

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G764	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/12/2021
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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W 0000 Bldg. 00	<p>This visit was for the investigation of complaints #IN00324651 and #IN000326062.</p> <p>This visit was in conjunction with the annual recertification and licensure survey. This visit included a COVID-19 focused infection control survey.</p> <p>Complaint #IN000324651: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W149 and W227.</p> <p>Complaint #IN000326062: Substantiated, federal and state deficiencies related to the allegation(s) are cited at W149 and W227.</p> <p>Dates of Survey: 3/2, 3/3, 3/4, 3/5, and 3/12/21.</p> <p>Facility number: 012371 Provider number: 15G764 AIM number: 200986870</p> <p>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.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 3 of 22 BDDS (Bureau of Developmental Disabilities Services) reports reviewed, the facility failed to implement their Abuse, Neglect, and</p>	W 0149	All staff were retrained on the Abuse and Neglect Policy. A competency test was also given to all staff regarding what constitutes	04/11/2021

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>Exploitation Policy to ensure client A was not neglected and had appropriate staff supervision.</p> <p>Findings include:</p> <p>The facility's BDDS reports were reviewed on 3/2/21 at 11:24 AM and indicated the following:</p> <p>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 of the day ...".</p> <p>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</p>		<p>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 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</p>	

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	<p>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] Sheriff's 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 ...".</p> <p>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 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].</p>		objectives/BSP. These interventions will help ensure that client A is safe and that he is monitored with the appropriate staffing supervision.	

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	<p>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)...".</p> <p>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 For Elopement: 1. Walk with [client A]. 2. Ask him to return home with you.</p>			

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W 0227 Bldg. 00	<p>3. Set a distance [client A] is allowed to travel once his outside of his area.</p> <p>4. Reward positive action. Be friendly and attentive when he returns home.</p> <p>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.</p> <p>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."</p> <p>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...".</p> <p>This federal tag relates to complaints #IN00324651 and #IN000326062.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the</p>						

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	<p>specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>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.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 3/2/21 at 11:24 AM and indicated the following:</p> <p>1. 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</p>	W 0227	<p>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.</p> <p>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 treadmill 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</p>	04/11/2021			

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	<p>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 of the day ...".</p> <p>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] Sheriff's 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 ...".</p> <p>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</p>		<p>homes weight and diets were reviewed to ensure that their plans address any weight or diet issues.</p> <p>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.</p>	

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	<p>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 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</p>			

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	<p>others (which at that time he denied getting a ride)...".</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Qualified Intellectual Disability Professional (QIDP) #1, agency LPN, and Residential</p>			

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	<p>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 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.</p> <p>This federal tag relates to complaints #IN00324651 and #IN000326062.</p> <p>9-3-4(a)</p>				