

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G372	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/02/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 7631 WHEELLOCK RD FORT WAYNE, IN 46835
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W000000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of Survey: January 20, 21, 23, 29, 30 and February 2, 2015.</p> <p>Facility number: 000886 Provider number: 15G372 AIM number: 100244330</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/9/15 by Ruth Shackelford, QIDP.</p>	W000000		

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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W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review, observation and interview, the governing body failed to meet the Condition of Participation: Governing Body. The governing body failed to provide oversight and direction to implement its policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. The governing body failed to complete their investigation into the choking incident within 5 working days, and failed to develop and implement effective corrective action to ensure staff were trained to implement client B and G's dining plans.</p> <p>Findings include:</p> <p>1. The governing body failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (B and C) by failing to provide oversight and direction to implement its policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. The</p>	W000102	See Plan of Correction for W104	03/03/2015

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	<p>governing body failed to complete their investigation into the choking incident within 5 working days, and failed to develop and implement effective corrective action to ensure staff were trained to implement client B and G's dining plans. Please see W122.</p> <p>2. The governing body failed to provide oversight and direction for 2 of 4 sampled clients (B and C) by failing to provide oversight and direction to implement its policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. The governing body failed to complete their investigation into the choking incident within 5 working days, and failed to develop and implement effective corrective action to ensure staff were trained to implement client B and G's dining plans. Please see W104.</p> <p>9-3-1(a)</p>			

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon record review and interview, the governing body failed to provide oversight and direction for 2 of 4 sampled clients (B and C) to implement its policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of behavior of gaining food and choking had been identified. The governing body failed to complete their investigation into the choking incident within 5 working days, and failed to develop and implement effective corrective action to ensure staff were trained to implement client B and G's dining plans.</p> <p>Findings include:</p> <p>1. The governing body neglected to provide oversight and direction for 2 of 4 sampled clients (clients B and C) to implement policy and procedures to protect client C from gaining access to</p>	W000104	<p>Client C had no history of choking and received a regular diet as ordered by his physician and dietician. Client C had no food access restrictions in his home or at any time while at day service or in the community. There is indication of limiting food being left out by others in the BSP which was not included as an intervention of Client C eating too fast, but the BSP interventions for stealing. Client C would independently gain food when he was hungry in his home or by taking his lunchbox to staff when he was ready to eat his lunch at day service. Large quantities of uncooked food was restricted at one time due to Client C taking food and placing it in inappropriate places such as stuffing food behind items in his home or in drains or dumping full gallons of fluids down the sink. Client C did eat fast but did not have a history of taking food from his lunchbox and would be given verbal prompts per his ISP to take bites and</p>	03/03/2015

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	<p>food which resulted in a choking incident causing death after a history of gaining food and choking had been identified. The governing body failed to complete their investigation into 1 of 2 choking incidents within 5 working days. The governing body failed to ensure staff correctly implemented CPR (cardiopulmonary resuscitation) during an incident of choking. The governing body failed to implement effective corrective action to ensure staff were competently trained to implement dining plans for 1 of 4 clients with identified choking risks (client B). Please see W149.</p> <p>2. The governing body failed to provide oversight and direction to complete an investigation into 1 of 2 choking incidents within 5 working days for 1 of 4 sampled clients (client C). Please see W156.</p> <p>3. The governing body failed to provide oversight and direction to implement effective corrective action to ensure staff were competently trained to implement dining plans for 2 of 4 clients with identified choking risks (clients B and C). Please see W157.</p> <p>4. The governing body failed to provide oversight and direction to ensure staff</p>		<p>alternate bites with drinks with verbal prompts. Gorging/stealing food was included in the BSP which would include Client C taking food from others when food was served and for staff to remind him to eat slowly to follow the guidelines set in the ISP. The dining plan indicated that Client C would take food from others but that this was a rare occasion. The nurse, dietician nor physician had determined any need for cutting food or restricting access to food other than verbal prompts when eating.</p> <p>The facilities dining plans have been updated to include behavior that may make individuals to be at increased risk for choking. The QIDP is monitoring the IDT process to ensure that any information included on the BSP or history of behavior be listed on the dining plan to ensure that staff have multiple avenues to obtain the information throughout their training. The information includes behavioral, environmental or safety concerns related to food or having access to food and level of staff supervision required when around food. All the plans will be updated to include this information and people without dining plans with behavioral concerns or an increased level of staff assistance will have a dining plan developed. All staff will receive</p>	

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	<p>correctly implemented CPR during an incident of choking for 1 of 4 sampled clients (client C). Please see W192.</p> <p>9-3-1(a)</p>		<p>training on all individuals with a dining plan including the house staff, day service or work services staff and families for individuals who spend time outside of the facilities care. All staff from residential and day services have received re-training on Client B and G's dining protocols and need for adaptive equipment on 1/23/15, 1/26/15, 1/27/15 and 1/30/15. In order to ensure this training has been effective, the nurse and director will complete mealtime observation monitoring at each location at least three times prior to the correction date and will document this monitoring which will be reviewed by the Regional Director to ensure compliance. This practice will be weekly as an ongoing quality assurance practice in the home and day service for a period of three months to ensure that the training has been effective.</p> <p>The facility director shared the 5 day investigation conclusion which was noted to be ongoing. The staff had been interviewed with completed statements and mapping of the area where the incident occurred had been completed. The staff who administered the Heimlich and back blows to Client C had completed a re-training on CPR and choking prevention as part of that investigation prior to this survey and</p>	

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			<p>was signed up for the complete recertification class thereafter which was shared with the surveyor. All plans had been reviewed and staff training on Client C's support plans and CPR had been verified. It was explained to the surveyor that the recommendations section of the Benchmark Investigation Conclusion had not been completed as this was ongoing and we had not yet received hospital or EMT records and had just received the death certificate. The MRC timelines were explained to the surveyor in addition to the progress on the investigation and as this was ongoing at the time of review. The progress report to the investigation was offered to the surveyor which was declined.</p> <p>The investigation form has been modified to include preliminary recommendations separately instead of being included in the body of the investigation. Investigations that will continue past the 5 day preliminary timeframe will be completed and include immediate precautions and preliminary recommendations. The policy has been updated to include these changes and process that the preliminary report will be forwarded to the Vice President and Director of Compliance for preliminary review. All directors and investigators will be trained on the changes to the form</p>	

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			<p>and policy and this will be monitored by the Regional Director to ensure compliance.</p> <p>The staff who administered the Heimlich and back blows to Client C was certified in CPR. The staff by his statement and throughout the interview could not recall the exact procedure followed but was clear that he had provided both the Heimlich and back blows. This was witnessed and documented by the coworker as well. He was unable to state specifically when Client C went unresponsive as he explained he thought Client C was better for a period of time. He did state that he had begun to position Client C to begin chest compressions when the paramedics arrived. He was unable to provide more specific information at that time and when questioned after. The staff had already participated in a CPR and choking prevention refresher training prior to this survey and was signed up for the complete recertification class thereafter.</p> <p>A CPR refresher was developed which includes basic emergency procedures to be implemented and a post-test to be completed by staff to assist them in recalling CPR guidelines while under stress. This</p>	

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W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (clients B and C). The facility neglected to implement policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of gaining food and choking had been identified. The facility failed to complete their investigation into 1 of 2 choking incidents within 5 working days. The facility failed to</p>	W000122	<p>will be an ongoing process at staff meetings for day service and residential staff to continually remind them of the steps to take in case of emergency. Post tests will be completed and monitored by the director and human resources for compliance. Staff will continue to be required to maintain certification and should certification lapse, staff will be removed from the schedule as monitored by the director and human resources. The staff person involved in this incident took the refresher course on 1/6/15 before working with consumers again and completed the full certification class on 1/29/15.</p> <p>See Plan of Correction for W149, W156 and W157.</p>	03/03/2015

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	<p>ensure staff correctly implemented CPR (cardiopulmonary resuscitation) during an incident of choking. The facility failed to implement effective corrective action to ensure staff were competently trained to implement dining plans for 1 of 4 clients with identified choking risks (client B).</p> <p>Findings include:</p> <p>1. The facility neglected for 2 of 4 sampled clients (clients B and C) to implement policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of gaining food and choking had been identified. The facility failed to complete their investigation into 1 of 2 choking incidents within 5 working days. The facility failed to ensure staff correctly implemented CPR (cardiopulmonary resuscitation) during an incident of choking. The facility failed to implement effective corrective action to ensure staff were competently trained to implement dining plans for 1 of 4 clients with identified choking risks (client B). Please see W149.</p> <p>2. The facility failed for 1 of 4 sampled clients (client C) to complete an investigation into 1 of 2 choking</p>			

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W000149	<p>incidents within 5 working days. Please see W156.</p> <p>3. The facility failed to implement effective corrective action to ensure staff were competently trained to implement dining plans for 2 of 4 clients with identified choking risks (clients B and C). Please see W157.</p> <p>4. The facility failed for 1 of 4 sampled clients (client C) to ensure staff correctly implemented CPR during an incident of choking. Please see W192.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit</p>			

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	<p>mistreatment, neglect or abuse of the client. Based upon record review and interview for 2 of 4 sampled clients (clients B and C), the facility neglected to implement policy and procedures to protect client C from gaining access to food which resulted in a choking incident causing death after a history of gaining food and choking had been identified. The facility failed to completed their investigation into 1 of 2 choking incidents within 5 working days. The facility failed to ensure staff correctly implemented CPR (cardiopulmonary resuscitation) during an incident of choking. The facility failed to implement effective corrective action to ensure staff were competently trained to implement dining plans for 1 of 4 clients with identified choking risks (client B).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/20/15 at 4:30 PM. A BDDS report dated 1/5/15 indicated "On 1/5/15 [client C] was attending the [name] day program at the [library]. [Client C] was participating in recreational activities as normal. Per staff's statement, close to 11:00 am, [client C] got up and started walking to the bathroom. The staff</p>	W000149	<p>Client C had no history of choking and received a regular diet as ordered by his physician and dietician. Client C had no food access restrictions in his home or at any time while at day service or in the community. There is indication of limiting food being left out by others in the BSP which was not included as an intervention of Client C eating too fast, but the BSP interventions for stealing. Client C would independently gain food when he was hungry in his home or by taking his lunchbox to staff when he was ready to eat his lunch at day service. Large quantities of uncooked food was restricted at one time due to Client C taking food and placing it in inappropriate places such as stuffing food behind items in his home or in drains or dumping full gallons of fluids down the sink. Client C did eat fast but did not have a history of taking food from his lunchbox and would be given verbal prompts per his ISP to take bites and alternate bites with drinks with verbal prompts. Gorging/stealing food was included in the BSP which would include Client C taking food from others when food was served and for staff to remind him to eat slowly to follow the guidelines set in the ISP. The dining plan indicated that Client C would take food from others but that this was a rare occasion. The nurse, dietician nor</p>	03/03/2015

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	<p>immediately followed [client C] to the bathroom and heard him hiccup. [Client C] then knelt down in the stall and spit out what looked like a quarter of a sandwich. [Client C] then stood up and began to walk, his eyes rolled back and he went faint. The staff assisted him to the ground and yelled to his coworker (sic) to call 911. The staff came from behind [client C] and placed [client C] against his chest and began attempting the Heimlich and back blows. The staff then positioned [client C] flat on his back and began chest compressions but the paramedics arrived and took over emergency care. [Client C] was transported to [hospital] by ambulance as the paramedics continued to give treatment. Benchmark staff arrived at the hospital shortly after the ambulance arrived and [client C] was pronounced dead at approximately 11:41 am." Corrective action indicated "When the paramedics left with [client C], the staff checked [client C's] lunch box and everything was still in there except for his sandwich. Also, his sandwich bag was empty indicating he had taken out his sandwich and grabbed it eating it on the way to the bathroom and had choked on the sandwich. Benchmark will follow up through the Mortality Review Process."</p> <p>Systemic actions being taken to assume</p>		<p>physician had determined any need for cutting food or restricting access to food other than verbal prompts when eating.</p> <p>The facilities dining plans have been updated to include behavior that may make individuals to be at increased risk for choking. The QIDP is monitoring the IDT process to ensure that any information included on the BSP or history of behavior be listed on the dining plan to ensure that staff have multiple avenues to obtain the information throughout their training. The information includes behavioral, environmental or safety concerns related to food or having access to food and level of staff supervision required when around food. All the plans will be updated to include this information and people without dining plans with behavioral concerns or an increased level of staff assistance will have a dining plan developed. All staff will receive training on all individuals with a dining plan including the house staff, day service or work services staff and families for individuals who spend time outside of the facilities care. All staff from residential and day services have received re-training on Client B and G's dining protocols and need for adaptive equipment on 1/23/15, 1/26/15, 1/27/15 and 1/30/15. In order to</p>	

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	<p>health and safety issues in the report indicated client C had a dining plan in place "which indicated he received a non-modified, regular diet with regular fluids. [Client C's] plan indicated that staff should encourage him to slow down when drinking fluids and to slow down when eating. The choking did not occur at a regularly scheduled mealtime. It appears that [client C] had taken his sandwich out of his lunch box while at his day service." The report indicated client C did not have any previous choking incidents, difficulties chewing or swallowing, and client C "did not have a specific level of supervision/monitoring during mealtimes and the incident did not occur during a mealtime. Staff were however present and in close proximity to [client C]...All staff working with [client C] were trained on his plans and completed competency based training. [Client C] did not require any modifications to his diet...[Client C] did not exhibit any sign of choking prior to getting up to use the restroom."</p> <p>Statements from day service staff #7 and #8 were reviewed on 1/20/15 at 4:50 PM. Staff #7 indicated in a statement dated 1/5/15 "Arrived at the library at 10 am. When we arrived individuals put coats up and began activities. [Client C] colored and enjoyed music. At that time their</p>		<p>ensure this training has been effective, the nurse and director will complete mealtime observation monitoring at each location at least three times prior to the correction date and will document this monitoring which will be reviewed by the Regional Director to ensure compliance. This practice will be weekly as an ongoing quality assurance practice in the home and day service for a period of three months to ensure that the training has been effective. The day service staff have been inserviced on proper completion of the Client Specific Training form and that they must document all needs identified on the plan. These will be monitored by the day service and residential director to ensure compliance. These are completed every time there is a change in the condition, care or diagnosis of the individuals and annually after completion of their annual meeting and review. These are tracked by Human Resources to ensure that staff are trained on the needs of the individuals they are working with. All residential and day service staff have been retrained on the Abuse and Neglect policy and have completed a post test to ensure their understanding of the policy. This training is required upon hire and then annually to maintain employment. Compliance is tracked through Human Resources and reported to the program director if</p>	

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	<p>bags were at the front, and lunch boxes at the table with individuals. I took [client C] to the bathroom multiple times. Close to 11 am [client C] got up and started walking to the bathroom. I followed him to the bathroom and heard him began to hicup (sic). [Client C] then kneeled down in the stall, and spit out what looked like a quarter of a sandwich. There was no evidence of the rest of the sandwich. [Client C] stood up (sic) began to walk. His eyes rolled in the back of his head and he went faint. I grabbed him and helped him onto the ground. I got him against my chest and began hymlyc (sic) and back blows roughly for 10 mins (minutes). I then positioned him flat on the ground to begin chest compressions. After paramedics left with [client C], I checked [client C's] lunchbox and everything was still in there except for his sandwich. His sandwich bag was empty in his lunchbox. Since working with [client C] I've had no issues with him grabbing food or stuffing his mouth. Typically when [client C] is ready to eat he will open his own bag and allows (sic) staff to help him prepare his lunch."</p> <p>A statement from staff #8 dated 1/5/15 indicated "...[Client C] was sitting by [client I] and their lunch bags were sitting on the table. Around 10:30 (AM or PM not specified) [client C] got into his lunch</p>		<p>the training is not maintained.</p> <p>The facility director shared the 5 day investigation conclusion which was noted to be ongoing. The staff had been interviewed with completed statements and mapping of the area where the incident occurred had been completed. The staff who administered the Heimlich and back blows to Client C had completed a re-training on CPR and choking prevention as part of that investigation prior to this survey and was signed up for the complete recertification class thereafter which was shared with the surveyor. All plans had been reviewed and staff training on Client C's support plans and CPR had been verified. It was explained to the surveyor that the recommendations section of the Benchmark Investigation Conclusion had not been completed as this was ongoing and we had not yet received hospital or EMT records and had just received the death certificate. The MRC timelines were explained to the surveyor in addition to the progress on the investigation and as this was ongoing at the time of review. The progress report to the investigation was offered to the surveyor which was declined.</p> <p>The investigation form has been</p>	

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	<p>bag, yet ceased when I asked him to wait until lunch time. I did not see him take anything out at that time. About 15 minutes later, [client C] gets up and heads straight for the bathroom, followed closely by [staff #7]...In the time I've worked with [client C], I was not aware of any food shovelling (sic) behaviors, and to my knowledge, I only believed he needed verbal encouragement to slow down."</p> <p>The Conclusion of Internal Mortality Investigation dated 1/9/15 was reviewed on 1/21/15 at 1:45 PM and indicated client C's Individual Support Plan (ISP), Behavior Support Plan (BSP) and Risk Protocols had been reviewed and staff #7 and #8 had been interviewed/completed statements. Summary of the investigations indicated "On 1/5/15 [client C] was attending the [name] day program at the [library]. [Client C] was participating in recreational activities as normal. Per staff's statement, close to 11:00 am, [client C] got up and started walking to the bathroom. The staff immediately followed [client C] to the bathroom and heard him hiccup. [Client C] then knelt down in the stall and spit out what looked like a quarter of a sandwich. [Client C] then stood up and began to walk, his eyes rolled back and he went faint. The staff assisted him to</p>		<p>modified to include preliminary recommendations separately instead of being included in the body of the investigation. Investigations that will continue past the 5 day preliminary timeframe will be completed and include immediate precautions and preliminary recommendations. The policy has been updated to include these changes and process that the preliminary report will be forwarded to the Vice President and Director of Compliance for preliminary review. All directors and investigators will be trained on the changes to the form and policy and this will be monitored by the Regional Director to ensure compliance.</p> <p>The staff who administered the Heimlich and back blows to Client C was certified in CPR. The staff by his statement and throughout the interview could not recall the exact procedure followed but was clear that he had provided both the Heimlich and back blows. This was witnessed and documented by the coworker as well. He was unable to state specifically when Client C went unresponsive as he explained he thought Client C was better for a period of time. He did state that he had begun to position Client C to begin chest compressions when the paramedics arrived. He was unable to provide more specific information</p>	

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	<p>the ground and yelled to his coworker (sic) to call 911. The staff came from behind [client C] and placed [client C] against his chest and began attempting the Heimlich and back blows. The staff then positioned [client C] flat on his back and began chest compressions but the paramedics arrived and took over emergency care. " Conclusion of the investigation indicated "This investigation remains open pending the MRC (Mortality Review Committee) and death certificate...Recommendations: None at this time."</p> <p>Client C's Dysphagia Care/Dining Plan dated 5/6/14 was reviewed on 1/21/15 at 1:40 PM. The plan indicated a regular diet and regular fluids. Staff were to encourage client C "throughout meals to eat food slowly and chew/process each bite thoroughly before swallowing" and client C "should be encouraged to slow down when drinking fluid as he/she tends to drink too fast."</p> <p>Competency-Based Tests for staff #7 and #8 were reviewed on 1/21/15 at 4:40 PM. Staff #7's Competency Test dated 1/4/14 indicated client C's health and risk needs included "MR (mental retardation) and autism. Behavior Supports Needs indicated refusals, physical aggression, property abuse, verbal (sic), stealing,</p>		<p>at that time and when questioned after. The staff had already participated in a CPR and choking prevention refresher training prior to this survey and was signed up for the complete recertification class thereafter.</p> <p>A CPR refresher was developed which includes basic emergency procedures to be implemented and a post-test to be completed by staff to assist them in recalling CPR guidelines while under stress. This will be an ongoing process at staff meetings for day service and residential staff to continually remind them of the steps to take in case of emergency. Post tests will be completed and monitored by the director and human resources for compliance. Staff will continue to be required to maintain certification and should certification lapse, staff will be removed from the schedule as monitored by the director and human resources. The staff person involved in this incident took the refresher course on 1/6/15 before working with consumers again and completed the full certification class on 1/29/15.</p>				

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	<p>hoarding...What are the Individual's Diet and Nutritional Needs? Reg (regular) diet..."</p> <p>Staff #8's Competency Test dated 1/4 (no year documented) indicated client C's risk health and risk needs were "severe ID (intellectual disability) and autism..." Behavioral Supports Needs indicated "history of behaviors: refusals, PA (physical aggression), prop (property abuse), verbal agitation, stealing, inappropriate soc (social behavior), hoarding, obsessive." Diet and Nutrition Needs indicated "reg diet, history of gorging self on food."</p> <p>Staff #8's American Red Cross Certificate of Completion for Adult First Aid/CPR dated 4/10/14 was reviewed on 1/21/15 at 4:25 PM and indicated he had successfully completed the course.</p> <p>The American Red Cross First Aid/CPR/AED (auxiliary external defibrillator) Instructor's Manual dated 2011 was reviewed on 1/21/15 at 4:30 PM. Topic: Breathing Emergency indicated "A breathing emergency occurs when a person is having trouble breathing or cannot breathe at all...." The lesson indicated "If a conscious choking person becomes unconscious, carefully lower the person to the ground, open the mouth and</p>			
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	<p>look for an object. If an object is seen, remove it with your finger. If no object is seen, open the person's airway and give 2 rescue breaths. If the chest does not clearly rise, give 30 chest compressions. Open the mouth to look for and remove a foreign object with a finger, if seen, then give 2 rescue breaths. As long as the chest does not clearly rise, continue cycles of giving 30 chest compressions, looking for a foreign object and giving 30 chest compressions, looking for a foreign object and giving 2 rescue breaths...For chest compressions to the most effective, the person should be on his or her back on a firm, flat surface...."</p> <p>Client C's record was reviewed on 1/21/15 at 4:50 PM. An ISP dated 5/13/14 indicated a desired outcome "will continue to slow down when he eats by taking three bites of food and then putting his utensil down. Current Status: [client C] has a history of gorging his mouth with food when he is eating." Objectives to address dining indicated "will take 3 bites of food and then put his utensil down" with 1-4 verbal prompts. Health and Behavioral Issues indicated client C "has a history of gorging himself on food."</p> <p>A Therapeutic Support Plan for client C dated 5/19/14 indicated target objectives</p>			

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	<p>of inappropriate social behavior, taking others belongings, physical aggression, hoarding and gorging. Proactive strategy indicated "Do not leave drinks/food unattended...."</p> <p>Health Issues/Nursing Notes dated December, 2014 indicated on 12/4/14, "He does attempt to grab food from tables and kitchen at times. This is not a new behavior. Staff is present at meals to slow [client C] from eating to (sic) fast...." October, 2014 on 10/2/14 "He does eat fast and staff does attempt to slow him....." June, 2014 indicated on 6/3/14 "He does rush somewhat thru (through) meals and must be reminded to slow down. He will try to grab food that does not belong to him also.. Staff does watch him closely....."</p> <p>A day services assessment dated 5/6/14 indicated for choking risk client C was I (Independent) and "Regular diet/thin liquids."</p> <p>Staff #8 was interviewed on 1/23/15 at 11:50 AM. Staff #8 stated client C had "started to go through his (lunch) bag, but stopped when I redirected him at 10:30 AM. I then turned my attention to the client who was a food thief. [Client C] got up to use the restroom and [staff #7] followed him." Staff #8 stated client C</p>			

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	<p>had a behavior plan and was "aware of food seeking behavior, usually sodas. He would check out his lunch, part of a ritual, but not usually take it out to eat it, but to inventory (the contents). On that day he stopped going through the lunch box when I asked and neither I nor [staff #7] saw him go through it again." He indicated client C went to the restroom and had on his coat and may have had the sandwich hiding in his coat at that time. Staff #8 stated client C had taken a cookie out of the trash while at the park and eaten it before staff could stop him "about 8 months ago" when staff #8 had started employment. Staff #8 indicated he was not supervising client C at the time, but if he had been, he would have completed an incident report into client C's grabbing of the food out of the trash and eating it rapidly.</p> <p>A Prehospital Care Report Summary completed by the ambulance medic staff and emergency room hospital records for client C dated 1/5/15 was reviewed on 1/23/15 at 9:30 AM. The Prehospital Care Report Summary indicated the staff had received the call at 10:49 AM and "Upon entering the public library we went to the men's restroom where we found a 69 y/o (year old) pt (patient) sitting on the floor leaning against a guy right inside of the door of the bathroom</p>			

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	<p>stall...When I opened the door to the stall to be able to help move the pt medic [number] was laying the pt flat, I noticed the pt to be pale, not moving or breathing...The male that was with the pt stated he did not know much about the pt because he had just started working with him. He stated the pt is MR (mentally retarded) however he could not tell us any other hx (history), allergies or medications. He stated that prior to calling 911 the pt had been choking however he had stopped and said (sic) the guy he was doing better just prior to going unresponsive where we found him.... " The Report Summary indicated client C was transported to the hospital.</p> <p>The Emergency Department Chart dated 1/5/15 for client C indicated client C had arrived at the hospital at 11:19 AM, was unresponsive and after resuscitation efforts were unsuccessful was pronounced dead at 11:41 AM.</p> <p>A Certificate of Death dated 1/15/15 was reviewed on 1/23/15 at 1:45 PM and indicated client C's cause of death was "Asphyxia, aspiration of food."</p> <p>Staff #7 was interviewed on 1/23/15 at 2:55 PM and indicated client C had stealing behavior of putting objects into his pockets. He stated "stuffing food was</p>			
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	<p>not in his plan, but he is a choking risk." He indicated staff were to remind client C to slow down his rate of eating. Staff #7 indicated he had not looked for food in client C's mouth, but had completed back blows and Heimlich thrusts for 10 minutes after client C became unresponsive. Staff #7 stated, client C "must have gotten his sandwich out on the way to the restroom," and indicated his attention was focused on assisting client B with activities prior to client C getting up to use the restroom. Staff #7 indicated there were no client ISPs, dining plans or BSPs on site when working with clients at the library except the MAR (Medication Administration Record).</p> <p>The Residential Director was interviewed on 1/20/15 at 4:51 PM. She indicated client C had no previous history of choking and his plan did include prompts to put his utensil down between bites, and did not include food stealing behavior. Client C had checked his lunch box but didn't take food prior to the incident.</p> <p>The Residential Director was interviewed again on 1/23/15 at 1:50 PM and indicated staff #7 had not followed the agency's protocol to address choking incidents.</p>			

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	<p>The Residential Director was interviewed on 1/29/15 at 11:31 AM and indicated there was no additional investigation completed within 5 working days as indicated in the investigation dated 1/9/15. She indicated additional investigation steps had been taken and the next step of the mortality review process was due on 2/6/15.</p> <p>2. Workshop services staff #1 was interviewed on 1/23/15 at 12:45 PM. She indicated client G did not have a dining plan and she was only aware of high risk clients' dining plans. She indicated dining plans for clients who did not have high risk for dining were not present in the workshop. She indicated client G did not use adaptive equipment while at workshop.</p> <p>Client G's dining plan was reviewed on 1/30/15 at 3:28 PM and indicated he was not a choking risk, and received a regular diet. Client G was to use a divided plate, large-weighted utensils.</p> <p>Client B's record was reviewed on 1/23/15 at 2:50 PM. A nutritional assessment date 12/14 indicated he received a mechanical soft diet.</p> <p>Competency-Based Tests dated 12/1/14</p>						

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	<p>were reviewed on 1/23/15 at 4:40 PM and indicated Day Services staff #1-28 indicated client B received a regular diet.</p> <p>The Residential Director was interviewed on 1/29/15 at 11:14 AM and indicated staff should have been trained to correctly identify clients' dining plans.</p> <p>The facility's Group Home Abuse and Neglect policy dated 8/08 was reviewed on 1/30/15 at 4:45 PM and indicated "Benchmark Human Services (BHS) does not tolerate abuse in any form by any person; this includes physical abuse, verbal abuse, psychological abuse or sexual abuse...Neglect includes failure to provide appropriate care, food, medical care or supervision," and "If any staff witness, observe, or suspects abuse or neglect of a client, they are to report this immediately to their supervisor and the BHS Residential Director. The supervisor is responsible for reporting the incident to all appropriate entities. These include, but are not limited to: Bureau of Developmental Disability Services, Adult/Child Protective Services, and client representatives...Other entities may need to be notified depending upon from which program the client is receiving services."</p> <p>9-3-2(a)</p>			

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based upon record review and interview for 1 of 4 sampled clients (client C), the facility failed to complete their investigation into a choking incident resulting in death within 5 working days.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on</p>	W000156	<p>The facility director shared the 5 day investigation conclusion which was noted to be ongoing. The staff had been interviewed with completed statements and mapping of the area where the incident occurred had been completed. The staff who administered the Heimlich and back blows to Client C had completed a re-training on CPR and choking prevention as part of that investigation prior to this survey and was signed up for the complete recertification class</p>	03/03/2015

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	<p>1/20/15 at 4:30 PM. A BDDS report dated 1/5/15 indicated "On 1/5/15 [client C] was attending the [name] day program at the [library]. [Client C] was participating in recreational activities as normal. Per staff's statement, close to 11:00 am, [client C] got up and started walking to the bathroom. The staff immediately followed [client C] to the bathroom and heard him hiccup. [Client C] then knelt down in the stall and spit out what looked like a quarter of a sandwich. [Client C] then stood up and began to walk, his eyes rolled back and he went faint. The staff assisted him to the ground and yelled to his coworker (sic) to call 911. The staff came from behind [client C] and placed [client C] against his chest and began attempting the Heimlich and back blows. The staff then positioned [client C] flat on his back and began chest compressions but the paramedics arrived and took over emergency care. [Client C] was transported to [hospital] by ambulance as the paramedics continued to give treatment. Benchmark staff arrived at the hospital shortly after the ambulance arrived and [client C] was pronounced dead at approximately 11:41 am." Corrective action indicated "When the paramedics left with [client C], the staff checked [client C's] lunch box and everything was still in there except for his</p>		<p>thereafter which was shared with the surveyor. All plans had been reviewed and staff training on Client C's support plans and CPR had been verified. It was explained to the surveyor that the recommendations section of the Benchmark Investigation Conclusion had not been completed as this was ongoing and we had not yet received hospital or EMT records and had just received the death certificate. The MRC timelines were explained to the surveyor in addition to the progress on the investigation and as this was ongoing at the time of review. The progress report to the investigation was offered to the surveyor which was declined. The investigation form has been modified to include preliminary recommendations separately instead of being included in the body of the investigation. Investigations that will continue past the 5 day preliminary timeframe will be completed and include immediate precautions and preliminary recommendations. The policy has been updated to include these changes and process that the preliminary report will be forwarded to the Vice President and Director of Compliance for preliminary review. All directors and investigators will be trained on the changes to the form and policy and this will be monitored by the Regional Director to</p>	

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	<p>sandwich. Also, his sandwich bag was empty indicating he had taken out his sandwich and grabbed it eating it on the way to the bathroom and had choked on the sandwich. Benchmark will follow up through the Mortality Review Process."</p> <p>Statements from day service staff #7 and #8 were reviewed on 1/20/15 at 4:50 PM. Staff #7 indicated in a statement dated 1/5/15 "Arrived at the library at 10 am. When we arrived individuals put coats up and began activities. [Client C] colored and enjoyed music. At that time their bags were at the front, and lunch boxes at the table with individuals. I took [client C] to the bathroom multiple times. Close to 11 am [client C] got up and started walking to the bathroom. I followed him to the bathroom and heard him began to hicup (sic). [Client C] then kneeled down in the stall, and spit out what looked like a quarter of a sandwich. There was no evidence of the rest of the sandwich. [Client C] stood up (sic) began to walk. His eyes rolled in the back of his head and he went faint. I grabbed him and helped him onto the ground. I got him against my chest and began hymlyc (sic) and back blows roughly for 10 mins (minutes). I then positioned him flat on the ground to begin chest compressions. After paramedics left with [client C], I checked [client C's] lunchbox and</p>		ensure compliance.	

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	<p>everything was still in there except for his sandwich. His sandwich bag was empty in his lunchbox. Since working with [client C] I've had no issues with him grabbing food or stuffing his mouth. Typically when [client C] is ready to eat he will open his own bag and allows (sic) staff to help him prepare his lunch."</p> <p>A statement from staff #8 dated 1/5/15 indicated "...[Client C] was sitting by [client I] and their lunch bags were sitting on the table. Around 10:30 (AM or PM not specified) [client C] got into his lunch bag, yet ceased when I asked him to wait until lunch time. I did not see him take anything out at that time. About 15 minutes later, [client C] gets up and heads straight for the bathroom, followed closely by [staff #7]...In the time I've worked with [client C], I was not aware of any food shovelling (sic) behaviors, and to my knowledge, I only believed he needed verbal encouragement to slow down."</p> <p>The Conclusion of Internal Mortality Investigation dated 1/9/15 was reviewed on 1/21/15 at 1:45 PM and indicated client C's Individual Support Plan (ISP), Behavior Support Plan (BSP) and Risk Protocols had been reviewed and staff #7 and #8 had been interviewed/completed statements. Summary of the</p>			

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	<p>investigations indicated "On 1/5/15 [client C] was attending the [name] day program at the [library]. [Client C] was participating in recreational activities as normal. Per staff's statement, close to 11:00 am, [client C] got up and started walking to the bathroom. The staff immediately followed [client C] to the bathroom and heard him hiccup. [Client C] then knelt down in the stall and spit out what looked like a quarter of a sandwich. [Client C] then stood up and began to walk, his eyes rolled back and he went faint. The staff assisted him to the ground and yelled to his coworker (sic) to call 911. The staff came from behind [client C] and placed [client C] against his chest and began attempting the Heimlich and back blows. The staff then positioned [client C] flat on his back and began chest compressions but the paramedics arrived and took over emergency care. " Conclusion of the investigation indicated "This investigation remains open pending the MRC (Mortality Review Committee) and death certificate...Recommendations: None at this time."</p> <p>The Residential Director was interviewed on 1/29/15 at 11:31 AM and indicated there was no additional investigation completed within 5 working days as indicated in the investigation dated</p>						

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W000157	<p>1/9/15. She indicated additional investigation steps had been taken and the next step of the mortality review process was due on 2/6/15.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based upon record review and interview, the facility failed to develop and implement effective corrective action to prevent choking incidents for 2 of 4 sampled clients (clients B and C).</p> <p>Findings include:</p> <p>1. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/20/15 at 4:30 PM. A BDDS report dated 1/5/15 indicated "On 1/5/15 [client C] was attending the [name] day program at the [library]. [Client C] was participating in recreational activities as normal. Per staff's statement, close to 11:00 am, [client C] got up and started walking to the bathroom. The staff</p>	W000157	Client C had no history of choking and received a regular diet as ordered by his physician and dietician. Client C had no food access restrictions in his home or at any time while at day service or in the community. There is indication of limiting food being left out by others in the BSP which was not included as an intervention of Client C eating too fast, but the BSP interventions for stealing. Client C would independently gain food when he was hungry in his home or by taking his lunchbox to staff when he was ready to eat his lunch at day service. Large quantities of uncooked food was restricted at one time due to Client C taking food and placing it in inappropriate places such as stuffing food behind items in his home or in drains or dumping full	03/03/2015

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	<p>immediately followed [client C] to the bathroom and heard him hiccup. [Client C] then knelt down in the stall and spit out what looked like a quarter of a sandwich. [Client C] then stood up and began to walk, his eyes rolled back and he went faint. The staff assisted him to the ground and yelled to his coworker (sic) to call 911. The staff came from behind [client C] and placed [client C] against his chest and began attempting the Heimlich and back blows. The staff then positioned [client C] flat on his back and began chest compressions but the paramedics arrived and took over emergency care. [Client C] was transported to [hospital] by ambulance as the paramedics continued to give treatment. Benchmark staff arrived at the hospital shortly after the ambulance arrived and [client C] was pronounced dead at approximately 11:41 am." Corrective action indicated "When the paramedics left with [client C], the staff checked [client C's] lunch box and everything was still in there except for his sandwich. Also, his sandwich bag was empty indicating he had taken out his sandwich and grabbed it eating it on the way to the bathroom and had choked on the sandwich. Benchmark will follow up through the Mortality Review Process."</p> <p>Systemic actions being taken to assume</p>		<p>gallons of fluids down the sink. Client C did eat fast but did not have a history of taking food from his lunchbox and would be given verbal prompts per his ISP to take bites and alternate bites with drinks with verbal prompts. Gorging/stealing food was included in the BSP which would include Client C taking food from others when food was served and for staff to remind him to eat slowly to follow the guidelines set in the ISP. The dining plan indicated that Client C would take food from others but that this was a rare occasion. The nurse, dietician nor physician had determined any need for cutting food or restricting access to food other than verbal prompts when eating.</p> <p>The facilities dining plans have been updated to include behavior that may make individuals to be at increased risk for choking. The QIDP is monitoring the IDT process to ensure that any information included on the BSP or history of behavior be listed on the dining plan to ensure that staff have multiple avenues to obtain the information throughout their training. The information includes behavioral, environmental or safety concerns related to food or having access to food and level of staff supervision required when around food. All the plans will be updated to include this</p>	

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	<p>health and safety issues in the report indicated client C had a dining plan in place "which indicated he received a non-modified, regular diet with regular fluids. [Client C's] plan indicated that staff should encourage him to slow down when drinking fluids and to slow down when eating. The choking did not occur at a regularly scheduled mealtime. It appears that [client C] had taken his sandwich out of his lunch box while at his day service." The report indicated client C did not have any previous choking incidents, difficulties chewing or swallowing, and client C "did not have a specific level of supervision/monitoring during mealtimes and the incident did not occur during a mealtime. Staff were however present and in close proximity to [client C]...All staff working with [client C] were trained on his plans and completed competency based training. [Client C] did not require any modifications to his diet...[Client C] did not exhibit any sign of choking prior to getting up to use the restroom."</p> <p>Statements from day service staff #7 and #8 were reviewed on 1/20/15 at 4:50 PM. Staff #7 indicated in a statement dated 1/5/15 "Arrived at the library at 10 am. When we arrived individuals put coats up and began activities. [Client C] colored and enjoyed music. At that time their</p>		<p>information and people without dining plans with behavioral concerns or an increased level of staff assistance will have a dining plan developed. All staff will receive training on all individuals with a dining plan including the house staff, day service or work services staff and families for individuals who spend time outside of the facilities care. All staff from residential and day services have received re-training on Client B and G's dining protocols and need for adaptive equipment on 1/23/15, 1/26/15, 1/27/15 and 1/30/15. In order to ensure this training has been effective, the nurse and director will complete mealtime observation monitoring at each location at least three times prior to the correction date and will document this monitoring which will be reviewed by the Regional Director to ensure compliance. This practice will be weekly as an ongoing quality assurance practice in the home and day service for a period of three months to ensure that the training has been effective.</p> <p>The staff who administered the Heimlich and back blows to Client C was certified in CPR. The staff by his statement and throughout the interview could not recall the exact procedure followed but was clear that he had provided both the</p>	

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	<p>bags were at the front, and lunch boxes at the table with individuals. I took [client C] to the bathroom multiple times. Close to 11 am [client C] got up and started walking to the bathroom. I followed him to the bathroom and heard him began to hicup (sic). [Client C] then kneeled down in the stall, and spit out what looked like a quarter of a sandwich. There was no evidence of the rest of the sandwich. [Client C] stood up began to walk. His eyes rolled in the back of his head and he went faint. I grabbed him and helped him onto the ground. I got him against my chest and began hymlyc (sic) and back blows roughly for 10 mins (minutes). I then positioned him flat on the ground to begin chest compressions. After paramedics left with [client C], I checked [client C's] lunchbox and everything was still in there except for his sandwich. His sandwich bag was empty in his lunchbox. Since working with [client C] I've had no issues with him grabbing food or stuffing his mouth. Typically when [client C] is ready to eat he will open his own bag and allows (sic) staff to help him prepare his lunch."</p> <p>A statement from staff #8 dated 1/5/15 indicated "...[Client C] was sitting by [client I] and their lunch bags were sitting on the table. Around 10:30 (AM or PM not specified) [client C] got into his lunch</p>		<p>Heimlich and back blows. This was witnessed and documented by the coworker as well. He was unable to state specifically when Client C went unresponsive as he explained he thought Client C was better for a period of time. He did state that he had begun to position Client C to begin chest compressions when the paramedics arrived. He was unable to provide more specific information at that time and when questioned after. The staff had already participated in a CPR and choking prevention refresher training prior to this survey and was signed up for the complete recertification class thereafter.</p> <p>A CPR refresher was developed which includes basic emergency procedures to be implemented and a post-test to be completed by staff to assist them in recalling CPR guidelines while under stress. This will be an ongoing process at staff meetings for day service and residential staff to continually remind them of the steps to take in case of emergency. Post tests will be completed and monitored by the director and human resources for compliance. Staff will continue to be required to maintain certification and should certification lapse, staff will be removed from the schedule as monitored by the director and human resources. The staff person</p>	

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	<p>bag, yet ceased when I asked him to wait until lunch time. I did not see him take anything out at that time. About 15 minutes later, [client C] gets up and heads straight for the bathroom, followed closely by [staff #7]...In the time I've worked with [client C], I was not aware of any food shovelling (sic) behaviors, and to my knowledge, I only believed he needed verbal encouragement to slow down."</p> <p>The Conclusion of Internal Mortality Investigation dated 1/9/15 was reviewed on 1/21/15 at 1:45 PM and indicated client C's Individual Support Plan (ISP), Behavior Support Plan (BSP) and Risk Protocols had been reviewed and staff #7 and #8 had been interviewed/completed statements. Summary of the investigations indicated "On 1/5/15 [client C] was attending the [name] day program at the [library]. [Client C] was participating in recreational activities as normal. Per staff's statement, close to 11:00 am, [client C] got up and started walking to the bathroom. The staff immediately followed [client C] to the bathroom and heard him hiccup. [Client C] then knelt down in the stall and spit out what looked like a quarter of a sandwich. [Client C] then stood up and began to walk, his eyes rolled back and he went faint. The staff assisted him to</p>		involved in this incident took the refresher course on 1/6/15 before working with consumers again and completed the full certification class on 1/29/15.				

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	<p>the ground and yelled to his coworker (sic) to call 911. The staff came from behind [client C] and placed [client C] against his chest and began attempting the Heimlich and back blows. The staff then positioned [client C] flat on his back and began chest compressions but the paramedics arrived and took over emergency care. " Conclusion of the investigation indicated "This investigation remains open pending the MRC (Mortality Review Committee) and death certificate...Recommendations: None at this time."</p> <p>Client C's Dysphagia Care/Dining Plan dated 5/6/14 was reviewed on 1/21/15 at 1:40 PM. The plan indicated a regular diet and regular fluids. Staff were to encourage client C "throughout meals to eat food slowly and chew/process each bite thoroughly before swallowing" and client C "should be encouraged to slow down when drinking fluid as he/she tends to drink too fast."</p> <p>Competency-Based Tests for staff #7 and #8 were reviewed on 1/21/15 at 4:40 PM. Staff #7's Competency Test dated 1/4/14 indicated client C's health and risk needs included "MR (mental retardation) and autism. Behavior Supports Needs indicated refusals, physical aggression, property abuse, verbal (sic), stealing,</p>			

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	<p>hoarding...What are the Individual's Diet and Nutritional Needs? Reg (regular) diet..."</p> <p>Staff #8's Competency Test dated 1/4 (no year documented) indicated client C's risk health and risk needs were "severe ID (intellectual disability) and autism..." Behavioral Supports Needs indicated "history of behaviors: refusals, PA (physical aggression), prop (property abuse), verbal agitation, stealing, inappropriate soc (social behavior), hoarding, obsessive." Diet and Nutrition Needs indicated "reg diet, history of gorging self on food."</p> <p>Client C's record was reviewed on 1/21/15 at 4:50 PM. An ISP dated 5/13/14 indicated a desired outcome "will continue to slow down when he eats by taking three bites of food and then putting his utensil down. Current Status: [client C] has a history of gorging his mouth with food when he is eating." Objectives to address dining indicated "will take 3 bites of food and then put his utensil down" with 1-4 verbal prompts." Health and Behavioral Issues indicated client C "has a history of gorging himself on food."</p> <p>A Therapeutic Support Plan for client C dated 5/19/14 indicated target objectives</p>			
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	<p>of inappropriate social behavior, taking others belongings, physical aggression, hoarding and gorging. Proactive strategy indicated "Do not leave drinks/food unattended...."</p> <p>Health Issues/Nursing Notes dated December, 2014 indicated on 12/4/14, "He does attempt to grab food from tables and kitchen at times. This is not a new behavior. Staff is present at meals to slow [client C] from eating to (sic) fast...." October, 2014 on 10/2/14 "He does eat fast and staff does attempt to slow him....." June, 2014 indicated on 6/3/14 "He does rush somewhat thru (through) meals and must be reminded to slow down. He will try to grab food that does not belong to him also.. Staff does watch him closely....."</p> <p>A day services assessment dated 5/6/14 indicated for choking risk client C was I (Independent) and "Regular diet/thin liquids."</p> <p>Staff #8 was interviewed on 1/23/15 at 11:50 AM. Staff #8 stated client C had "started to go through his (lunch) bag, but stopped when I redirected him at 10:30 AM. I then turned my attention to the client who was a food thief. [Client C] got up to use the restroom and [staff #7] followed him." Staff #8 stated client C</p>			

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	<p>had a behavior plan and was "aware of food seeking behavior, usually sodas. He would check out his lunch, part of a ritual, but not usually take it out to eat it, but to inventory (the contents). On that day he stopped going through the lunch box when I asked and neither I nor [staff #7] saw him go through it again." He indicated client C went to the restroom and had on his coat and may have had the sandwich hiding in his coat at that time. Staff #8 stated client C had taken a cookie out of the trash while at the park and eaten it before staff could stop him "about 8 months ago" when staff #8 had started employment. Staff #8 indicated he was not supervising client C at the time, but if he had been, he would have completed an incident report into client C's grabbing of the food out of the trash and eating it rapidly.</p> <p>A Prehospital Care Report Summary completed by the ambulance medic staff and emergency room hospital records for client C dated 1/5/15 was reviewed on 1/23/15 at 9:30 AM. The Prehospital Care Report Summary indicated the staff had received the call at 10:49 AM and "Upon entering the public library we went to the men's restroom where we found a 69 y/o (year old) pt (patient) sitting on the floor leaning against a guy right inside of the door of the bathroom</p>			

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	<p>stall...When I opened the door to the stall to be able to help move the pt medic [number] was laying the pt flat, I noticed the pt to be pale, not moving or breathing...The male that was with the pt stated he did not know much about the pt because he had just started working with him. He stated the pt is MR (mentally retarded) however he could not tell us any other hx (history), allergies or medications. He stated that prior to calling 911 the pt had been choking however he had stopped and said (sic) the guy he was doing better just prior to going unresponsive where we found him.... " The Report Summary indicated client C was transported to the hospital.</p> <p>The Emergency Department Chart dated 1/5/15 for client C indicated client C had arrived at the hospital at 11:19 AM, was unresponsive and after resuscitation efforts were unsuccessful was pronounced dead at 11:41 AM.</p> <p>A Certificate of Death dated 1/15/15 was reviewed on 1/23/15 at 1:45 PM and indicated client C's cause of death was "Asphyxia, aspiration of food."</p> <p>Staff #7 was interviewed on 1/23/15 at 2:55 PM and indicated client C had stealing behavior of putting objects into his pockets. He stated "stuffing food was</p>			

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	<p>not in his plan, but he is a choking risk." He indicated staff were to remind client C to slow down his rate of eating. Staff #7 indicated he had not looked for food in client C's mouth, but had completed back blows and Heimlich thrusts for 10 minutes after client C became unresponsive. Staff #7 stated, client C "must have gotten his sandwich out on the way to the restroom," and indicated his attention was focused on assisting client B with activities prior to client C getting up to use the restroom. Staff #7 indicated there were no client ISPs, dining plans or BSPs on site when working with clients at the library except the MAR (Medication Administration Record).</p> <p>The Residential Director was interviewed on 1/20/15 at 4:51 PM. She indicated client C had no previous history of choking and his plan did include prompts to put his utensil down between bites, and did not include food stealing behavior. Client C had checked his lunch box but didn't take food prior to the incident.</p> <p>2. Client B's record was reviewed on 1/23/15 at 2:50 PM. A nutritional assessment date 12/14 indicated he received a mechanical soft diet.</p>						

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W000192	<p>Competency-Based Tests dated 12/1/14 were reviewed on 1/23/15 at 4:40 PM and indicated Day Services staff #1-28 indicated client received a regular diet.</p> <p>The Residential Director was interviewed on 1/29/15 at 11:14 AM and indicated staff should have been trained to correctly identify clients' dining plans.</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based upon record review and interview for 2 of 4 sampled clients (clients B and C) and 1 additional client (client G), the facility failed to ensure staff implemented client C's plans to prevent gorging, failed to correctly implement emergency first aid procedures as trained to address an incident of choking, and failed to identify client B and G's dining plan strategies.</p>	W000192	The facilities dining plans have been updated to include behavior that may make individuals to be at increased risk for choking. The QIDP is monitoring the IDT process to ensure that any information included on the BSP or history of behavior be listed on the dining plan to ensure that staff have multiple avenues to obtain the information throughout their training. The information includes behavioral,	03/03/2015

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	<p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 1/20/15 at 4:30 PM. A BDDS report dated 1/5/15 indicated "On 1/5/15 [client C] was attending the [name] day program at the [library]. [Client C] was participating in recreational activities as normal. Per staff's statement, close to 11:00 am, [client C] got up and started walking to the bathroom. The staff immediately followed [client C] to the bathroom and heard him hiccup. [Client C] then knelt down in the stall and spit out what looked like a quarter of a sandwich. [Client C] then stood up and began to walk, his eyes rolled back and he went faint. The staff assisted him to the ground and yelled to his coworker (sic) to call 911. The staff came from behind [client C] and placed [client C] against his chest and began attempting the Heimlich and back blows. The staff then positioned [client C] flat on his back and began chest compressions but the paramedics arrived and took over emergency care. [Client C] was transported to [hospital] by ambulance as the paramedics continued to give treatment. Benchmark staff arrived at the hospital shortly after the ambulance arrived and [client C] was pronounced</p>		<p>environmental or safety concerns related to food or having access to food and level of staff supervision required when around food. All the plans will be updated to include this information and people without dining plans with behavioral concerns or an increased level of staff assistance will have a dining plan developed. All staff will receive training on all individuals with a dining plan including the house staff, day service or work services staff and families for individuals who spend time outside of the facilities care. All staff from residential and day services have received re-training on Client B and G's dining protocols and need for adaptive equipment on 1/23/15, 1/26/15, 1/27/15 and 1/30/15. In order to ensure this training has been effective, the nurse and director will complete mealtime observation monitoring at each location at least three times prior to the correction date and will document this monitoring which will be reviewed by the Regional Director to ensure compliance. This practice will be weekly as an ongoing quality assurance practice in the home and day service for a period of three months to ensure that the training has been effective. The day service staff have been inserviced on proper completion of the Client Specific Training form and that they must document all needs identified on the plan. These will be monitored by</p>	

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	<p>dead at approximately 11:41 am." Corrective action indicated "When the paramedics left with [client C], the staff checked [client C's] lunch box and everything was still in there except for his sandwich. Also, his sandwich bag was empty indicating he had taken out his sandwich and grabbed it eating it on the way to the bathroom and had choked on the sandwich. Benchmark will follow up through the Mortality Review Process."</p> <p>Systemic actions being taken to assume health and safety issues in the report indicated client C had a dining plan in place "which indicated he received a non-modified, regular diet with regular fluids. [Client C's] plan indicated that staff should encourage him to slow down when drinking fluids and to slow down when eating. The choking did not occur at a regularly scheduled mealtime. It appears that [client C] had taken his sandwich out of his lunch box while at his day service." The report indicated client C did not have any previous choking incidents, difficulties chewing or swallowing, and client C "did not have a specific level of supervision/monitoring during mealtimes and the incident did not occur during a mealtime. Staff were however present and in close proximity to [client C]...All staff working with [client C] were trained on his plans and</p>		<p>the day service and residential director to ensure compliance. These are completed every time there is a change in the condition, care or diagnosis of the individuals and annually after completion of their annual meeting and review. These are tracked by Human Resources to ensure that staff are trained on the needs of the individuals they are working with.</p>	

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	<p>completed competency based training. [Client C] did not require any modifications to his diet...[Client C] did not exhibit any sign of choking prior to getting up to use the restroom."</p> <p>The Residential Director was interviewed on 1/20/15 at 4:51 PM. She indicated client C had no previous history of choking and his plan did include prompts to put his utensil down between bites, and did not include food stealing behavior. Client C had checked his lunch box but didn't take food prior to the incident.</p> <p>Statements from day service staff #7 and #8 were reviewed on 1/20/15 at 4:50 PM. Staff #7 indicated in a statement dated 1/5/15 "Arrived at the library at 10 am. When we arrived individuals put coats up and began activities. [Client C] colored and enjoyed music. At that time their bags were at the front, and lunch boxes at the table with individuals. I took [client C] to the bathroom multiple times. Close to 11 am [client C] got up and started walking to the bathroom. I followed him to the bathroom and heard him began to hicup (sic). [Client C] then kneeled down in the stall, and spit out what looked like a quarter of a sandwich. There was no evidence of the rest of the sandwich. [Client C] stood up began to walk. His</p>			

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	<p>eyes rolled in the back of his head and he went faint. I grabbed him and helped him onto the ground. I got him against my chest and began hymlyc (sic) and back blows roughly for 10 mins (minutes). I then positioned him flat on the ground to begin chest compressions."</p> <p>Client C's Dysphagia Care/Dining Plan dated 5/6/14 was reviewed on 1/21/15 at 1:40 PM. The plan indicated a regular diet and regular fluids. Staff were to encourage client C "throughout meals to eat food slowly and chew/process each bite thoroughly before swallowing" and client C "should be encouraged to slow down when drinking fluid as he/she tends to drink too fast."</p> <p>Competency-Based Tests for staff #7 and #8 were reviewed on 1/21/15 at 4:40 PM. Staff #7's Competency Test dated 1/4/14 indicated client C's health and risk needs included "MR (mental retardation) and autism. Behavior Supports Needs indicated refusals, physical aggression, property abuse, verbal (sic), stealing, hoarding...What are the Individual's Diet and Nutritional Needs? Reg (regular) diet..."</p> <p>Staff #8's Competency Test dated 1/4 (no year documented) indicated client C's risk health and risk needs were "severe ID</p>			

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	<p>(intellectual disability) and autism..." Behavioral Supports Needs indicated "history of behaviors: refusals, PA (physical aggression), prop (property abuse), verbal agitation, stealing, inappropriate soc (social behavior), hoarding, obsessive." Diet and Nutrition Needs indicated "reg diet, history of gorging self on food."</p> <p>Staff #8's American Red Cross Certificate of Completion for Adult First Aid/CPR dated 4/10/14 was reviewed on 1/21/15 at 4:25 PM and indicated he had successfully completed the course.</p> <p>The American Red Cross First Aid/CPR/AED (auxiliary external defibrillator) Instructor's Manual dated 2011 was reviewed on 1/21/15 at 4:30 PM. Topic: Breathing Emergency indicated "A breathing emergency occurs when a person is having trouble breathing or cannot breathe at all..." The lesson indicated "If a conscious choking person becomes unconscious, carefully lower the person to the ground, open the mouth and look for an object. If an object is seen, remove it with your finger. If no object is seen, open the person's airway and give 2 rescue breaths. If the chest does not clearly rise, give 30 chest compressions. Open the mouth to look for and remove a foreign object with a finger, if seen, then</p>						

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	<p>give 2 rescue breaths. As long as the chest does not clearly rise, continue cycles of giving 30 chest compressions, looking for a foreign object and giving 30 chest compressions, looking for a foreign object and giving 2 rescue breaths...For chest compressions to the most effective, the person should be on his or her back on a firm, flat surface...."</p> <p>Client C's record was reviewed on 1/21/15 at 4:50 PM. An ISP dated 5/13/14 indicated a desired outcome "will continue to slow down when he eats by taking three bites of food and then putting his utensil down. Current Status: [client C] has a history of gorging his mouth with food when he is eating." Objectives to address dining indicated "will take 3 bites of food and then put his utensil down" with 1-4 verbal prompts. Health and Behavioral Issues indicated client C "has a history of gorging himself on food."</p> <p>A Therapeutic Support Plan for client C dated 5/19/14 indicated target objectives of inappropriate social behavior, taking others belongings, physical aggression, hoarding, gorging. Proactive strategy indicated "Do not leave drinks/food unattended...."</p> <p>Health Issues/Nursing Notes dated</p>			

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	<p>December, 2014 indicated on 12/4/14, "He does attempt to grab food from tables and kitchen at times. This is not a new behavior. Staff is present at meals to slow [client C] from eating to (sic) fast..." October, 2014 on 10/2/14 "He does eat fast and staff does attempt to slow him....." June, 2014 indicated on 6/3/14 "He does rush somewhat thru (through) meals and must be reminded to slow down. He will try to grab food that does not belong to him also.. Staff does watch him closely....."</p> <p>A day services assessment dated 5/6/14 indicated for choking risk client C was I (Independent) and "Regular diet/thin liquids."</p> <p>A Prehospital Care Report Summary completed by the ambulance medic staff and emergency room hospital records for client C dated 1/5/15 was reviewed on 1/23/15 at 9:30 AM. The Prehospital Care Report Summary indicated the staff had received the call at 10:49 AM and "Upon entering the public library we went to the men's restroom where we found a 69 y/o (year old) pt (patient) sitting on the floor leaning against a guy right inside of the door of the bathroom stall...When I opened the door to the stall to be able to help move the pt medic [number] was laying the pt flat, I noticed</p>						

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	<p>the pt to be pale, not moving or breathing...The male that was with the pt stated he did not know much about the pt because he had just started working with him. He stated the pt is MR (mentally retarded) however he could not tell us any other hx (history), allergies or medications. He stated that prior to calling 911 the pt had been choking however he had stopped and said (sic) the guy he was doing better just prior to going unresponsive where we found him.... " The Report Summary indicated client C was transported to the hospital.</p> <p>Staff #7 was interviewed on 1/23/15 at 2:55 PM and indicated client C had stealing behavior of putting objects into his pockets. He stated "stuffing food was not in his plan, but he is a choking risk." He indicated staff were to remind client C to slow down his rate of eating. Staff #7 indicated he had not looked for food in client C's mouth, but had completed back blows and Heimlich thrusts for 10 minutes after client C became unresponsive. Staff #7 stated, client C "must have gotten his sandwich out on the way to the restroom," and indicated his attention was focused on assisting client B with activities prior to client C getting up to use the restroom.</p> <p>The Residential Director was interviewed</p>			

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	<p>again on 1/23/15 at 1:50 PM and indicated staff #7 had not followed the agency's protocol to address choking incidents.</p> <p>The Residential Director was interviewed on 1/29/15 at 11:31 AM and indicated there was no additional investigation completed within 5 working days as indicated in the investigation dated 1/9/15. She indicated additional investigation steps had been taken and the next step of the mortality review process was due on 2/6/15.</p> <p>2. Workshop services staff #1 was interviewed on 1/23/15 at 12:45 PM. She indicated client G did not have a dining plan and she was only aware of high risk clients' dining plans. She indicated dining plans for clients who did not have high risk for dining were not present in the workshop. She indicated client G did not use adaptive equipment while at workshop.</p> <p>Client B's record was reviewed on 1/23/15 at 2:50 PM. A nutritional assessment dated 12/14 indicated he received a mechanical soft diet.</p> <p>Client G's dining plan was reviewed on 1/30/15 at 3:28 PM and indicated he was not a choking risk, and received a regular</p>			

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W000369	<p>diet. Client G was to use a divided plate, large-weighted utensils.</p> <p>Competency-Based Tests dated 12/1/14 were reviewed on 1/23/15 at 4:40 PM and indicated Day Services staff #1-28 indicated the client received a regular diet.</p> <p>The Residential Director was interviewed on 1/29/15 at 11:14 AM and indicated staff should have been trained to correctly identify clients' dining plans.</p> <p>9-3-3(a)</p> <p>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.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client D) to follow the medication label instructions.</p>	W000369	The surveyor notified the director and nurse of the error on 1/21/15. The staff who made the error received a medication error per policy. On 1/21/15, all staff received training on the	03/03/2015

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 7631 WHEELOCK RD FORT WAYNE, IN 46835		
(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>Medication administration was observed at the group home on 1/20/15 at 6:10 PM. Staff #2 gave client D Carbamazepine 100 mg (milligrams) and client D swallowed the tablet whole. The label indicated "Chew medication before swallowing."</p> <p>Staff #2 was interviewed on 1/20/15 at 6:08 PM and indicated she had not noticed the instructions on client D's medication label.</p> <p>The group home nurse was interviewed on 1/29/15 at 11:16 AM and indicated client D should have chewed the medication before swallowing it.</p> <p>9-3-6(a)</p>		<p>medication administration policy which includes administering medications as ordered and checking the order multiple times. Medication administration quality assurance checks have been implemented and the manager or nurse will be monitoring staff three times a week for two weeks to ensure compliance. This will include evening, morning and weekend staff to ensure that all staffs training was effective and medications are being passed without error. Ongoing monitoring will continue to be done weekly at various times, documented on the Medication Administration checklist and turned in to the director for review.</p>		