not do any tests. [Client A] was discharged and transported home by staff. On			

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	12/28/22 the residential manager transported [client A] to [another area hospital] ER for a 2nd evaluation, since [area hospital] didn't run labs. A full evaluation was completed including EKG (electrocardiogram), labwork (sic), and urine analysis. No other issues were found other than the fractured sternum. [Client A] was discharged with a prescription for [med] for pain and instructions to follow up with his PCP (primary care physician) as soon as possible. " The facility's investigative report summary for client A dated 1/3/23 was reviewed 4/3/24 at 1:45 PM and indicated, " ...On 12/27/22, [client A] was taken to [area hospital] ER due to acting like he was in pain. CT scan revealed a fractured sternum ... Analysis and Findings ...On 12/17/22 [client A] was observed by staff to trip and fall straight into the side of the coffee table in the living room then landing (sic) on his side on the floor. At the time he was checked for injuries and none found (sic). However, no incident/injury report was completed. The staff immediately moved the coffee table from his path and reported the incident to the residential manager. [Client A] has had no other falls since this incident per staff statements. Therefore, this fall is most likely the cause of his injury." Client A's record was reviewed on 4/4/24 at 9:50 AM. Client A's emergency documentation dated 12/27/22 indicated, "[Client A] was seen and evaluated. Medical screening examination was performed ....CT imaging evidence of a nondisplaced renal fracture (sic). [MD] discussed with the aide. She is uncertain of any falls however (sic) it is likely that he did fall ... Impression and Plan - Diagnosis: Sternal fracture."			

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Client A's office/clinic note dated 1/15/23 indicated, "chief complaint: [Client A] here for follow up on fractured sternum. Still some pain and is unable to sleep at night. Would like [med] for pain at HS (hour of sleep). History of Present Illness: He has been on (sic) pain with sternal fracture, (sic) He has been agitation, (sic) HE (sic) was given [pain med] has relief (sic). He has had a fall, (sic) He has noted worsening agitation .... Assessment/Plan: 1. Sternal Fracture."

An interview with staff #7 was completed on 4/2/24 at 5:00 PM. Staff #7 stated client A was on a medication that wasn't "setting well" and had him off balance. Staff #7 indicated client A had multiple falls and the nurse was called to assess him after the falls. Staff #7 indicated multiple incident reports had been filled out after client A's falls. Staff #7 stated, "[client A] had no bruising or complaints of pain but I knew he had an issue going on because of abnormal vital signs - his pulse rate was very high (no # given)." Staff #7 indicated client A was taken to the ER and was diagnosed with a fractured sternum.

An interview with the Residential Director (RD) was completed on 4/3/24 at 1:45 PM. The RD indicated he was responsible for completing the investigation. The RD indicated an investigation should have been thorough and complete. The RD indicated he did not have staff statements or corrective action paperwork available. The RD was interviewed regarding staff reports of multiple falls by client A with incident report documentation being completed and the nurse assessment form/documentation being completed, and the RD stated, "I don't have any of those forms. I don't know where they would be as they should have been in the hanging files (the medical

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	books given by the agency)." An interview with the Licensed Practical Nurse (LPN) on 4/5/24 at 8:30 AM indicated she had no further documentation for the investigation that was completed. The LPN indicated she was not a part of the investigation process. The LPN indicated she did not have any fall risk assessment forms or injury forms for post fall of 12/17/22 or 12/20/22. An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM. The QIDP stated, "it was a result of an unknown fall, and no investigation was completed because nothing bad happened." The QIDP indicated he had not seen the completed documentation for the investigation and did not have a copy of the investigation available. This federal tag relates to complaint #IN00430139. 9-3-2(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure the staff were competent in notifying the nurse with a change in condition for client B. Findings include: An observation at the group home was completed on 4/3/24 from 5:45 AM to 8:06 AM. During the	W 0192	W0192 The facility failed to ensure the staff were competent in notifying the nurse with a change of condition form for client B. All staff were retrained on and completed a posttest 5/3/24 on the Health Issue Note / Change in Individual Condition Reporting policy. To	05/03/2024

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	observation, client B was seen picking at his right ankle. At 6:38 AM, the QIDP indicated client B had an open area on his right ankle. At 6:46 AM, staff #3 indicated to keep client B from picking at his scabs, they will keep longer socks on his legs and keep his hands busy. Staff #3 indicated attempts to wrap his leg had not been successful as the client removed the bandages as quickly as staff applied the bandages. At 6:48 AM on 4/3/24, the HM (house manager) pulled up client B's pant leg to reveal a quarter sized wound on the right ankle. The area was wet, glossy looking and oozing a white colored drainage. There was a ring of red noted around the area. The HM stated this was a "big change" from yesterday and the QIDP agreed this was a change from her assessment a few days ago. The HM indicated the LPN had been in the home and examined client B on Thursday, March 28, 2024. The staff had been applying bacitracin to the open area on the right ankle since that visit. The HM stated, "[client B] needs to see the doctor. I can't keep him out of his ankle. He digs at it making it worse. We can't make it better and it looks red, and I will call the LPN today. I will call the LPN to see about telehealth if he can't be seen today." Client B's record was reviewed on 4/3/24 at 2:50 PM. Client B's ambulatory visit discharge instruction sheet dated 10/30/23 indicated, "If [client B] develops purulent (pus) drainage from the wound, increasing redness around the wound, or develops fevers, follow up ...." An interview with the Residential Director (RD) was completed on 4/4/24 at 4:15 PM and indicated the HM should have used a change in condition form and called the nurse for an assessment as soon as the change in condition was noted. The RD indicated staff should have made the HM		verify their understanding of the importance of this form, management will monitor Health Issue Note/ Change of Condition form as they are completed. Documentation will be done until compliance can be verified. Documentation will be done on Change of Condition form as staff submit them for completion. The managers and the director will monitor for compliance.	

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	aware when changes in the ankle were first noticed. The RD indicated staff was trained in Core A/B and First Aid and should have followed the guidelines of this training. An interview with the Licensed Practical Nurse (LPN) on 4/5/24 at 8:30 AM indicated she had seen client B last on Thursday, March 28, 2024. The LPN indicated client B had 2 small scabs on the right ankle and instructed staff to use the PRN (as needed) bacitracin. The LPN indicated she was not made aware of the change in condition to an open wound with drainage and a red ring around it until 4/4/24. The LPN indicated she had called for an appointment and was given 5/1/24 with the wound clinic and later next week for his PCP (Primary Care Physician). The LPN indicated she would have the HM call and do a telehealth visit today due to the worsening condition of the wound since her last visit. 9-3-3(a)			
W 0255 Bldg. 00	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. Based on record review and interview for 2 of 3 sampled clients (B and C), the facility failed to ensure the clients' programs were updated after the clients met their goals. Findings include: 1. Client B's record review was completed on	W 0255	The QIDP was retrained on the progression of goals in an ISP and if goals have been 100% successful we need to progress the goal or change it. ISPs for client #A and #B have had an addendum done to them to address new goal or different	05/03/2024

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	4/3/24 at 2:27 PM. Client B's ISP (Individual Support Plan) dated 9/19/23 indicated the following goals: Laundry goal was to meet 80% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 82% Nov 100% Oct 100% Vacuum goal was to meet 80% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 93% Nov 100% Oral Hygiene goal was to meet 80% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% Toileting goal to was to meet 80% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% Med Administration goal was to meet 80% for 3		prompt levels for achieving goals. All staff have been retrained on ISP goals for each client and have completed IST training forms that contain a competency test to ensure knowledge. The QIDP and director have reviewed the IST forms for all staff. The forms will be maintained in their personnel file as well as in the POC binder. The QIDP will ensure all staff are trained on ISP goals at least annually or as addendums are made. The director will be notified of any changes made to plans to ensure staff are all retrained. Monitoring to ensure compliance of implementing ISP goals will be monitored by the QIDP, director, or manager three times weekly by doing a home visit. The visits will be documented on a home visit form. The director will monitor all home visit forms and they will be maintained in the POC binder. Once compliance has been verified, home visits will be completed on a monthly schedule ongoing.	

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	consecutive months. Achieved: Feb 2024 97% Jan 100% Dec 2023 100% Nov 100% Oct 100% 2. Client C record review was completed on 4/3/24 at 9:00 PM. Client B's ISP was dated 6/2/23 indicated the following goals: Dining goal was to meet 70% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% Bathing goal was to meet 70% for 3 consecutive months. Achieved: Feb 2024 91% Jan 77% Dec 2023 100% Nov 100% Oct 100% Dining goal was to meet 70% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% Laundry goal was to meet 60% for 3 consecutive			

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	months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% Med Administration goal was to meet 60% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2024 100% Nov 100% Oct 100% Day Service goal was to meet 60% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% Household goal was to meet 70% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% Toilet goal was to meet 70% for 3 consecutive months. Achieved: Feb 2024 100% Jan 90%			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Dec 2023 100% Nov 100% Oct 100% Oral Hygiene goal was to meet 60% for 3 consecutive months. Achieved: Feb 2024 100% Jan 100% Dec 2023 100% Nov 100% Oct 100% An interview with the Residential Director (RD) was completed on 4/4/24 at 4:15 PM and indicated the QIDP (Qualified Intellectual Disability Professional) was responsible for updating the goals. The RD indicated the goals should have been turned into the QIDP monthly by the house manager. The RD indicated the QIDP should have been reviewing and updating goals based on completion or lack of progression of goals. The RD indicated the QIDP should have reviewed the goals at the yearly ISP meeting. An interview with the Qualified Intellectual Disability Professional (QIDP) was completed on 4/5/24 at 8:36 AM. The QIDP indicated he should have been reviewing the goals monthly and made changes when parameters in the ISP had been met. The QIDP indicated he was the one responsible for completing this objective. 9-3-4(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and			

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	15G766	A. BUILDING 00 B. WING	04/09/2024

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	hearing. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility failed to complete hearing screening evaluations annually. Findings include: 1. Client A's record review was completed on 4/3/24 at 2:50 PM. Client A's hearing screen dated 11/15/19 indicated the hearing screening needed to be completed. No other hearing screen documentation was available. Client A's nurses notes dated 1/17/24 were reviewed on 4/3/24 at 2:50 PM and indicated, " ...client needs hearing completed" ...." An interview with the Residential Director (RD) was completed on 4/4/24 at 4:15 PM and indicated the LPN was responsible for scheduling the needed screenings. The RD indicated hearing screenings should be completed yearly unless otherwise indicated. The RD indicated the facility's standards are different than the federal standards. An interview with the Licensed Practical Nurse (LPN) on 4/5/24 at 8:30 AM indicated client A had a hearing appointment scheduled on 2/27/24 but was unable to provide the documentation for this visit. The LPN indicated the hearing screen could have been done every three years unless the hearing was compromised, or clients had a hearing aid and then those clients would be screened yearly. 2. Client B's record review was completed on 4/3/24 at 2:50 PM. Client B's audiologic assessment dated 8/30/18	W 0323	W0323 The Facility failed to complete hearing screening evaluations annually, for clients (A and B). Client A's last hearing screening dated 11/15/19 and client B's last hearing screening is dated for 8/30/18. Client A's hearing screening evaluation is scheduled for 6/27/24 at 8am. Client B hearing screening evaluation is scheduled for 7/1/24. Both have been scheduled with the ENT. To ensure all clients receive hearing screening evaluations annually or recommended by the PCP, management staff and nurse were retrained to ensure the hearing screening evaluations gets scheduled and is completed. There is a form for tracking all medical appointments that management staff will complete to ensure all required medical appointments are completed timely.	05/03/2024

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	was the last screening in the client's record. No other hearing screening documentation was available. An interview with the RD was completed on 4/4/24 at 4:15 PM and indicated the LPN is responsible for scheduling the needed screenings. The RD indicated hearing should be completed yearly unless otherwise indicated. The RD indicated the facility's standards are different than the federal standards. An interview with the Licensed Practical Nurse (LPN) on 4/5/24 at 8:30 AM indicated this hearing screening needed to be scheduled but was unable to provide the documentation for this visit. The LPN indicated the hearing screenings could have been done every three years unless the hearing was compromised, or clients had a hearing aid and then those clients would be screened yearly. 9-3-6(a)			
W 0325 Bldg. 00	483.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to complete the routine screening lab work per the physician's orders. Findings include: Client A's record was reviewed on 4/3/24 at 2:50 PM. Client A's lab work dated 10/19/22 indicated no	W 0325	W0325 The facility failed to complete the routine screening lab work per physician's orders, for client A. Client A's annual physical examination was dated 10/23/24, indicated current orders for CBC, CMP, lipid, TSH, Hepatic, and a PSA. But no documentation of	05/03/2024

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	recent lab work documentation was available. Client A's annual physical examination dated 10/3/23 indicated current orders for CBC (complete blood count), CMP (complete metabolic panel), lipid (cholesterol panel), TSH (thyroid stimulating hormone), Hepatic (liver profile) and PSA (prostate-specific antigen) but no documentation of completion was available. An interview with the Resident Director (RD) was completed on 4/4/24 at 4:15 PM and indicated the LPN was responsible for scheduling the needed lab work. The RD indicated labs were drawn yearly. An interview with the Licensed Practical Nurse (LPN) on 4/5/24 at 8:30 AM indicated labs were drawn as needed by the physician (annually unless physician indicated otherwise), or medication requires routine scheduled labs. The psychiatrist or the PCP (primary care physician) will order PRN (as needed labs). The LPN indicated recent labs had been drawn but provided no date or copy of documentation for the missing labs. 9-3-6(a)		completion was available. That lab was completed 3/11/24 and we do have the paperwork. Client A had multiple failure attempts when trying to complete that labwork. Extra staffing was sent all those times to get labwork done, and client A was still unsuccessful. After multiple unsuccessful attempts, the Pathology Lab company recommended Client A to be sedated to have a successful lab drawn. This lab was drawn without sedation at Lutheran hospital 3/11/24. Client A will have a descentization plan for medical appointments. To ensure all clients complete labwork, management staff and nurse were retrained to ensure the labwork gets scheduled and is completed. There is a form for tracking all medical appointments that management staff will complete to ensure all required medical appointments and labwork are completed timely.	
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 2 of 3	W 0327	W0327	05/03/2024

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	sampled clients (B and C), the facility failed to complete the TB (tuberculosis) screenings per the physician's orders. Findings include: 1. Client B's record was reviewed on 4/3/24 at 2:50 PM. Client B's annual physical examination dated 10/3/23 indicated a TB test was to be completed. No documentation was available for the missing screening. An interview with the Resident Director (RD) was completed on 4/4/24 at 4:15 PM and indicated the nurse was responsible for getting the TB screens completed. The TB screen should have been done yearly. An interview with the Licensed Practical Nurse (LPN) on 4/5/24 at 8:30 AM indicated she requested results for the TB screen but didn't provide the needed documentation for the missing screening. 2. Client C's record was reviewed on 4/3/24 at 2:50 PM. Client C's T-spot (tuberculosis screen) dated 10/04/22 indicated a TB screen was to be completed. No documentation was available for the missing screening. An interview with the Resident Director (RD) was completed 4/4/24 at 4:15 PM and indicated the nurse was responsible for getting the TB screens completed. The TB screen should have been done yearly.		The facility failed to complete the TB screening per physician's orders. Client B had an annual physical 10/3/23 indicated a TB test was to be completed. No documentation was available for the missing screening. Client TB shot is scheduled to be completed before the date of 5/30/24 with client B's primary physician. Client C's T-spot (TB shot) was dated for 10/4/22 indicated a TB screen was to be completed. No documentation was available for missing screening. Client C's mother (guardian), refused the TB shot, at the time it was requested. Mother stated, she let the manager at the time of the appointment know that she does not want her son to receive the TB shot. Instead of receiving the Mantoux, he will have the t-spot screening through his blood work. To ensure all clients T-spot and TB shots screening are completed, management staff and nurse were retrained 5/3/24 to ensure the T-spot/TB shot screenings gets scheduled and completed. There is a form for tracking all medical appointments that management staff will complete to ensure all required medical appointments are completed timely.	

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	An interview with the Licensed Practical Nurse (LPN) was completed on 4/5/24 at 8:30 AM. The LPN indicated she requested for a refusal form to be created as the guardian had been refusing the TB screening. The LPN stated, "the guardian reported it isn't necessary to be done yearly." No documentation of the completed screening or the refusal form was available. 9-3-6(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (A, B and C) and 3 additional clients (D, E and F), the facility failed to conduct quarterly evacuation drills for each shift. Findings include: The facility's evacuation drills for the group home dated 1/1/23-1/21/24 were reviewed on 4/3/24 at 1:45 PM. The review did not include documentation of evacuation drills being conducted from: May 2023 through November 2023 The last drill documented for day shift was 4/4/23. The next drill completed and documented on the day shift was on 12/7/23. Day shift hours for the group home are from 6:00 AM to 2:00 PM. July 2023 through November 2023 The last drill documented for evening shift was 6/19/23. The next drill completed and documented on the evening shift was in 2024. Evening shift hours for the group home are from 2:00 PM to 11:00 PM.	W 0440	W0440 The review did not include documentation of evacuation drills being conducted from: May 2023 through November 2023 the last drill was documented for day shift 4/4/23. The next drill completed and documented on day shift was on 12/7/23. Those drills have been found and have been placed in the Emergency Preparedness Book within the home 4/29/24. Management staff has been retrained on Emergency Preparedness Staff Training procedure form, 5/3/24. For management and their staff to demonstrate knowledge of Benchmark Human Service's Emergency Preparedness Program including preparation, response, recovery, and testing plans. Staff will understand their roles and responsibilities in	05/03/2024

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	July 2023 to Jan 2024 The last drill documented for night shift was 6/9/23. The next drill completed and documented on the night shift was in 2024. Night shift hours for the group home are from 11:00 PM to 6:00 AM. This affected clients A, B, C, D, E and F. On 4/4/24 at 4:15 PM, the Residential Director (RD) was interviewed. The RD indicated drills should have been conducted once per shift per quarter. The RD indicated the facility had a schedule to follow for all shifts to be covered in the month. The RD did not provide documentation for the missing drills. 9-3-7(a)		meeting the health, safety, and security needs of our clients during an emergency or disaster, community response and resources and Benchmark response and resource sharing as applicable. Also, making sure that all Drill documentation is accessible and available at any time. This will help ensure that Fire/Tornado drills are done correctly, completed, and stored properly in the EPP books within the home. The residential managers will conduct an audit of their EPP book to make sure that all drills are completed and currently stored in its proper place (3) times monthly for a month. (1) times monthly ongoing.	