

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G792	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/14/2021
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 9285 W CR 950 N ELIZABETHTOWN, IN 47232
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00355363.</p> <p>Complaint #IN00355363: Unsubstantiated; due to a lack of sufficient evidence.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: 6/10/21, 6/11/21 and 6/14/21.</p> <p>Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/24/21.</p>	W 0000		
W 0153  Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on observation, record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure an allegation of abuse toward client A was immediately reported to the administrator.</p> <p>Findings include:</p> <p>On 6/14/21 at 10:09 AM, a review of the Bureau of Developmental Disabilities Services (BDDS)</p>	W 0153	<p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice;</b></p> <p>The allegation was investigated and staff that failed to report suspicions were suspended and retrained on reporting process immediately. All staff will be</p>	07/14/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>incident reports and accompanying Investigative Summaries was completed. The reports indicated:</p> <p>BDDS report dated 6/11/21 indicated, "On 6/10/21 a complaint survey was opened regarding an allegation of suspected abuse. It was discovered during a preliminary investigation the allegation was physical abuse towards [client A]. Based on early information the incident may have occurred on 5/19/21. The staff person accused was immediately suspended as were two staff that failed to follow Benchmark policy with regards to reporting ...".</p> <p>Investigation Summary dated 6/13/21 indicated, "Brief summarization of the initial allegation: That staff [staff #1] smacked [client A] and caused a black eye. Disposition of the investigation: Unsubstantiated ... Summary of Analysis of Findings: [Staff #2] did report as required as a mandated reporter ... She also reported her suspicions to her immediate supervisor but did not indicate it was an allegation. Just a feeling. The supervisor said she reported to the Director who in turn failed to pick up on the report as an allegation as well. [Staff #3] failed to report to anyone until the day the complaint survey was initiated that [staff #1] had smacked [client A] in the face with an open hand ...".</p> <p>Observation was conducted on 6/10/21 from 12:08 PM to 2:22 PM. At 12:13 PM, client A was seated at the table eating her lunch. Client A had a pea sized red spot below her left eye. At 1:15 PM, client A was asked about the red mark under her left eye. Client A stated, "Somebody punched me in the eyeball. It was this evil fat guy. Chubby as h--- ...".</p>		<p>retrained to report any behavioral incidents or injuries to the Director for review. The staff that failed to report and/or follow policy were retrained on 6/10/21.</p> <p>¿ <b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All residents have the potential to be affected by staff failing to report suspicions of ANE. All staff in the home will be retrained using competency based training.</p> <p>¿ <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur;</b> Routine camera reviews will be completed and documented. All behavioral incidents and medical incidents will also be reported and reviewed. Managerial/ Professional staff will also report any injuries or behavioral incidents to the Director for review. Routine camera reviews began on 6/14/21.</p> <p>¿ <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and</b> Managerial and Professional staff</p>	

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	<p>Confidential interview (CI) #1 stated, "I believe you have the pictures of [client A's] eye". CI #1 stated, "The pictures I took were about 2 days old. I've hurt myself many ways, I don't see how you black your eye on a door. She had the eye (bruising) and a bruise under her chin". CI #1 indicated CI #1 had never seen someone hit client A and stated, "I would be on the horn. Like I said, I was just trying to connect the dots. Nobody saw it (client A being hit)". The CI #1 was asked if the suspected abuse had been reported to the provider agency and stated, "No, no. Everybody else saw it and formed their own opinion on the situation".</p> <p>CI #2 was asked about client A's red mark under her left eye. CI #2 stated, "Which red mark, under her left eye? That's because she was (hit). I witnessed it". CI #2 was asked if CI #2 witnessed the incident. CI #2 shook his head yes. CI #2 indicated the alleged incident of client A being hit in the eye occurred on the same date as when client A had slipped and fell. CI #2 stated, "She slipped and fell getting undressed for her shower. It was that day. I immediately called [Nurse] to let her know". CI #2 was asked if the fall happened in the morning. CI #2 stated, "Yeah". CI #2 was asked if CI #2 actually saw client A get hit. CI #2 stated, "Yeah". CI #2 was asked what CI #2 did after seeing client A being hit. CI #2 stated, "I immediately called management. I can't remember who ...".</p> <p>On 6/10/21 at 4:04 PM, the Regional Director (RD) and Vice President (VP) were interviewed. The RD and VP were asked about protection of client A concerning alleged mistreatment and/or abuse. The VP stated to the RD, "Identify what the allegation is. Then when we get people over</p>		<p>to notify Director or other authorized personnel to review any reports of injury or behavioral issues resulting in injury in order to review incident as soon as possible. All reported incidents will be reviewed and documented by the Director.</p> <p>¿ What is the date by which the systemic changes will be completed. 7/14/21</p>	

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	<p>to the home and relieve them (suspend staff and investigate)". Both the RD and VP indicated they were unaware of any alleged mistreatment and/or abuse of client A.</p> <p>On 6/11/21 at 6:49 AM staff #5 was interviewed. Staff #5 was asked about client A's red mark under her left eye. Staff #5 stated, "I believe what happened is she had a dramatic moment or behavior, she may have spun and hit her door ... I did not see anything, but from reading the reports, I believed that it was her behavior when she spun around and hit her door ...". Staff #5 indicated he did not suspect abuse and did not have a reason to report suspected abuse of client A.</p> <p>On 6/11/21 at 7:05 AM, staff #6 was interviewed. Staff #6 was asked about client A's red mark under her left eye. Staff #6 stated, "I heard from a seizure. She either hit the wall or corner of the wall. I looked. There were seizure papers made out for it". Staff #6 was asked if she had ever witnessed mistreatment of client A by anyone. Staff #6 indicated no. Staff #6 stated, "We have the one that likes to exaggerate everything". Staff #6 was asked to whom she was referring. Staff #6 stated, "[Client B]. She tells stories from her past and that it changes 4 or 5 times. [Client A] doesn't know. She might tell you god or her family". Staff #6 indicated clients A and B would not be consistent and reliable with their responses to questions. Staff #6 indicated she did not suspect abuse and did not have a reason to report suspected abuse of client A.</p> <p>On 6/11/21 at 7:15 AM, staff #4 was interviewed. Staff #4 was asked about the red mark under client A's left eye. Staff #4 stated, "Her nursing note said she hit her door. That's</p>			

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	<p>what her nursing notes said...". Staff #4 was asked if she had ever witnessed mistreatment of client A by anyone. Staff #4 stated, "[Regional Director] asked if [client A] had ever said [staff #1] had hit her. I told [Regional Director] no, she (client A) will say that guy hit me, but she thinks [client B] is a guy. She has thought that since [client B] got here (moved into the home). When [client B] got here, [client B] had half of her hair shaved. [Client A] thinks short hair is a guy. She does, she thinks short hair is a guy". Staff #4 indicated she did not suspect abuse and did not have a reason to report suspected abuse of client A.</p> <p>On 6/11/21 at 10:35 AM, the RD was interviewed. The RD was asked about the status of the investigation in client A's alleged mistreatment and abuse. The RD stated, "I do know [staff #3's] reporting of [staff #1] was not reported. Yesterday (6/10/21) was the first time anybody heard of that ...". The RD indicated staff training for reporting suspected abuse, routine camera reviews and management staff would notify her of any client A injury or behavior of client A resulting in injury for further monitoring. The RD indicated staff should report any suspected or alleged abuse, neglect and mistreatment immediately to administration.</p> <p>9-3-2(a)</p>			