

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 PERRY TR FORT WAYNE, IN 46825
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W000000	<p>This visit was for the investigation of complaint #IN00157401.</p> <p>Complaint #IN00157401: SUBSTANTIATED.</p> <p>Federal and state deficiencies related to the allegations are cited at W192 and W331.</p> <p>Dates of Survey: October 2, 3, 6, 7, 8 and 9, 2014.</p> <p>Facility number: 011213 Provider number: 15G728 AIM number: 200833320</p> <p>Surveyor: Kathy Wanner, QIDP.</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 23, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000192	<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>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Based on observation, record review and interview, the facility failed to provide all direct care staff (DCS) who worked in the group home with training on the current wound dressing order for 1 of 2 sampled clients (client B).</p> <p>Findings include:</p> <p>Observations of client B's wound were conducted on 10/2/14 at 2:31 P.M. The facility's RN removed the gauze dressing on client B's left foot. Client B had an open area on the outer side of the ball joint of his first metatarsal bone (bone in the foot just behind the great toe) of his left foot. Client B's left foot was turned outwards towards the left with the ball joint of his great toe and right side of the foot at the top of his foot. The wound area was 3 centimeters in size. The center was light in color with pink flesh surrounding and a thin red line connecting the wound to the intact skin of his foot. The wound was moist and lightly seeping a watery red substance. There was no evidence of pus. There was no noticeable swelling. There was no redness to his toes or the surrounding flesh of his foot or leg. There was no odor present. Client B's facial expression was without affect, non-smiling, with eyes open wide. Client B did smile one time at this writer.</p>	W000192	<p>Client's B wound dressing order was changed on 9/30/14 by Wound Care Clinic with an order to change the dressing every two days. The residential nurse changed the dressing on 10/2/14 as prescribed by the physician. The residential nurse trained a staff member and the on-call residential manager on the new wound dressing procedure. On 10/2/14 the dressing was dislodged during clothing change on client B. The staff member who was trained by the residential nurse on 10/2/14 arrived at the house and changed the dressing per physician's orders. The residential nurse had planned to train the remainder of the staff on the wound dressing procedure on 10/3/14. The residential nurse and on-call residential manager who were both trained on the wound dressing procedure were available to go to the group home and change the dressing at anytime if the dressing became dislodged. The QIDP, manager and nurse will be re-trained on ensuring that all medical treatments on the MAR and staff is trained. The QIDP, manager and nurse will meet after a new medical treatment is prescribed and ensure that it is placed on the Medication Administration Record. The QIDP, manager, and nurse will meet and develop a competency based training for the staff. The QIDP and manager will ensure that all staff have passed</p>	11/08/2014

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	<p>The facility's RN was interviewed on 10/2/14 at 2:29 P.M. The RN stated, "[Client B] has been going to the wound clinic once a week since early August 2014. His Mother/Co-guardian attends each appointment. The wound clinic has been dressing his wound each week and we were to monitor, keep it clean, dry and intact. I had the staff cover his foot with plastic when he got his shower, and monitor his leg and toes for any changes. His (client B's) last appointment at the wound clinic was Tuesday (9/30/14), the dressing order was changed at that appointment. The area is now to have a dressing change every two days. I changed it for the first time this morning. The next time it is to be changed is Saturday (10/4/14)."</p> <p>Client B's record was reviewed on 10/2/14 at 3:30 P.M. Client B's record and physician's order (PO) dated for 9/2014 indicated the following diagnoses, but not limited to, profound mental retardation, seizure disorder, gastritis/GERD (gastroesophageal reflux disease), spastic cerebral palsy with multiple flexion contractures (extremities and digits), short gut syndrome, scoliosis (an 80 degree curve of the spine), right hip dislocation, incontinence of bladder and bowel, contractures, limitation of</p>		a competency based test prior to working a group home with anew prescribed medical treatment. All competency based tests will be turned into the director for review to ensure compliance. The director will compare the MAR and the competency based tests to ensure accuracy.				

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	<p>motion and muscular weakness, iron deficiency, dry eyes, constipation/diarrhea, dysphasia/NPO (nothing by mouth), all nutrition and medications administered via G-tube (Gastrostomy tube inserted through the abdomen delivering nutrition to the stomach). Client B's yearly physical dated 4/22/14 indicated "Increased spasticity noted and discussed with primary care doctor. Mother (co-guardian) against any increase in medication at this time." Client B's nutrition assessment dated 8/2014 indicated "Has wound to L (left) foot/toe, to be seen by wound clinic." Physical Therapy (PT) evaluation dated 4/14/14 indicated "Continue current plan of care." Occupational Therapy (OT) evaluation dated 4/14/14 indicated "Recommend rolled wash cloth in left hand to prevent further contractures." There was no documentation from the OT or PT indicating client B had a wound on his left foot or at any other area of his body. Client B's skin risk protocol review dated 9/30/14 indicated: "Interventions: Bathe with mild soap and rinse and pat dry. Keep skin clean and dry. Moisturize with lotion. Keep linens dry and wrinkle free. Lift, do not slide client. Monitor skin daily for redness. Utilize assistive devices to avoid friction and shearing. If client wears incontinent briefs, check change</p>			

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	<p>every 1-2 hours. Initiate turning/repositioning schedule according to client's needs. Monitor skin beneath splints, braces, etc daily for signs of breakdown. Encourage activity as tolerated. Pressure reduction mattress on bed. Pressure reduction surface while in wheelchair. Protect elbows/heels. Instruct and encourage client to reposition self at 15-20 minute intervals. Monitor nutrition/hydration status with each meal and document on nourishment intake form. Nutritional supplement per physician order. Vitamins and Minerals per physician order. If wound exists: Monitor wound weekly and document on the weekly Skin Progress Report until resolved. Provide treatment per physician order. Other Interventions: 7/31/14 No shoe left foot at this time. Dress with 4x4 gauze dressing. Keep area clean and dry until seen by wound clinic. 8/5/14 Follow directions per wound care orders. Keep area clean and dry. Monitor left foot leg for circulation and monitor dressing. Continue with no shoe to l (left) foot. Only wound clinic to dress wound at this time. 9/30/14 Seen by wound clinic. Staff to do dressing changes every two days with Mepiplex (5 layer super absorbent breathable foam dressing), 4x4 (gauze pads) and gauze. Start date on 10/2/14." Weekly Skin Progress Reports for client B written by the facility RN indicated;</p>			

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	<p>"7/28/14 1 cm (centimeter) by 1/2 cm, no drainage, no odor, red. Applied Bacitracin (antibiotic topical ointment) to area along with padded dressing. No shoes to be worn on that foot at all time.</p> <p>7/29/14 1 cm x 1/2 cm, no drainage, no odor, red. Redressed area continue with no shoes on that foot. 7/31/14 1 cm x 1/2 cm. Area open at this time, no drainage, red. Patient seen by family physician. Orders to keep dry and intact. Follow-up with wound clinic. 8/1/14 1 cm x 1/2 cm, no odor, red. Area redressed with clean dressing. Slight drainage noted from wound area, yellowish drainage was noted. 8/4/14 1 cm x 1/2 cm 1/4 cm depth, yellow drainage, no odor, red. Continued with dry dressing change.</p> <p>8/5/14 Wound Care currently overseeing treatment. Nurse unable to assess. Please see documentation."</p> <p>Medical Appointment Forms for Wound: 7/31/14 Primary Care Physician (PCP): "Pressure ulcer left foot-1st (first) Metatarsal Phalangeal joint (MTP) (joint at base of great toe), examined, redressed, refer to wound clinic ASAP (as soon as possible).</p> <p>8/5/14 Wound Clinic (WC): "left foot ulcer, application of Mepiplex, Zinc, web roll, coban boot, ankle high dressing. Leave dressing intact for 1 week (till next visit)."</p> <p>8/12/14 WC: "L (left) foot</p>			

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	<p>rewrapped-leave dressing intact." 8/19/14 WC: "Flexion contractures of the toes. 1st MTP ulcer: 1.9 x 1.5 cm by 0.1 cm deep. Base has increased granulation (new connective tissue and tiny blood vessels that form on the surface of a wound during the healing process). No bone exposed...ankle high dressing to the left foot. Recheck in 1 week." 8/26/14 WC: "Foot re-wrapped-leave intact for 1 wk (week)... 1.1 x 0.5 cm by 0.1 cm deep base has increased granulation. Re-epithelializing (tissue reforming). No bone exposed." 9/3/14 WC: "Left foot ulcer, left foot dressing leave intact for 1 wk... 1.0 x 1.3 cm by 0.1 cm deep, base has increased granulation (hypertrophic granulation) (scarring within the boundary of the wound), Re-epithelializing. No bone exposed." 9/9/14 WC: "Dressing re-applied to left foot...1.2 x 0.7 cm by 0.1 cm deep. Base has increased granulation. (hypertrophic granulation). Re-epithelializing. No bone exposed." 9/16/14 WC: "Flexion contractures of the toes. 1st MTP ulcer: 1.1 x 0.6 cm by 0.1 cm deep. Base has increased granulation (hypertrophic granulation), Re-epithelializing. No bone exposed." 9/23/14 WC: "Flexion contractures of the toes. 1st MTP ulcer: 1.1 x 0.3 cm by 0.1 cm deep. Base has increased granulation</p>			

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	<p>(hypertrophic granulation), Re-epithelializing. No bone exposed." 9/30/14 WC: " [Client B] is here today for follow-up wound care of his left foot ulcer. It has unfortunately worsened this week and now has exposed bone (1st MT head)...Flexion contractures of the toes. 1st MTP ulcer: 1.2 x 2.1 cm by 0.1 cm deep. Base has decreased granulation. Bone now exposed. Discusses conservative tx (treatment) with Mepiplex and await culture. Or referral to [name of surgeon] for surgical intervention. They (parents/guardians) wish to go the conservative route." 9/30/14 WC: Physician at wound clinic ordered a culture of client B's wound and x-ray of his left foot. X-Ray results indicated, "The foot is markedly misshapened with severe pes planus (flat foot) deformity and marked valgus (bunion deformity) of the 1st toe at the MTP joint. The 1st toe is positioned beneath the 2nd, 3rd, and 4th toes. There is no evidence of lytic (loosening or dissolving) or destructive process in this region."</p> <p>An interview was conducted with direct care staff (DCS) #1 on 10/7/14 at 1:46 P.M. DCS #1 stated, "The doctor gave mom (client B's guardian) two options. 1. Keep coming to wound clinic, but it will reopen and get infected and his whole</p>			

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	<p>foot would then need to be amputated. 2. Have surgery to remove his great toe. Mom called Dad on the phone and had the doctor tell Dad (client B's father) about the two options. They choose to take the less invasive option and continue to have [client B] go to the wound clinic. The Dr. at the wound clinic said, 'I will see him one more time, next week, but there really is no use as the wound will never really heal without the surgery.'</p> <p>An interview was conducted with DCS #2 on 10/9/14 at 10:48 A.M. DCS #2 stated, "I was working at the group home on 10/2/14, I normally work at another medical fragile home, but they are pretty much the same. I have been at the group home before when I was trained, but this was my first shift there. I have been trained on how to do G-Tube feedings. [Client B] is on a continuous feed which was started that morning. I passed his medications by his tube. We put everyone else to bed and then the other staff working was showing me how they check and change [client B] and put him in his bed. Yes his G-tube was still hooked up, but it had just finished at 8:30 P.M. we had him laying (sic) on his bed. The bed was flat cause we had just changed him. The doorbell rang and I answered the door and a female came in and said 'I'm [client B's] sister, and I am an RN. Why</p>						

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	<p>is his bed flat, the head of his bed needs to be elevated. Why is his feeding pump still hooked up? Why does he have a Band-Aid on his foot, he is not to use Band-Aid.' She just sort of took over. We tried to explain we were still in the process of putting him to bed and that we had not finished with him. The other staff was looking for gauze to wrap his foot. The dressing had just come off when we took his pants off of him. The wound was bleeding a little and the other staff put a Band-Aid on just till the 9:00 P.M. staff arrived. She had been trained on how to do his new dressing change. We were to be trained the next morning. [Name of night shift staff] got there at 8:40 P.M. and she put on a clean dressing on [client B's foot]."</p> <p>An interview was conducted with DCS #3 on 10/7/14 at 2:36 P.M. DCS #3 stated, "I was working at the group home and we saved [client B] for last. At about 8:15 P.M. we started to put him to bed. I cleaned his G-tube area. We cleaned him up and changed him. His dressing came off his foot when we undressed him, and I didn't want the blood to get on him or his bed so I did what I thought was best, I put a Band-Aid on. The night shift girl was coming in early, and she had been trained on his new dressing order he just got on Tuesday. The Band-Aid might</p>			

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	<p>have been there 15 minutes. The doorbell rang. I never saw the woman before. She said she was [client B's] sister and an RN and she said 'Just let me do it.' I tried to find the new dressing order for her, but I couldn't find it. It was to be done every two days, and I knew it had just been done by [name of facility RN] that morning. I was supposed to be trained on Friday morning, but his (client B's) family came and got him yet that Thursday night."</p> <p>An interview was conducted with the facility's RN on 10/9/14 at 1:18 P.M. The RN stated, "He (client B) is allergic to adhesive tape. For an emergency situation I don't think it (Band-Aid) caused any harm. The staff could have put a 4x4 (gauze pad) on it. They should have called and would have been instructed on what to do. When his sister came the staff did the best they could. I was going to train them on the new dressing order the next morning." The RN indicated the two staff on duty from 6:30 P.M. until 8:40 P.M. had not yet been trained on client B's new dressing order.</p> <p>The Residential Director (RD) was interviewed on 10/9/14 at 1:05 P.M. The RD stated, "Yes the Band-Aid was appropriate to keep his wound from seeping until the appropriate bandage</p>						

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W000331	<p>could be secured." The RD indicated the two staff working at the group home on 10/2/14 from 6:30 P.M. until 8:40 P.M. had not yet been trained on [client B's] dressing order.</p> <p>This federal tag relates to complaint #IN00157401</p> <p>9-3-3(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility nursing services failed to provide all direct care staff (DCS) who worked in the group home with training on the current wound dressing order for 1 of 2 sampled clients (client B).</p>	W000331	Client's B wound dressing order was changed on 9/30/14 by Wound Care Clinic with an order to change the dressing every two days. The residential nurse changed the dressing on 10/2/14 as prescribed by the physician. The residential nurse trained a staff member and the on-call residential manager on the new	11/08/2014

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	<p>Findings include:</p> <p>Observations of client B's wound were conducted on 10/2/14 at 2:31 P.M. The facility's RN removed the gauze dressing on client B's left foot. Client B had an open area on the outer side of the ball joint of his first metatarsal bone (bone in the foot just behind the great toe) of his left foot. Client B's left foot was turned outwards towards the left with the ball joint of his great toe and right side of the foot at the top of his foot. The wound area was 3 centimeters in size. The center was light in color with pink flesh surrounding and a thin red line connecting the wound to the intact skin of his foot. The wound was moist and lightly seeping a watery red substance. There was no evidence of pus. There was no noticeable swelling. There was no redness to his toes or the surrounding flesh of his foot or leg. There was no odor present. Client B's facial expression was without affect, non-smiling, with eyes open wide. Client B did smile one time at this writer.</p> <p>The facility's RN was interviewed on 10/2/14 at 2:29 P.M. The RN stated, "[Client B] has been going to the wound clinic once a week since early August 2014. His Mother/Co-guardian attends each appointment. The wound clinic has</p>		<p>wound dressing procedure. On 10/2/14 the dressing was dislodged during clothing change on client B. The staff member who was trained by the residential nurse on 10/2/14 arrived at the house and changed the dressing per physician's orders. The residential nurse had planned to train the remainder of the staff on the wound dressing procedure on 10/3/14. The residential nurse and on-call residential manager who were both trained on the wound dressing procedure were available to go to the group home and change the dressing at anytime if the dressing became dislodged. The nurse will be re-trained to ensure that all staff are properly trained on any new medical treatments prescribed by a physician. The nurse will be informed of any new prescribed medical treatment by the QIDP or manager. The QIDP, manager and nurse will meet and ensure that the new treatment is placed on the Medication Administration Record. The QIDP, manager, and nurse will meet and develop a competency based training for the staff. The QIDP and manager will ensure that all staff have passed a competency based test prior to working a group home with a new prescribed medical treatment. All competency based tests will be turned into the director for review to ensure compliance. The director will compare the MAR and the competency based tests</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/09/2014
NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 2325 PERRY TR FORT WAYNE, IN 46825		
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	<p>been dressing his wound each week and we were to monitor, keep it clean, dry and intact. I had the staff cover his foot with plastic when he got his shower, and monitor his leg and toes for any changes. His (client B's) last appointment at the wound clinic was Tuesday (9/30/14), the dressing order was changed at that appointment. The area is now to have a dressing change every two days. I changed it for the first time this morning. The next time it is to be changed is Saturday (10/4/14)."</p> <p>Client B's record was reviewed on 10/2/14 at 3:30 P.M. Client B's record and physician's order (PO) dated for 9/2014 indicated the following diagnoses, but not limited to, profound mental retardation, seizure disorder, gastritis/GERD (gastroesophageal reflux disease), spastic cerebral palsy with multiple flexion contractures (extremities and digits), short gut syndrome, scoliosis (an 80 degree curve of the spine), right hip dislocation, incontinence of bladder and bowel, contractures, limitation of motion and muscular weakness, iron deficiency, dry eyes, constipation/diarrhea, dysphasia/NPO (nothing by mouth), all nutrition and medications administered via G-tube (Gastrostomy tube inserted through the abdomen delivering nutrition to the</p>		to ensure accuracy.		

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	<p>stomach). Client B's yearly physical dated 4/22/14 indicated "Increased spasticity noted and discussed with primary care doctor. Mother (co-guardian) against any increase in medication at this time."</p> <p>Client B's nutrition assessment dated 8/2014 indicated "Has wound to L (left) foot/toe, to be seen by wound clinic."</p> <p>Physical Therapy (PT) evaluation dated 4/14/14 indicated "Continue current plan of care." Occupational Therapy (OT) evaluation dated 4/14/14 indicated "Recommend rolled wash cloth in left hand to prevent further contractures."</p> <p>There was no documentation from the OT or PT indicating client B had a wound on his left foot or at any other area of his body.</p> <p>Client B's skin risk protocol review dated 9/30/14 indicated: "Interventions: Bathe with mild soap and rinse and pat dry. Keep skin clean and dry. Moisturize with lotion. Keep linens dry and wrinkle free. Lift, do not slide client. Monitor skin daily for redness. Utilize assistive devices to avoid friction and shearing. If client wears incontinent briefs, check change every 1-2 hours. Initiate turning/repositioning schedule according to client's needs. Monitor skin beneath splints, braces, etc daily for signs of breakdown. Encourage activity as tolerated. Pressure reduction mattress on bed. Pressure reduction surface while in</p>			

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	wheelchair. Protect elbows/heels. Instruct and encourage client to reposition self at 15-20 minute intervals. Monitor nutrition/hydration status with each meal and document on nourishment intake form. Nutritional supplement per physician order. Vitamins and Minerals per physician order. If wound exists: Monitor wound weekly and document on the weekly Skin Progress Report until resolved. Provide treatment per physician order. Other Interventions: 7/31/14 No shoe left foot at this time. Dress with 4x4 gauze dressing. Keep area clean and dry until seen by wound clinic. 8/5/14 Follow directions per wound care orders. Keep area clean and dry. Monitor left foot leg for circulation and monitor dressing. Continue with no shoe to l (left) foot. Only wound clinic to dress wound at this time. 9/30/14 Seen by wound clinic. Staff to do dressing changes every two days with Mepiplex (5 layer super absorbent breathable foam dressing), 4x4 (gauze pads) and gauze. Start date on 10/2/14." Weekly Skin Progress Reports for client B written by the facility RN indicated; "7/28/14 1 cm (centimeter) by 1/2 cm, no drainage, no odor, red. Applied Bacitracin (antibiotic topical ointment) to area along with padded dressing. No shoes to be worn on that foot at all time. 7/29/14 1 cm x 1/2 cm, no drainage, no odor, red. Redressed area continue with			

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 PERRY TR FORT WAYNE, IN 46825
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	<p>no shoes on that foot. 7/31/14 1 cm x 1/2 cm. Area open at this time, no drainage, red. Patient seen by family physician. Orders to keep dry and intact. Follow-up with wound clinic. 8/1/14 1 cm x 1/2 cm, no odor, red. Area redressed with clean dressing. Slight drainage noted from wound area, yellowish drainage was noted. 8/4/14 1 cm x 1/2 cm 1/4 cm depth, yellow drainage, no odor, red. Continued with dry dressing change. 8/5/14 Wound Care currently overseeing treatment. Nurse unable to assess. Please see documentation."</p> <p>Medical Appointment Forms for Wound: 7/31/14 Primary Care Physician (PCP): "Pressure ulcer left foot-1st (first) Metatarsal Phalangeal joint (MTP) (joint at base of great toe), examined, redressed, refer to wound clinic ASAP (as soon as possible). 8/5/14 Wound Clinic (WC): "left foot ulcer, application of Mepiplex,Zinc, web roll, coban boot, ankle high dressing. Leave dressing intact for 1 week (till next visit)." 8/12/14 WC: "L (left) foot rewrapped-leave dressing intact." 8/19/14 WC: "Flexion contractures of the toes. 1st MTP ulcer:1.9 x 1.5 cm by 0.1 cm deep. Base has increased granulation (new connective tissue and tiny blood vessels that form on the surface of a wound during the healing process). No</p>			

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	<p>bone exposed...ankle high dressing to the left foot. Recheck in 1 week." 8/26/14 WC: "Foot re-wrapped-leave intact for 1 wk (week).... 1.1 x 0.5 cm by 0.1 cm deep base has increased granulation. Re-epithelializing (tissue reforming). No bone exposed." 9/3/14 WC: "Left foot ulcer, left foot dressing leave intact for 1 wk.... 1.0 x 1.3 cm by 0.1 cm deep, base has increased granulation (hypertrophic granulation) (scarring within the boundary of the wound), Re-epithelializing. No bone exposed." 9/9/14 WC: "Dressing re-applied to left foot...1.2 x 0.7 cm by 0.1 cm deep. Base has increased granulation. (hypertrophic granulation). Re-epithelializing. No bone exposed." 9/16/14 WC: "Flexion contractures of the toes. 1st MTP ulcer: 1.1 x 0.6 cm by 0.1 cm deep. Base has increased granulation (hypertrophic granulation), Re-epithelializing. No bone exposed." 9/23/14 WC: "Flexion contractures of the toes. 1st MTP ulcer: 1.1 x 0.3 cm by 0.1 cm deep. Base has increased granulation (hypertrophic granulation), Re-epithelializing. No bone exposed." 9/30/14 WC: " [Client B] is here today for follow-up wound care of his left foot ulcer. It has unfortunately worsened this week and now has exposed bone (1st MT head)...Flexion contractures of the toes.</p>			

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 2325 PERRY TR FORT WAYNE, IN 46825			
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	<p>1st MTP ulcer: 1.2 x 2.1 cm by 0.1 cm deep. Base has decreased granulation. Bone now exposed. Discusses conservative tx (treatment) with Mepiplex and await culture. Or referral to [name of surgeon] for surgical intervention. They (parents/guardians) wish to go the conservative route."</p> <p>9/30/14 WC: Physician at wound clinic ordered a culture of client B's wound and x-ray of his left foot. X-Ray results indicated, "The foot is markedly misshapened with severe pes planus (flat foot) deformity and marked valgus (bunion deformity) of the 1st toe at the MTP joint. The 1st toe is positioned beneath the 2nd, 3rd, and 4th toes. There is no evidence of lytic (loosening or dissolving) or destructive process in this region."</p> <p>An interview was conducted with direct care staff (DCS) #1 on 10/7/14 at 1:46 P.M. DCS #1 stated, "The doctor gave mom (client B's guardian) two options. 1. Keep coming to wound clinic, but it will reopen and get infected and his whole foot would then need to be amputated. 2. Have surgery to remove his great toe. Mom called Dad on the phone and had the doctor tell Dad (client B's father) about the two options. They choose to take the less invasive option and continue to have [client B] go to the wound clinic.</p>						

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	<p>The Dr. at the wound clinic said, 'I will see him one more time, next week, but there really is no use as the wound will never really heal without the surgery.'</p> <p>An interview was conducted with DCS #2 on 10/9/14 at 10:48 A.M. DCS #2 stated, "I was working at the group home on 10/2/14, I normally work at another medical fragile home, but they are pretty much the same. I have been at the group home before when I was trained, but this was my first shift there. I have been trained on how to do G-Tube feedings. [Client B] is on a continuous feed which was started that morning. I passed his medications by his tube. We put everyone else to bed and then the other staff working was showing me how they check and change [client B] and put him in his bed. Yes his G-tube was still hooked up, but it had just finished at 8:30 P.M. we had him laying (sic) on his bed. The bed was flat cause we had just changed him. The doorbell rang and I answered the door and a female came in and said 'I'm [client B's] sister, and I am an RN. Why is his bed flat, the head of his bed needs to be elevated. Why is his feeding pump still hooked up? Why does he have a Band-Aid on his foot, he is not to use Band-Aid.' She just sort of took over. We tried to explain we were still in the process of putting him to bed and that we</p>			

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 PERRY TR FORT WAYNE, IN 46825
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	<p>had not finished with him. The other staff was looking for gauze to wrap his foot. The dressing had just come off when we took his pants off of him. The wound was bleeding a little and the other staff put a Band-Aid on just till the 9:00 P.M. staff arrived. She had been trained on how to do his new dressing change. We were to be trained the next morning. [Name of night shift staff] got there at 8:40 P.M. and she put on a clean dressing on [client B's foot]."</p> <p>An interview was conducted with DCS #3 on 10/7/14 at 2:36 P.M. DCS #3 stated, "I was working at the group home and we saved [client B] for last. At about 8:15 P.M. we started to put him to bed. I cleaned his G-tube area. We cleaned him up and changed him. His dressing came off his foot when we undressed him, and I didn't want the blood to get on him or his bed so I did what I thought was best, I put a Band-Aid on. The night shift girl was coming in early, and she had been trained on his new dressing order he just got on Tuesday. The Band-Aid might have been there 15 minutes. The doorbell rang. I never saw the woman before. She said she was [client B's] sister and an RN and she said 'Just let me do it.' I tried to find the new dressing order for her, but I couldn't find it. It was to be done every two days, and I knew it had just been</p>			

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 2325 PERRY TR FORT WAYNE, IN 46825			
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	<p>done by [name of facility RN] that morning. I was supposed to be trained on Friday morning, but his (client B's) family came and got him yet that Thursday night."</p> <p>An interview was conducted with the facility's RN on 10/9/14 at 1:18 P.M. The RN stated, "He (client B) is allergic to adhesive tape. For an emergency situation I don't think it (Band-Aid) caused any harm. The staff could have put a 4x4 (gauze pad) on it. They should have called and would have been instructed on what to do. When his sister came the staff did the best they could. I was going to train them on the new dressing order the next morning." The RN indicated the two staff on duty from 6:30 P.M. until 8:40 P.M. had not yet been trained on client B's new dressing order.</p> <p>The Residential Director (RD) was interviewed on 10/9/14 at 1:05 P.M. The RD stated, "Yes the Band-Aid was appropriate to keep his wound from seeping until the appropriate bandage could be secured." The RD indicated the two staff working at the group home on 10/2/14 from 6:30 P.M. until 8:40 P.M. had not yet been trained on [client B's] dressing order.</p> <p>This federal tag relates to complaint</p>						

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 PERRY TR FORT WAYNE, IN 46825
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