

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G717	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/14/2015
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2405 S CR 200 N NORTH VERNON, IN 47265
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey dates: October 9, 13 and 14, 2015.</p> <p>Facility number: 004132 Provider number: 15G717 AIM number: 200494750</p> <p>This federal deficiency reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/27/15.</p>	W 0000		
W 0249  Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and</p>	W 0249	All staff at this home will receive re-training regarding the correct implementation of each client's	11/13/2015

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>record review for 1 of 2 sampled clients (#2), the facility failed to implement the client's dining program correctly to prevent potential choking.</p> <p>Findings include:</p> <p>Evening observations were conducted at the facility on 10/09/15 from 4:00 PM until 5:30 PM. The client's dinner meal and its preparation were observed. Client #2 was observed to consume a pureed consistency meal prepared by staff #2 with client assistance of pureed hotdogs, sauerkraut, and beets. The client's beverage was a mixture of ensure and milk. Staff #3 fed client #2 his meal of pureed food, offering bites of food on a spoon in a quick fashion. Staff #3 did not wait for client #2 to clear his mouth before offering another bite of food. Staff #3 did not offer sips of nectar thick fluids after 2 to 3 bites of food. The surveyor asked what consistency the beverage client #2 had at his place setting. Staff #2 indicated (10/09/15 at 5:08 PM) she had not thickened the fluids when she had supervised the meal preparation. Staff #3, who actually fed client #2, did not notice the fluids had not been thickened to a nectar consistency. Staff #3 thickened the fluids for client #2 with supervision by RN #1 after the surveyor's question.</p>		<p>dining plan. Monitoring will occur six times weekly for 2 months to ensure dining plans are being implemented correctly. Monitoring will be provided by the Residential Manager, QDDP, and Nurse and will be documented on a dining monitoring checklist. All checklists will be sent to the Benchmark Director to verify that monitoring is occurring.</p> <p>After the 2 month period, the dining monitoring checklist will be completed one time weekly to ensure dining plans are continuing to be implemented correctly.</p>		

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	<p>Review of client #2's record on 10/13/15 at 2:00 PM indicated he had a risk plan for Dysphagia (choking risk)/Care Dining Plan dated 5/17/15. The risk plan indicated client #2 was at risk for choking. His diet was a pureed/soft consistency with nectar thick liquids. Client #2's plan indicated he was to be given time to swallow between bites of food. Client #2's mouth was to be clear before he was to be offered additional food bites. "Offer bites slowly, do not feed him to (sic) fast." Food and fluids were to be alternated at every meal.</p> <p>Interview with Administrative staff #1 on 10/14/15 at 8:30 AM indicated staff may require additional training to practice offering clients food in a slower manner and to ensure beverages were the correct consistency.</p> <p>Interview with RN #1 on 10/14/15 at 9:00 AM indicated it was the staff's responsibility to work as a team and follow the client's diet orders according to the dietary guidelines.</p> <p>9-3-4(a)</p>			