STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
W 0000 Bldg. 00	This visit was for the pre-determined full annual recertification and licensure survey. This visit included a COVID-19 focused infection control survey. This visit was in conjunction with the investigation of complaints #IN00324651 and #IN000326062. Dates of Survey: 3/2, 3/3, 3/4, 3/5, and 3/12/21. Facility number: 012371 Provider number: 15G764 AIM number: 200986870 The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/29/21.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 sampled clients (A, B, and C) plus 5 additional clients (D, E, F, G, and H), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure broken furniture was removed from the group home and repairs in the home were completed. Findings include: Observations were completed in the group home on 3/2/21 from 3:50 PM through 5:51 PM and on	W 0104	Broken furniture was removed from the home and needed repairs were completed. Two new sitting chairs were purchased and the two old ones were disposed of. The hole on the front side of the hallway bathroom was repaired. The hole in client B's room next to his closet was repaired. The blinds in client E's room were replaced. To ensure maintenance and	04/11/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	3/3/21 from 6:12 AM through 8:06 AM. Throughout both observation periods there was a 2"(inch) by 3" hole on the front side of the hallway bathroom door and a 2" by 1" hole on the back of the hallway bathroom door. There was a 3" hole in client B's room next to the closet opening. The blinds in client E's room had 3 broken slats. There was a cloth chair in the back living room which had a sunken in cushion and appeared broken. There was a cloth chair in the main living room with a 3 inch rip in the cloth on the back side of it. The repairs and broken furniture affected clients A, B, C, D, E, F, G, and H. The Residential Manager (RM) was interviewed on 3/2/21 at 5:18 PM. The RM indicated the 2 cloth chairs were broken due to client B sitting on them and breaking them. The RM stated the holes in the doors, walls, and broken blinds had been broken for "at last a couple of months" and only emergency repairs were being completed in the group home. The Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The RD indicated she was unaware of repairs needing to be completed in the group home or broken furniture. The RD indicated staff should fill out maintenance request forms and the repairs can be scheduled. The RD indicated the broken furniture should be removed from the homes and new furniture should be ordered. 9-3-1(a)		repairs are completed at the group home in a timely manner, the management was retrained on Environmental checks - CQA's. These are completed monthly. To ensure compliance with the training and that repairs are identified and addressed, CQA's will be completed twice a month for 3 months. Also an additional monitoring form is being implemented. This form is a check off that the manager acknowledges any new needed repairs and the date they were observed/discovered and reported to Talon for repair. It also includes when the repair was completed. This will be turned into the residential director monthly for compliance.	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 22 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to implement their Abuse, Neglect, and Exploitation Policy to ensure client A was not neglected and had appropriate staff supervision. Findings include: The facility's BDDS reports were reviewed on 3/2/21 at 11:24 AM and indicated the following: A 2/1/21 BDDS report indicated " ...On 1/31/21 [client A] wanted to out and shovel driveways due to the snowstorm. He grabbed the shovel out of the garage and said he wanted to go through the neighborhood and see who needed their driveway shoveled. Staff informed [client A] that he could shovel the group home driveway but could not walk all over the neighborhood due to recently recovering from Covid (respiratory disease). [Client A] got angry and ran out the door with his shovel in hand. Staff made notifications and staff were in route to get [client A]. [Client A] did have appropriate clothing on when he was out (snow wear/boots/gloves etc.). [Client A] made it to [name of road]. He was gone approximately 45 minutes total. A police officer saw [client A] and transported him back to the group home where the residential director and BC (Behavior Consultant) were there to greet him. [Client A] was not angry, he just wanted to shovel and make some money he reported. He reported he was not cold and did not have any injuries or complaints. [Client A] was counseled on making better choices and he expressed an understanding. [Client A] went inside the group home with the manager who came in to assist. [Client A] did not have any issues the remainder	W 0149	All staff were retrained on the Abuse and Neglect Policy. A competency test was also given to all staff regarding what constitutes neglect and that not ensuring appropriate levels can be considered neglect. Client A's BSP was reviewed and revisions were made to his BSP. The BCBA was consulted for recommendations and function of client A's behavior. His BSP includes elopement. This section was reviewed and additional protective measures were added to his plan to ensure his safety. Proactive measures were added to assist client A with handling anger/frustration over not being able to obtain a desired activity immediately. Client A's psychiatrist will also be contacted to discuss his impulsivity and any needed medication adjustments. Client A will also be integrated back into the workshop setting after a year due to the pandemic and this will help client A with his productivity and meaningful day. If client A elopes from the group home, the police will be notified (911) immediately. The other administrative notifications will be made as well. This will assist client A to be located sooner. The group home staff will also still follow the missing person's policy and follow client A. Client A will also have a formal objective added	04/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	of the day ...". A 4/28/20 BDDS report indicated " ...On 4/27/20 at 10:55am, the residential director received a call from the residential manager. She reported that [client A] was frustrated with not being able to work and make money (due to the Covid-19 quarantine) and while outside, [client A] ran off from the group home. Staff were not able to locate him. Communications were made and numerous Benchmark staff members started driving and searching for [client A]. The [name of city #1] Police were called and the residential director followed their direction (per their new COVID-19 guidelines) for following a missing person report. [report number]. The residential director received a call at 2:59pm from the [name of county] Sheriffs office that [client A] was located near [name of highway] marker 323 approximately half way between [name of city #1] and [name of city #2] (12.5 miles). [Client A] complained to the deputies that his side hurt so the paramedics took [client A] to [name of hospital] for assessment. [Client A] was diagnosed with constipation and given an enema. All other tests and labs came back within normal limits. No injuries noted. His group home managers transported [client A] back to his group home. He showered, ate and went to bed for the evening with no issues ...". A 4/5/20 BDDS report indicated " ...On 4/4/20 at 10:30am, the residential director received a call from the residential manager. She reported that [client A] had become angry at another peer in the group home and had ran (sic) out the front door. The QIDP and another staff were at the home. The QIDP followed [client A] out of the door and ran after him. [Client A] proceeded through the housing addition and across the golf course. The QIDP continued to follow him but lost sight of		to his ISP for safe pedestrian skills. Client A will also have a formal objective added for stranger/danger and community safety. for All staff will be trained on his new ISP objectives/BSP. These interventions will help ensure that client A is safe and that he is monitored with the appropriate staffing supervision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	him. [Client A] is a very fast walker and runner. The QIDP called for assistance to the manager and residential director, immediately communications were made and six Benchmark staff were driving and searching for [client A]. The [name of city #1] Police were called and the residential director followed their direction (per their new COVID-19 guidelines) for filing a missing person report. However, [client A] was found before that report could be formally made. [Client A] was located in [name of city #2] (15 miles) at [name of retail store] and the [name of city #2] police brought him back to the group home. [Client A] has told two different stories how he got to [name of city #2]. One was that he walked to [name of city #2] and the other was that he got a ride. He told the [name of city #2] police that he walked to [name of city #2]. However due to the amount of time he was gone (approximately 2 1/2 hours) it is not likely that he walked to [name of city #2]. [Client A] will fabricate stories as indicated in his BSP (Behavior Support Plan), so it is difficult to determine ...The residential managers, QIDP, nurse, residential director and guardian were all notified of the incident. [Client A] was assessed by the manager/QIDP and did not have any injuries...Both the manager and the QIDP were present and gave additional support. [Client A] expressed an understanding of handling his anger frustration with his peers in an appropriate manner and not running out. It was also discussed with [client A] the dangers of elopement and being in the community and accepting rides from others (which at that time he denied getting a ride)...". Client A's record was reviewed on 3/3/21 at 1:31 PM. Client A's 5/1/20 Behavior Support Plan (BSP) indicated he had a behavior of elopement. Client A's 5/1/20 BSP indicated " ...Reactive Strategies			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	For Elopement: 1. Walk with [client A]. 2. Ask him to return home with you. 3. Set a distance [client A] is allowed to travel once his outside of his area. 4. Reward positive action. Be friendly and attentive when he returns home. If [client A] gets out of supervision of staff Benchmark Policy and Group Home Procedure for Missing Persons will be followed ...". Client A's 4/6/20 Group Home Individual Support Plan Assessment (GHISPA) indicated client A could not independently look both ways before crossing a street, cross the street safely, recognize dangers of a moving vehicle, demonstrate personal safety, and understand the concept of strangers. The 4/6/20 GHISPA indicated client A can easily be taken advantage of by peers, strangers, and acquaintances. Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The RD stated she did not feel "that staff was neglectful. [Client A] is fast and they followed him until they lost sight of him and followed his plan." The facility's 11/1/2014 policy and procedure for Abuse, Neglect, and Exploitation was reviewed on 3/5/21 at 1:00 PM. The policy and procedure defined neglect as "...failure to provide appropriate supervision, care, or training...". 9-3-2(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility failed to develop a plan or goal to address client A's pedestrian safety skills in the community and client B's increased weight gain since moving into the group home and refusals to wear a mask for doctor's appointments. Findings include: 1. The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 3/2/21 at 11:24 AM and indicated the following: A 2/1/21 BDDS report indicated " ...On 1/31/21 [client A] wanted to out and shovel driveways due to the snowstorm. He grabbed the shovel out of the garage and said he wanted to go through the neighborhood and see who needed their driveway shoveled. Staff informed [client A] that he could shovel the group home driveway but could not walk all over the neighborhood due to recently recovering from Covid (respiratory disease). [Client A] got angry and ran out the door with his shovel in hand. Staff made notifications and staff were in route to get [client A]. [Client A] did have appropriate clothing on when he was out (snow wear/boots/gloves etc.). [Client A] made it to [name of road]. He was gone approximately 45 minutes total. A police officer saw [client A] and transported him back to the group home where the residential director and BC (Behavior Consultant) were there to greet him. [Client A] was not angry, he just wanted to shovel and make some money he reported. He reported he was not cold and did not have any injuries or complaints. [Client A] was counseled on making	W 0227	The team met for client A and discussed his ISP objectives and his pedestrian safety skills. The ISP assessment was utilized. Client A will have a formal objective added to his ISP for safe pedestrian skills (looking both ways before crossing the street). Client A will also have a formal objective added for stranger/danger and community safety. All staff will be trained on his new ISP objectives/BSP. These interventions will help ensure that client A is safe and that he is monitored with the appropriate staffing supervision. The team for client B met and discussed his weight gain since his admission. Client B was admitted during the pandemic and during a time with less community involvement. Client B was also admitted from his family home in which food was not as accessible. Client B gained 15 pounds from May 2020 to December 2020. A formal goal was added to his ISP to exercise daily by walking (either on the tredmill or outside) for 20 minutes. The nurse will monitor his weight monthly and notify the dietitian for any recommended diet changes. All the other clients in the group homes weight and diets were reviewed to ensure that their	04/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	better choices and he expressed an understanding. [Client A] went inside the group home with the manager who came in to assist. [Client A] did not have any issues the remainder of the day ...". A 4/28/20 BDDS report indicated " ...On 4/27/20 at 10:55am, the residential director received a call from the residential manager. She reported that [client A] was frustrated with not being able to work and make money (due to the Covid-19 quarantine) and while outside, [client A] ran off from the group home. Staff were not able to locate him. Communications were made and numerous Benchmark staff members started driving and searching for [client A]. The [name of city #1] Police were called and the residential director followed their direction (per their new COVID-19 guidelines) for following a missing person report. [report number]. The residential director received a call at 2:59pm from the [name of county] Sheriffs office that [client A] was located near [name of highway] marker 323 approximately half way between [name of city #1] and [name of city #2] (12.5 miles). [Client A] complained to the deputies that his side hurt so the paramedics took [client A] to [name of hospital] for assessment. [Client A] was diagnosed with constipation and given an enema. All other tests and labs came back within normal limits. No injuries noted. His group home managers transported [client A] back to his group home. He showered, ate and went to bed for the evening with no issues ...". A 4/5/20 BDDS report indicated " ...On 4/4/20 at 10:30am, the residential director received a call from the residential manager. She reported that [client A] had become angry at another peer in the group home and had ran (sic) out the front door. The QIDP and another staff were at the home. The		plans address any weight or diet issues. Client B was admitted during the pandemic. He did not have an admission vision, hearing or dental evaluation. A goal was added for client B to his ISP to wear a mask. This will help ensure that client B can go to medical appointments safely. Also, hearing evaluation, dental exam and vision exam will be scheduled. The QIDP will report monthly on client B's progress on his tolerance to wear a mask and his medical appointments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	QIDP followed [client A] out of the door and ran after him. [Client A] proceeded through the housing addition and across the golf course. The QIDP continued to follow him but lost sight of him. [Client A] is a very fast walker and runner. The QIDP called for assistance to the manager and residential director, immediately communications were made and six Benchmark staff were driving and searching for [client A]. The [name of city #1] Police were called and the residential director followed their direction (per their new COVID-19 guidelines) for filing a missing person report. However, [client A] was found before that report could be formally made. [Client A] was located in [name of city #2] (15 miles) at [name of retail store] and the [name of city #2] police brought him back to the group home. [Client A] has told two different stories how he got to [name of city #2]. One was that he walked to [name of city #2] and the other was that he got a ride. He told the [name of city #2] police that he walked to [name of city #2]. However due to the amount of time he was gone (approximately 2 1/2 hours) it is not likely that he walked to [name of city #2]. [Client A] will fabricate stories as indicated in his BSP (Behavior Support Plan), so it is difficult to determine ...The residential managers, QIDP, nurse, residential director and guardian were all notified of the incident. [Client A] was assessed by the manager/QIDP and did not have any injuries...Both the manager and the QIDP were present and gave additional support. [Client A] expressed an understanding of handling his anger frustration with his peers in an appropriate manner and not running out. It was also discussed with [client A] the dangers of elopement and being in the community and accepting rides from others (which at that time he denied getting a ride)...".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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

Client A's record was reviewed on 3/3/21 at 1:31 PM. Client A's 5/1/20 Individual Support Plan (ISP) did not indicate he had a goal to teach him about pedestrian safety. Client A's 4/6/20 Group Home Individual Support Plan Assessment (GHISPA) indicated client A could not independently look both ways before crossing a street, cross the street safely, recognize dangers of a moving vehicle, demonstrate personal safety, and understand the concept of strangers. The 4/6/20 GHISPA indicated client A can easily be taken advantage of by peers, strangers, and acquaintances.

Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The RD indicated client A did not have a goal for pedestrian safety and could benefit from having one due to his elopement risk.

2. Client B's record was reviewed on 3/4/21 at 11:27 AM. Client B's record indicated he was admitted into the group home on 4/17/2020. Client B's record indicated he had gained 15 pounds between the months of 5/2020 to 12/2020. Client B's record indicated he had not been seen or assessed for his hearing, vision, or dental. The facility was unable to provide current vision, hearing, or dental assessments.

Client B's 6/1/20 ISP did not indicate he had a goal to encourage him to exercise or a goal to encourage him to practice wearing a mask.

Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The agency LPN indicated client B had gained weight but did not appear to be overweight. The agency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	LPN indicated it had been hard to get the clients active due to the pandemic. The agency LPN indicated a goal to exercise more could help him lose some weight. The RD indicated client B was not able to wear a mask for long periods of time and could benefit from practicing wearing a mask in the group home, so he could be able to go to doctor's appointments. 9-3-4(a)			
W 0264 Bldg. 00	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.			
	Based on observation, record review, and interview for 1 of 3 sampled clients (B), the facility failed to obtain HRC (Human Rights Committee) approval for the restriction of client B's remote controllers during the sleeping hours. Findings include: Observations were completed in the group home on 3/3/21 from 6:12 AM through 8:06 AM. At 7:24 AM, the Residential Manager pulled out 2 remote controllers from a box located on top of the computer hutch. The RM stated they were client B's remote controllers to his television and staff #1 "probably put them in here because [client B] will wake up in the middle of the night and turn his television up to the highest volume. Staff can't get him to turn it down and then it wakes up all the	W 0264	The team met for client B and discussed his BSP related to if a restriction is needed for his 2 remote controllers. The team agreed that the 2 remote controllers needed to be listed in his BSP as restrictions. This is put in place due to client B waking up in the middle of the night and turning the volume up to the highest levels. The restriction was added to the BSP and the QIDP will ensure that HRC approval is obtained for the restriction. This restriction will be addressed monthly by the QIDP in the monthly behavior report. All staff were trained on the new BSP with	04/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	other clients in the home." Client B's record was reviewed on 3/4/21 at 11:27 AM. Client B's record indicated there was no Human Rights Committee (HRC) approval for the restriction of client B's remote controllers during the sleeping hours. Client B's 6/1/20 Behavior Support Plan (BSP) did not indicate the need for a restriction of client B's remote controllers. Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The RD indicated the restriction of client B's remotes should be in a plan. The QIDP indicated she would contact client B's guardian to get the proper approval for the restriction and contact the HRC as well to get approval. 9-3-4(a)		the added restrictions. The BSP's for the others clients at this group home were reviewed to ensure that any restrictions were included in an approved BSP including HRC.	
W 0289 Bldg. 00	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review, and interview for 1 of 3 sampled clients (B), the facility failed to ensure the restriction of client B's remote controllers during the sleeping hours was included in a plan. Findings include: Observations were completed in the group home on 3/3/21 from 6:12 AM through 8:06 AM. At 7:24	W 0289	The team met for client B and discussed his BSP related to if a restriction is needed for his 2 remote controllers. The team agreed that the 2 remote controllers needed to be listed in his BSP as restrictions. This is put in place due to client B waking up in the middle of the night and turning the volume up to the	04/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	AM, the Residential Manager pulled out 2 remote controllers from a box located on top of the computer hutch. The RM stated they were client B's remote controllers to his television and staff #1 "probably put them in here because [client B] will wake up in the middle of the night and turn his television up to the highest volume. Staff can't get him to turn it down and then it wakes up all the other clients in the home." Client B's record was reviewed on 3/4/21 at 11:27 AM. Client B's 6/1/20 Behavior Support Plan (BSP) did not indicate the need for a restriction of client B's remote controllers. Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The RD indicated the restriction of client B's remotes should be in a plan. The QIDP indicated she would contact client B's guardian to get the proper approval for the restriction and contact the HRC as well to get approval. 9-3-5(a)		highest levels. The restriction was added to the BSP and the QIDP will ensure that HRC approval is obtained for the restriction. This restriction will be addressed monthly by the QIDP in the monthly behavior report. All staff were trained on the new BSP with the added restrictions. The BSP's for the others clients at this group home were reviewed to ensure that any restrictions were included in an approved BSP including HRC.	
W 0334 Bldg. 00	483.460(c)(3)(i) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination. Based on record review and interview for 3 of 3 sampled clients (A, B, and C), the facility failed to ensure clients A, B, and C had an in-person physical examination completed by a nurse. Findings include:	W 0334	Due to the pandemic, the Benchmark nurses did not go into the group homes over the past several month to complete client physical examinations due to the risk of exposure for all. In- person	04/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	Client A's record was reviewed on 3/3/21 at 1:31 PM. Client A's 12/5/20, 9/15/20, and 6/7/20 Quarterly Nursing Assessments (QNA) were completed virtually and not in person. Client B's record was reviewed on 3/4/21 at 11:27 AM. Client B's 12/5/20, 9/15/20, 6/7/20, and 4/20/20 QNAs were completed virtually and not in person. Client C's record was reviewed on 3/4/21 at 10:23 AM. Client #3's 12/5/20, 9/15/20, and 6/7/20 QNAs were completed virtually and not in person. Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The agency LPN indicated all assessments during COVID-19 (respiratory illness) had been completed virtually and documents had been reviewed. The agency LPN indicated she had not done an in-person assessment once COVID-19 had appeared around middle of March 2020. 9-3-6(a)		physical exams are now occurring as required. All the clients in this group home will have in- person physical examinations. Going forward, the residential director is scheduling the nurses to complete the in –person physical examinations at all the group homes. This will ensure that a review of the clients health status is by direct physical examination.	
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview for 1 additional client (D), the facility failed to ensure medications were administered according to physician's orders (PO). Findings include: Observations were completed in the group home on 3/3/21 from 6:12 AM through 8:06 AM. At 6:41	W 0369	To ensure that the clients medications are administered according to physicians orders, all staff were retrained on the Medication Administration Policy focusing on the RIGHT TIME. The staff were also retrained on client D's medication Pantoprazole to be	04/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	AM, staff #6 administered Pantoprazole Sod (sodium) DR (Daily release) (for Gastroesophageal reflux disease) 40 mg (milligrams) to client D. The medication administration punch card indicated client D was to take 1 tablet Pantoprazole Sod DR 40 mg 30 minutes before a meal. At 6:44 AM, client D sat down at the table and started eating his breakfast. Client D's record was reviewed on 3/5/21 at 12:00 PM. Client D's 3/2021 POs indicated client D was to take 1 tablet Pantoprazole Sod DR 40 mg " ...by mouth daily-30 minutes before meals." Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The agency LPN indicated staff should have made sure client D waited 30 minutes before eating after taking his Pantoprazole 40 mg. 9-3-6(a)		taken 30 minutes before a meal. The management staff will complete monitoring during medication administration 3 times weekly for 2 months, then 1 time weekly ongoing to ensure staff are administering medication as prescribed. These forms will be turned into the residential direction for compliance.	
W 0488 Bldg. 00	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 3 of 3 sampled clients (A, B, and C) plus 5 additional clients (D, E, F, G, and H), the facility failed to teach and encourage clients to help make dinner and help set the table for breakfast. Findings include: Observations were completed in the group home on 3/2/21 from 3:50 through 5:51 PM. At 3:50 PM, staff #1, staff #3, client A, and client D were in the group home. Clients B, C, E, F, G, and H were at	W 0488	All staff were retained on family style dining and allowing the clients to participate in the meal planning/preparing/table setting and serving their own food to the best of their ability to increase their independence. The principles of active treatment were also discussed. Competency testing was completed to ensure that the training was effective. Also –	04/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 00 B. WING	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(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
	the office for their vaccination appointments. At 4:01 PM, staff #3 went to the stove and was stirring food in a pot. Staff #3 pulled a pan of pork steak out of the oven and covered it with foil. Staff #3 continued to stir the food in 2 separate pots on the stove. In one pan was cabbage and carrots and in the other pan was water for the mashed potatoes. Staff #3 put biscuits on a foil lined pan and put them in the oven to cook. Staff #3 did not prompt clients A or D to help with cooking the food. At 4:18 PM, clients B, C, E, F, G, and H entered the home with the Residential Manager (RM) and Qualified Intellectual Disability Professional (QIDP) #2. Staff #3 did not prompt clients A, B, C, D, E, F, G or H to help with cooking dinner. At 5:03 PM, all of the clients sat down at the table to eat dinner. Observations were completed in the group home on 3/3/21 from 6:12 AM through 8:06 AM. At 6:12 AM, the kitchen table was set with dishes, cups, and silverware. The RM was interviewed at 8:00 AM and indicated staff #5 probably set the table before she left. The RD asked staff #2 who set the table this morning and staff #2 stated "the table was already set when I got here, so probably [staff #5]." The Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential Director (RD) were interviewed on 3/5/21 at 1:34 PM. The RD indicated clients should be prompted to help make dinner and set the table for breakfast. 9-3-8(a)		management will be monitoring dining times 3 times a week for 2 months then once weekly ongoing, focusing on clients being encouraged to be independent and participate in family style dining. These forms are turned into the residential director to ensure compliance.	