

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G764	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/06/2025
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP COD 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00451752.</p> <p>Complaint #IN00451752: Federal/state deficiencies related to the allegation(s) are cited at W149 and W156.</p> <p>Survey Dates: 1/31, 2/3, 2/4, 2/5 and 2/6/2025.</p> <p>Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/24/25.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>Based on observation and interview for 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, E, F and G), the facility's governing body failed to exercise operating direction over the facility to ensure the home was in good repair.</p> <p>Findings include:</p> <p>An observation at the group home was conducted on 2/4/25 from 3:30 PM to 5:30 PM. The following environmental issues were noted as affecting clients A, B, C, D, E, F and G:</p> <p>a) The outside of the windows around the entire</p>	W 0104	<p>W104 /p></p> <p>To maintain compliance all Benchmark Group Homes are required monthly to complete a Health and Wellness assessment of the homes. This assessment is due the 15th of each month and emailed to the homes Director. The Health and Wellness Assessment (H&W) is completed to ensure that Benchmark Human Services (Benchmark) monitors</p>	08/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Eldridge	Residential Director	03/08/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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>house had varying stages of disrepair. The outside of every window around the house was missing a portion of the wood that holds the glass in the window. Greater than 75% of each window around the entire home had chipped and peeling paint around the window casings.</p> <p>b) The dishwasher in the kitchen was observed to be balanced in place. The countertop didn't meet the top of the dishwasher. There was not a place on the current countertop that hung over far enough to help brace the dishwasher.</p> <p>An interview with Direct Support Professional (DSP) #1 was completed on 2/4/25 at 4:41 PM. DSP #1 indicated there was a new dishwasher ready for installation. DSP #1 stated, "the installer for the new dishwasher is citing safety reasons being the hold-up for our new dishwasher. Specifically, the group home needs a new countertop that will come over the dishwasher to hold it in place and the current lip of the countertop is too narrow and will not hold the dishwasher in place."</p> <p>c) The countertop had 3 worn away areas which left dark brown/blackened areas that were 7 inches by 2 inches, 1 inch by 2 inches and ½ inch by ½ inch. When cleaned, the areas stayed wet.</p> <p>d) A chair in the dining room at the far end of the kitchen nearest the kitchen sink had its right top corner chipped off leaving a wood-like surface behind that was rough and difficult to clean as clients completed their household chores.</p> <p>e) The flooring in the dining room and kitchen had worn patterns which created white streaks and patchy white areas on the floor. In the largest area there was a dining room chair and all four</p>		<p>the individual's health, safety, and service. The H&W must be conducted monthly for individuals receiving 24/7 residential services and/or who receive less than 24/7 services in their own house/apartment. This is not required when an individual receives residential services in their family's home.</p> <p>A walk through of the home was completed with Talon Custom Construction. On 2/21/25 an estimate of the total repairs and concerns made by the Surveyor was totaled, sent by Talon, to the Director. Total repair estimate of all concerns totaled to \$48,110.00 as of 2/21/25. Talon and the Director are developing a plan to complete all repairs quoted, ordering supplies, and which project will be the first to start. Management will continue to complete Health & Wellness Assessments monthly by the 15th and submit results to the Director via email. Management will track and schedule other repairs weekly or as needed and submit work orders in a timely manner to maintenance (Talon Custom Construction). Documentation of those visits will be completed on the Health & Wellness Assessment monthly, done by the Managers and the director will monitor for compliance. Additional management oversight will be conducted monthly for 3 months.</p>	

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	<p>legs of that chair had patches of white on them that extended beyond the borders of the chair's legs touching the floor. This also was noted around three areas in the dining room.</p> <p>f) Walking in the front door there was a rug covering a portion of the tiles laid as flooring in the entry way. When the rug was moved, multiple tiles were cracked and broken, and pebble-like substances mixed with a dirt-like substance were noted. The tiles were put back into place by the staff and the rug was replaced.</p> <p>An interview with DSP #1 was completed on 2/4/25 at 4:41 PM. DSP #1 stated, "The rug is the safety mechanism to keep clients from falling or using the cracked pieces of tile as weapons because the broken tiles are sharp and easily picked up by the clients in the home."</p> <p>g) Client A's room had areas of white on the peach-colored walls. When asked about the white areas, client A stated, "They came in and filled holes, but they left a few." Client A pointed to holes above her window. Client A stated, "The holes up there are from the curtain rods they took down. I've asked about getting to pick out a color but keep getting told to hang on, not now." Client A had some broken slats in her blinds and no other curtains hanging. Client A stated, "I would like to have a pretty room."</p> <p>h) In the adjoining bathroom shared by clients D, F and G, there was an exposed area under the whirlpool style tub where a board was missing. The whirlpool style bathtub wires from underneath the tub were sitting out and on the floor.</p> <p>An interview with DSP #1 was completed on</p>		Then monthly or until compliance can be verified.	

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W 0149 Bldg. 00	<p>2/4/25 at 4:41 PM. DSP #1 stated, "The clients aren't using the tub at this time and have been told not to touch the wires." DSP #1 indicated the workers were waiting for a part to complete the work order on the tub.</p> <p>i) In the adjoining bathroom shared by clients D, F and G, there were cracked and broken tiles with missing grout. The tiles with missing grout had a blackened substance in them.</p> <p>An interview with DSP #1 was completed on 2/4/25 at 4:41 PM. DSP #1 stated, "We are cleaning the floors but until it gets repaired there is only so much we can do."</p> <p>On 2/4/25 at 5:00 PM an interview with the House Manager (HM) was completed. The HM stated, "We have many things that need repaired or replaced and once a year I can turn in a survey of the needs. I did that a month ago and will see what they elect to fix in 2025. The clients' home should be kept up."</p> <p>On 2/5/25 at 3:47 PM an interview with the Residential Director (RD) was completed. The RD stated, "The clients' home should be in good repair."</p> <p>9-3-1(a) 483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>Based on record review and interview for 3 of 3 sampled clients (A, B and C) plus 4 additional clients (D, E, F and G), the facility failed to implement its written abuse, neglect and exploitation (ANE) policy and procedure (1) to prevent the substantiated neglect of clients A, B,</p>	W 0149	W149 Based on record review and interview for 3 of 3 sampled clients (A, B and C) plus 4 additional clients (D, E, F and G), the facility failed to implement its written	02/19/2025

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	<p>C, E and G by staff #4 when clients A, B, C, E and G were left unsupervised in the group home; and (2) to complete the investigation of client F's elopement incident within 5 working days affecting clients A, B, C, E, F and G.</p> <p>Findings include:</p> <p>The facility's BDS (Bureau of Disability Services) reports were reviewed on 2/4/25 at 12:45 PM.</p> <p>A 1/20/25 BDS report from 4:31 PM indicated "On 1/20/25 at approximately 4:31 PM, [client F] became upset when staff asked him if he had a package of cookies. [Client F] got his coat and headed to the door. The staff on duty called the manager at that time and reported that [client F] walked off from the group home. The staff also stated that she was the only staff present because the other staff scheduled, had not reported to work. The manager told the staff on shift to take 1 individual (client D) and to follow [client F] in the van. The manager advised the staff to have the other individuals go to their bedrooms as these individuals are fairly independent and can follow directions. [Client F] was located in the housing addition just 2 blocks away from the group home. [Client F] was out of eyesight and the other individuals were unsupervised for approximately 5 minutes.</p> <p>Plan to Resolve (Immediate and Long Term). The Residential Director, QIDP (Qualified Intellectual Disabilities Professional) Coordinator, Residential Managers, Nurse, and Guardian were all notified. An investigation was started immediately. It was determined that the on-duty staff never reported to the manager that the other staff had failed to report to work for their shift. The manager will be retrained on the Missing Person's protocol listed</p>		<p>abuse, neglect and exploitation (ANE) policy and procedure (1) to prevent the substantiated neglect of clients A, B, C, E and G by staff #4 when clients A, B, C, E and G were left unsupervised in the group home; and (2) to complete the investigation of client F's elopement incident within 5 working days affecting clients A, B, C, E, F and G.</p> <p>The internal investigation showed that the staff working was following the instruction of the Residential Manager. The manager told the staff on shift to take 1 individual and to follow peer in the van. The manager advised the staff to have the other individuals go to their bedroom as these individuals are fairly independent and can follow directions. The staff working was not suspended, due to the staff following the instruction of her manager. The investigation was completed and the allegation of Neglect, due to individuals being unsupervised for approximately 5 min, was substantiated. Per Benchmark's ANE policy, the group home failed to provide appropriate supervision for the 5 individuals left home alone. Also, none of the individuals involved had negative outcomes. The individual</p>	

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	<p>in the Group Home Emergency Procedures Policy. All staff will be retrained in this as well. All staff will be retrained on the appropriate staffing ratio for this group home and to report to the manager immediately if staff do not report to work as scheduled. [Client F] nor any other peers suffered any negative outcomes from incident. The team discussed the incident regarding [client F] and reviewed his BSP (Behavior Support Plan). He does have awol (absence without leave) listed in his plan. However, he has not engaged in this behavior for approximately 1 year. The team discussed that he is off of his routine due to the extreme (sic) cold weather and needing to stay home. This may have been a contributor. The Director went to the group home that evening and counseled [client F] on making better decisions."</p> <p>A 1/20/25 Follow Up BDS report indicated " ...4. Was staff suspended per IAC 460? There was no staff suspended, due to the staff following the instruction of her manager. 5. If not, what is the provider's policy on staff suspension during an investigation into ANE? ANE Policy states, if a Benchmark employee is accused of abuse, neglect or exploitation of an individual served they will be immediately suspended, and an internal investigation will be completed in 5 business days unless evidence is not available to make a final conclusion within 5 business days. An external investigation time frame will be determined by the entity conducting the investigation."</p> <p>A 1/21/25 Witness Statement Form indicated "At 3:18 PM [DSP #4] (Direct Support Professional) text (sic) me videos of clients start (sic) doing their daily goals. They were cleaning and riding the exercise bike. At the time [DSP #4] did not notify me that she was the only one working. In my mind its (sic) like a normal day. At 4:15 PM I</p>		<p>(TeetQui) BSP was reviewed and does not need revisions at this time. The staff person working with him at the time is a newer staff and will receive retraining on allowing choice with where TeetQui stores his personal food items.</p> <p>The investigation was completed in the 5 days given. All staff and Management were retrained on 2/19/25 on the Missing Person's protocol listed in the Group Home Emergency Procedure Policy. Appropriate staffing ration for this group home and to notify management immediately when staff does not report to work as scheduled to ensure appropriate staffing ratios.</p> <p>All staff and management were retrained on the Abuse, Neglect, and Exploitation Policy. A posttest will be completed for both training, to verify their understanding of the policy and specifically their responsibility to prevent ANE from occurring. Increase management oversight to ensure appropriate staffing ratios are in place. Documentation of those visits will be completed on the home visit form by the Managers and the director will monitor for compliance. Additional management oversight will be conducted 3 times weekly for 1 month. Then 1 time weekly for 1 month or until compliance can be</p>	

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	<p>gotten (sic) a text message from [DSP #4] that [client F] asking (sic) 'Did you tell [client F] he can have his [chocolate cookies] in his room!' 'I told him to label it with his name and put it in the pantry, (sic) he said that you told him he can keep it in his room!' At the time she still hasn't stated she was working alone. Next time I heard from her was at 4:25 PM, which was a phone call. [Client F] called at 4:22 PM upset stating he was going to run away. [Client F] asked 'why he could not have cookies in his room.' I replied '[Client F] we just got rid of bugs.' He then told me he was going to run away. And (sic) hung up the phone. At 4:25 PM [DSP #4] called stating [client F] was preparing to leave the home. I asked where is [staff #5], can he follow him. She stated, 'I'm the only one here the boys are usually late (sic).' I states (sic) why didn't you tell me your alone (sic), we just talked about this at the last house meeting reminding you that you shouldn't be here alone or feel overwhelmed on your shift. If so notify your managers.' She responded they are usually late so she was unaware. I told [DSP #4] to call [DSP #5] and to try and get in contact and I told her I will call [DSP #2] to see is (sic) she can meet [DSP #4] and [client F] at the [name] because [HM (House Manager) #1] knew [DSP #2] could beat [HM #1] faster to the scene. Before hanging up I (HM #1) told [DSP #4] to tell peers to go to there (sic) rooms and take [client D] with you and to follow after [client F]. I told her to place them in their rooms due to clients were getting upset and I was panicking, worried and scared due to she was working alone.</p> <p>At 4:27 PM I called [DSP #2] after we hung up and she did not answer. At 4:28 PM I (HM #1) texted in group text 'Is anyone available like right now!!' and no one responded. While waiting on responses I waited until 4:32 PM and called the</p>		verified.	

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	<p>[Residential Director (RD)] and told him the situation. At 4:40 PM I was heading over to [street name] group home. At 4:44 PM [DSP #4] called me stating he's at the stop sign and he turning (sic) back around to go home but refused to get in the van. At 4:51 PM the [RD] called stating he was in the area but did not see the (sic). I told the [RD] that they are back at the house and that I was in the area as well. I arrived at 4:58 PM. When I arrived [DSP #4] and the [RD] was (sic) in the home already. [DSP #5] was supposed to work 3:00 PM to 9:00 PM. After stating Friday that him and another staff will be switching on 1/17/25 (sic). Due to miscommunication as [DSP #5] stated he was not suppose (sic) to work. [DSP #5] came into work later and worked the shift."</p> <p>A 1/25/25 Investigative Report Summary (IRS) that was still in progress indicated "The internal investigation showed that the staff working was following the instruction of the [Residential Manager/RM]. The manager told the staff on shift to take 1 individual and to follow peer in the van. The manager advised the staff to have the other individuals go to their bedroom as these individuals are fairly independent and can follow directions. The staff working was not suspended, due to the staff following the instruction of her manager. The investigation was completed and the allegation of Neglect, due to individuals being unsupervised for approximately 5 min, was unsubstantiated, due to the staff following the instruction of her manager. Also, none of the individuals involved had negative outcomes. The individual [client F's] BSP was reviewed and does not need revisions at this time. The staff person working with him at the time is a newer staff and will receive retraining on allowing choice with where [client F] stores his personal food items."</p>			

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	<p>A review of the 1/20/25 BDS report, Follow Up BDS Report and IRS indicated: An investigation was not completed within 5 working days. The group home staff were not competently trained when a client elopes, reporting when staff doesn't show for their scheduled shift, or on allowing client choice for personal food items in the group home. The Residential Manager (RM) did not ensure appropriate staffing ratios were in place for this shift. The RM was not competently trained on the missing person's protocol.</p> <p>A review of client records indicated the following: Client A's record was reviewed on 2/4/25 at 12:30 PM. Client A's 6/1/24 BSP indicated "Methods of intervention: ...3. Staff will always maintain visual supervision of [client A] while she is awake except when she is in the restroom. Also, when in the community [client A] needs to stay within eye site (sic) of staff." 4. Any time [client A] is in her room ...the house alarm while (sic) need to be activated because of her past history of elopement while at other provider ...History of: elopement: Leaving or attempting to leave without supervision. Restriction: Door and Window Alarms - because of the extensive collateral data obtained concerning the frequency of wandering type behavior, window alarms are required to ensure safety. This device is a magnetic sensor that sounds an alarm when the magnetic connection is broken ...Reduce incidents of elopement to no more than 1 incidents per month for 6 consecutive months ... History of: a. Elopement: leaving or attempting to leave without supervision ... She is to be in eye sight (sic) of staff and should be encouraged to interact appropriately with peers</p>			

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	<p>...Restrictions ...Door and Window Alarms- Because of the extensive collateral data obtained concerning the frequency of wandering type behavior, window alarms are required to ensure safety. This device is a magnetic sensor that sounds an alarm when the magnetic connection is broken. This device is not a lock ...Goals ...[Client A] will reduce targeted behaviors: ...Reduce incidents of Elopement to no more than 0 incidents per month for 6 consecutive months"</p> <p>Client B's record was reviewed on 2/4/25 at 9:53 AM. Client B's 5/1/24 BSP indicated "Restrictions ...Door and Window Alarms- Because of the extensive collateral data obtained concerning the frequency of wandering type behavior, window alarms are required to ensure safety. This device is a magnetic sensor that sounds an alarm when the magnetic connection is broken. This device is not a lock. Annual Goals: [client B] will reduce his (sic) incidents of escape, verbal aggression, and physical aggression."</p> <p>Client C's record was reviewed on 2/4/25 at 8:52 AM. Client C's 10/1/24 BSP indicated " ...Targeted behaviors that are historical for [client C] are Calling 911 and Elopement Restrictions ...Door and Window Alarms- Because of extensive collateral data obtained concerning the frequency of wandering type behavior, window alarms are required to ensure safety. The device is a magnetic sensor that sounds an alarm when the magnetic connection is broken. The device is not a lock"</p> <p>Client E's record was reviewed on 2/4/25 at 1:15 PM. Client E's 10/1/24 BSP indicated "Elopement:</p>			

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	<p>[Client E] has a history of eloping. This is a historical behavior that occurs when he is living in the family setting that will reappear when faced with something he is not wanting to doVIII. Functional: Elopement: The function of elopement appears to be to escape from tasks, demands, or peer interactions. Typically [client E] will engage or threaten to engage in elopement behaviors when tasks are presented that are difficult for him, or something that he does not want to do. This often occurred in the classroom setting at the previous placement. [Client E] will also engage in wandering in the community when he is wanting access to items that he wants</p> <p>Justification of Restrictive Procedures ...According to he (sic) Group Home Individual Support Plan Assessment inclusive of collateral data, historical and current record reviews, current environmental observations, and current staff interviews he following precautionary restrictions are necessary in he (sic) current living environment ...3. Door Alarms- Because of the extensive collateral data obtained concerning the possibility of elopement behavior door alarms are required to ensure safety. This device is a magnetic sensor that sounds an alarm when the magnetic connection is broken. This device is not a lock."</p> <p>Client F's record was reviewed on 2/4/25 at 1:30 PM. Client F's 11/1/24 BSP indicated " ...Other Targeted Behavior: ...Elopement: when [client F] willingly leaves the group home or workshop area. Antecedent (cause): [Client F] is not getting the attention that he feels he needs or wants. He is agitated and not responding to redirection. Strategy when [client F] elopes: Keep [client F] in eyesight at all times. Ask [client F] to return to the building with you.</p>			

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP COD 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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	<p>Supervise [client F] at all times while outside the building implementing his BSP Once [client F] decides to return to the home or building walk with him to the building/home. Minimize conversations with [client F] while walking back ... Restrictions Door and Window Alarms- Because of the extensive collateral data obtained concerning the frequency of wandering type behavior, window alarms are required to ensure safety. This device is a magnetic sensor that sounds an alarm when the magnetic connection is broken. This device is not a lock. Annual Goals: ... [client F] will have zero incidents of elopement for six months."</p> <p>Client G's record was reviewed on 2/4/25 at 1:45 PM. Client G's 5/1/24 BSP indicated "Targeted Behaviors: Elopement: [client G] leaving his residence without telling anyone where he is going. When asked he will either refuse to answer or become physically aggressive.</p> <p>Reactive Strategies for Elopement: If [client G] AWOL off Benchmark property; call 911 for police to pick up. Reward positive action. Be friendly and attentive when he returns home. If [client G] gets out of supervision of staff, Benchmark Policy and Group Home Procedure for Missing Persons will be followed.</p> <p>Staff should take note of his location, what he is wearing and what direction he is heading and report to manager right away to ensure that the police have that information as well ...Restrictions: ...Door Alarms- The home that [client G] resides in has door alarms to announce to the staff which door is opened to allow staff to keep [client G] safe due to his past history of elopement</p>			

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	<p>behaviors. Supervision While Outside: Based on historical information and recent behavioral incidents, [client G] will not be able to be outside of the group home without direct staff supervision. [Client G] has a history of attempting to operate dangerous machinery, and recent incidents have occurred for the need for this restriction. Anytime that a door of the group home is opened, an alarm sounds. If [client G] is attempting to go outside, staff must go outside with him. The team will re-evaluate this restriction monthly to determine the continued need. Annual goals: [Client G] will reduce targeted behaviors of elopement, stating he's hurt, and physical aggression ... [client G] will reduce incidents of elopement from 4 to 3 for six months."</p> <p>On 2/4/25 at 5:00 PM an interview with the House Manager (HM) was completed. The HM stated, "I panicked when I found out the staff was by herself. None of the clients should have been left home alone."</p> <p>On 2/5/25 at 3:47 PM an interview with the Residential Director (RD) was completed. The RD stated, "The clients should never have been left at home alone. Everyone should have been placed in the van and as a group they should have gone and looked for him. We should have followed our missing person's policy. The investigation should have been completed within the 5 working days."</p> <p>On 2/4/25 at 3:00 PM the facility's ANE policy was reviewed.</p> <p>A 2/26/24 Abuse, Neglect, and Exploitation Policy - Indiana. Purpose: To educate and inform individuals served, employees, contractors, and volunteers of definitions and reporting requirements for abuse, neglect, and exploitation ...</p>			

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	<p>Description:</p> <p>Benchmark Human Services (Benchmark) does not tolerate abuse, neglect or exploitation in any form by any person. Benchmark strives to be proactive in preventing incidents of abuse, neglect, and exploitation (A-N-E) against the individuals served. Benchmark promotes a culture of openness and honesty in talking about and reporting potential abuse. All staff have a duty to report incidents if they have witnessed or have knowledge thereof, to their supervisor ... Alleged, suspected, or actual abuse, neglect, or exploitation of a participant. An incident in this category must also be reported to Adult Protective Services (APS) or Child Protective Services (CPS) or the Department of Child Services (DCS) as applicable. Staff involved in an incident will be suspended from duties pending the outcome of the investigation. If APS, CPS, or DCS has reason to believe that a participant is endangered, they will investigate the complaint or cause the complaint to be investigated by law enforcement or another agency and make a determination as to whether the participant is endangered.</p> <p>Abuse, neglect and exploitation are defined as follows:</p> <p>...B. Neglect includes but is not limited to, failure to:</p> <ol style="list-style-type: none"> 1. Provide appropriate supervision, 2. Train ...Failure to report suspected abuse is considered neglect and directly against agency policy. If a Benchmark employee is accused of abuse, neglect or exploitation of an individual served they will be immediately suspended, and an internal investigation will be completed within 5 business days unless evidence is not available to make a final conclusion within 5 business days. An external investigation timeframe will be determined by the entity conducting the 			
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W 0156 Bldg. 00	<p>investigation. All appropriate safeguards and emotional support for individual(s) will be put into place. Benchmark will work closely with outside authorities and will cooperate fully during their investigation. If the allegations are not substantiated by the investigation, the employee may return to work. Should the charges be substantiated, disciplinary action will be taken which may include termination and criminal charges."</p> <p>This federal tag relates to complaint #IN00451752.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS</p> <p>Based on record review and interview for 1 additional client (F), the facility failed to complete the investigation of client F's elopement incident within 5 working days affecting clients A, B, C, E, F and G.</p> <p>Findings include:</p> <p>The facility's BDS (Bureau of Disability Services) reports were reviewed 2/4/25 at 12:45 PM.</p> <p>A 1/20/25 BDS report from 4:31 PM indicated "On 1/20/25 at approximately 4:31 pm, [client F] became upset when staff asked him if he had a package of cookies. [Client F] got his coat and headed to the door. The staff on duty called the manager at that time and reported that [client F] walked off from the group home. The staff also stated that she was the only staff present because the other staff scheduled, had not reported to work. The manager told the staff on shift to take 1 individual (client D) and to follow [client F] in the van. The manager</p>	W 0156	<p>W156 /p></p> <p>The internal investigation was completed within the 5 days allowed. The staff failed to communicate to the manager that she was working alone and staff did not report for the 3p-11p shift. The manager during this time was at the Fillmore road office turning in paperwork and being assisted with receipts. Hence why she was not at the home at the time of the incident. The internal investigation showed that the staff working was following the instruction of the Residential Manager. The manager told the staff on shift to take 1 individual and to follow peer in the van. The manager advised the staff to have the other</p>	02/19/2025

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	<p>advised the staff to have the other individuals go to their bedroom as these individuals are fairly independent and can follow directions. [Client F] was located in the housing addition just 2 blocks away from the group home. [Client F] was out of eyesight and the other individuals were unsupervised for approximately 5 minutes.</p> <p>Plan to Resolve (Immediate and Long Term). The Residential Director, QIDP (Qualified Intellectual Disabilities Professional) Coordinator, Residential Managers, Nurse, and Guardian were all notified. An investigation was started immediately. It was determined that the on-duty staff never reported to the manager that the other staff had failed to report to work for their shift. The manager will be retrained on the Missing Person's protocol listed in the Group Home Emergency Procedures Policy. All staff will be retrained in this as well. All staff will be retrained on the appropriate staffing ratio for this group home and to report to the manager immediately if staff do not report to work as scheduled. [Client F] nor any other peers suffered any negative outcomes from incident. The team discussed the incident regarding [client F] and reviewed his BSP (Behavior Support Plan). He does have awol (absence without leave) listed in his plan. However, he has not engaged in this behavior for approximately 1 year. The team discussed that he is off of his routine due to the extreme (sic) cold weather and needing to stay home. This may have been a contributor. The Director went to the group (sic) home that evening and counseled [client F] on making better decisions." This affected clients A, B, C, E, F and G.</p> <p>An Investigative Report Summary (IRS) initiated on 1/25/25 indicated "The internal investigation showed that the staff working was following the</p>		<p>individuals go to their bedroom as these individuals are fairly independent and can follow directions. The staff working was not suspended, due to the staff following the instruction of her manager. The investigation was completed and the allegation of Neglect, due to individuals being unsupervised for approximately 5 min, was substantiated. Per Benchmark's ANE policy, the group home failed to provide appropriate supervision for the 5 individuals left home alone. Also, none of the individuals involved had negative outcomes from this incident.</p> <p>All staff and Manager will be retrained on the Missing Person's protocol listed in the Group Home Emergency Procedures Policy and the staffing ration for the Old Lantern group home. All staff and the manager will be retained on the Abuse, Neglect, and Exploitation Policy. A posttest will be completed by to verify their understanding of the policy and specifically their responsibility to prevent ANE and their obligation to report to the manager immediately when unable to provide appropriate supervision. Additional Management oversight will be conducted 3 times weekly for one month. 1 time weekly for one month or until compliance can be verified. Staff will be questioned on</p>	

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	<p>instruction of the Residential Manager. The manager told the staff on shift to take 1 individual and to follow peer in the van. The manager advised the staff to have the other individuals go to their bedroom as these individuals are fairly independent and can follow directions. The staff working was not suspended, due to the staff following the instruction of her manager. The investigation was completed and the allegation of neglect, due to individuals being unsupervised for approximately 5 min (minutes), was unsubstantiated, due to the staff following the instruction of her manager. Also, none of the individuals had negative outcomes. [Client F's] BSP was reviewed and does not need revisions at this time. The staff person working with him at the time is a newer staff and will receive retraining on allowing choice with where [client F] stores his personal food items."</p> <p>A review of the 1/20/25 BDS report and IRS indicated the investigation was not completed within 5 working days.</p> <p>On 2/5/25 at 3:47 PM an interview with the Residential Director (RD) was completed. The RD stated, "The investigation should have been completed in 5 working days. I didn't realize there was a discrepancy in the out of line-of-sight times, I will have to review the witness statements again as I have not submitted the investigation yet for review."</p> <p>This federal tag relates to complaint #IN00451752.</p> <p>9-3-2(a)</p>		<p>their responsibility to report and ways to prevent ANE from occurring. Documentation of those visits will be done on the Home Visit Form, and the Director will monitor for compliance.</p>		