

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614
--	---

(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 000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 10, 13, 14, and 21, 2015.</p> <p>Facility number: 003799 Provider number: 15G705 AIM number: 200447350</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 000		
W 189 Bldg. 00	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a DSP (Direct Support Professional) was continually trained to enable the DSP to perform his duties competently for 1 additional client (#3).</p>	W 189	Client#3's dining plan is being revised to include the use of a napkin to wipe hismouth as well as interventions to encourage swallowing of food. All staff are being trained on the reviseddining plan as well as dining plans for Client's #1, #2, and #4. This training	05/21/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614
--	---

(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
	<p>Findings include:</p> <p>On 4/13/15 between 6:21 AM and 8:29 AM, group home observations were conducted. At 6:43 AM, DSP (Direct Support Professional) #3 assisted Client #3 with breakfast. Client #3 was seated in his wheelchair, wore a shirt protector, and ate a puree diet. DSP #3 remained standing while assisting Client #3 with his breakfast. After each bite, DSP #3 held up Client #3's shirt protector straight (at a 90 degree angle) above his head to prevent food loss from Client #3's mouth. Each time DSP #3 held up Client #3's shirt protector, it blocked Client #3's view. DSP #3 did not prompt Client #3 to wipe his own mouth with a napkin.</p> <p>On 4/21/15 at 2:44 PM, record review indicated Client #3's diagnoses included, but were not limited by, cerebral palsy with quadriplegia (paralysis), chronic constipation, and microcephaly (small head size). Client #3's ISP (Individual Support Plan) dated 2/23/15 indicated a "Dining/Dysphagia (swallowing difficulty) Choking Prevention Plan" dated 3/4/15. Client #3's dining plan indicated he had "mild tongue and bite reflex when eating which can lead to choking and/or aspiration." The dining plan indicated "staff will sit down next to [Client #3] at the table during mealtimes</p>		<p>also included the use of the shirt protector as protecting clothing only and is not to be raised off of the clothing. For 30 days, unannounced spot checks will be completed three times at breakfast, three times at lunch and three times at dinner to monitor implementation of the dining plans. Once competency is ensured through those checks, management staff will conduct weekly checks of meals. These will be documented on the dining checklist which will be turned into the director monthly so compliance can be monitored.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614
--	---

(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 454 Bldg. 00	<p>and snacks." The dining plan indicated "[Client #3] likes to play during mealtimes and will often smile, laugh, spit out his food, and blow bubbles in his drinks." The dining plan indicated "staff must be patient with him during meals and medication administration."</p> <p>On 4/21/15 at 4:25 PM during an interview, the Administrator indicated it was not in Client #3's dining plan to hold his shirt protector up to catch food or prevent spitting. The Administrator indicated staff should not have been holding his shirt protector in this manner.</p> <p>9-3-3(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 1 of 2 sampled clients (Client #2), the facility failed to ensure infection control practices during medication administration.</p> <p>Findings include:</p>	W 454	All staff received additional training on the Benchmark Medication Administration and Handwashing policy as well as proper infection control procedures regarding the use of gloves. For 30 days, unannounced spot checks will be completed three times on first shift, three times on second shift and three times on overnight shift to	05/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614
--	---

(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
	<p>On 4/13/15 between 4:40 PM and 5:57 PM, group home observation was conducted. At 5:36 PM, DSP (Direct Support Professional) #2 assisted Client #2 with medication administration. DSP #2 had gloved hands when she pushed Client #2's wheelchair into the medication area. DSP #2 moved the soiled clothes hamper with her gloved hand out of the way to situate Client #2's wheelchair. DSP #2 popped Client #2's two pills (Calcium/Vitamin D tablet and Docusate Sodium tablet) into a medication cup. DSP #2 picked up one pill from the medication cup, wearing the same glove, and placed the tablet on a spoon with applesauce on it. DSP #2 gave Client #2 his medication. DSP #2 took the second pill out of the medication cup, wearing the same glove, and placed it on the spoon which had applesauce on it. DSP #2 gave Client #2 his medication.</p> <p>On 4/21/15 at 4:25 PM during an interview, the Administrator indicated DSP #2 should have used proper infection control measures during medication pass and not cross contaminate clean gloves with unsanitized surfaces.</p> <p>9-3-7(a)</p>		<p>ensure proper infection control procedures are being implemented during medication administration. Once competency is ensured through those checks, management staff will conduct monthly checks of medication administration. These will be documented on the MAR checklist which will be turned into the director monthly so compliance can be monitored.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G705	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/21/2015
NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 59310 IRELAND RIDGE CT SOUTH BEND, IN 46614		
(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	