

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G764	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/01/2016
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00195367.</p> <p>Dates of Survey: March 31 and April 1, 2016.</p> <p>COMPLAINT #IN00195367: Substantiated. Federal and state deficiencies related to the allegation(s) are cited at W331.</p> <p>Facility number: 012371 Provider number: 15G764 AIM number: 200986870</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed 4/8/16 by #09182.</p>	W 0000		
W 0331  Bldg. 00	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their 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 upon record review and interview, the facility's nursing services failed for 1 of 4 sampled clients (client A) to develop and implement a protocol to monitor him for influenza symptoms. The facility's nursing services failed to ensure staff documented medications administered and fluids offered. The facility's nursing services failed to develop and implement a system of accounting for client A's as needed medications to address his asthma.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services/BDDS were reviewed on 3/31/16 at 2:40 PM. A report dated 3/8/16 indicated the following:</p> <p>Client A is diagnoses included, but were not limited to, Seasonal Allergies and Asthma. On 3/7/16 client A was assessed by his group home nurse due to reported cold symptoms and a low grade fever. "After consulting with his mother/guardian and his diagnosis of Asthma, the decision was made to have client A seen by [allergy clinic]. He was evaluated and diagnosed with type A Influenza via a nasal swab. He was prescribed Tamiflu (anti-viral), Zpack (antibiotic), and Xopenex (asthma)</p>	W 0331	<p>The staff (#4 and #5) who failed to document the medications administered and the fluids offered were retrained on the Benchmark Medication Administration Policy. A Medication Administration Error Report was completed for both staff #4 and #5. All residential staff also received retraining on the Benchmark Medication Administration Policy. The Management staff completes weekly medication monitoring checks on the Medication Administration Tracking Form. Management will increase these checks to 3 times a week for one month. After that the monitoring will revert back to weekly checks ongoing. The Residential Director will review monthly the Medication Administration Tracking Form to ensure compliance.</p> <p>A Monitoring for Symptoms of Influenza Form was developed and will be implemented when a diagnosis of Influenza is given. The form will identify parameters on when to notify the Nurse or when to call 911. All staff will be trained on the Monitoring for Symptoms of Influenza form. The management staff will check daily to ensure that the form is getting implemented and completed. After completion, this form will then be given to the Director for review to ensure compliance.</p> <p>The Nurse and all staff have</p>	05/01/2016

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	<p>nebulizer treatments. He was also given a shot of Depomedrol (anti-inflammatory) while in the office. He returned home, medications were started and fluids were encouraged every hour. On 3/8/16 at approximately 7:15am the group home nurse arrived at the group home to assess [client A] due to him being diagnosed with Influenza on 3/7/16. Upon arrival the nurse assessed [client A] and determined that there was a need for further medical treatment. The nurse instructed staff to call 911 for emergency medical treatment. The EMS (emergency medical services) arrived at the house and transported [client A] to [Hospital]. [Client A] arrived at the hospital. He was much more alert and his O2 sats (oxygen saturation levels) were up to 98% with re-breather mask. His blood pressure was low at first but then up to 103/68. [Client A] was able to recognize his nurse and was agitated with the blood draws. The ER (emergency room) doctor ordered a chest xray which confirmed a diagnosis of pneumonia (sic). The ER doctor also ordered several labs and for a PICC (intravenous line for medications) line to be placed. [Dr.] ordered a Bi-pap (mask to aid breathing) to assist [client A] with his breathing. Oxygen saturation and Blood pressure was starting to fluctuate, but [client A] was tolerating the Bi-pap fairly well. The ER staff were unable to</p>		<p>received retraining on the Benchmark Medication Labeling Policy. All the medications have been checked by the Nurse and are labeled and dated appropriately. The Management staff completes weekly medication monitoring checks on the Medication Administration Tracking Form. Management will increase these checks to 3 times a week for one month. After that the monitoring will revert back to weekly checks ongoing. The Residential Director will review monthly the Medication Administration Tracking Form to ensure compliance.</p>	

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	<p>place PICC line at this time due to [client A's] declining condition. ER attempted to intubate, however CPR (cardiopulmonary resuscitation) was initiated immediately. They were unable to regain pulses with CPR. Mother/guardian present and gave consent to cease further life-saving measures. Time of death documented at 11:07 am. Plan to Resolve: The residential director, manager, QIDP (Qualified Intellectual Disabilities Professional), nurse and guardian were all notified. His guardian was at the Hospital and was making all decisions in regards to [client A's] care and treatment."</p> <p>Client A's records included in the facility's mortality review/investigation were reviewed on 3/31/16 at 2:55 PM and included the following:</p> <p>A doctor's visit note dated 3/7/16 from an allergy and asthma clinic indicated in a plan that client A was to receive "Tamiflu 75 mg (milligrams) 1 tablet twice a day for 5 days, Z pack-take 500 mg day 1 then 250 mg days 2-5, Xopenex nebulizer treatments every 4 hours while awake. Follow up in 2 weeks."</p> <p>Medication Change Forms written by the group home nurse dated 3/7/16 indicated client A was to receive "Xopenex neb</p>			

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	<p>(nebulizer) treatment three times a day PRN (as needed). The NP (nurse practitioner) at the [allergy and asthma clinic] would like to increase frequency of Xopenex nebulizer breathing treatments. New times put in place for the next three days. Times added in the MAR (medication administration record). Tamiflu 75 mg one tab twice a day for 5 days. This is an antiviral medication. [Client A] was diagnosed with Type A influenza per nasal swab test. This medication is to be given as ordered with plenty of fluids. Monitor for severe allergic reaction. Most common side effect is upset stomach and vomiting."</p> <p>Group Home Health Issues/Nursing Notes dated 3/7/16 indicated client A had been taken to the allergy and asthma clinic on 3/7/16 after being assessed with "SaO2 (oxygen saturation) 94% on room air; PRN (as needed) xopenex given as ordered. [Client A] has a slightly wheezy breath sound but with good airflow throughout. Cough noted at this time temp (temperature) of 98.2." Client A was prescribed medications as indicated in the BDDS report and "Staff also instructed to encourage 8 oz (ounces) of water every hour to help with keeping [client A] hydrated. @ (At) 7:15 am [nurse] assessed [client A]. Upon arrival [client A] was having difficulty breathing</p>			

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	<p>and cyanotic (blue in color) but he was able to sit up with assistance. He did accept his morning medications and had a breathing treatment. Writer instructed staff to call 911 for emergency medical treatment. @ 7:30 am Fire department then EMS (emergency medical services) arrived at the house and transported to [hospital]. [Client A] arrived at the hospital. He is much more alert and his O2 sats are up to 98% with re-breather mask his blood pressure was low at first but then up to 103/68. [Client A] was able to recognize [nurse] as was agitated with the blood draws. ER doctor ordered several labs and for a PICC line to be placed. [Doctor] ordered a Bi-pap (breathing device) to assist [client A] with his breathing. Oxygen saturation and blood pressure is starting to fluctuate. [Client A] is now tolerating Bi-pap fairly well...."</p> <p>A MAR (medication administration record) dated 3/16 indicated beginning 3/7/16 "For the next three days give Levalbuterol (Xopenex) 0.63% 3 ml (milliliters) breathing treatment per nebulizer 3 times extra a day." The 6:30 PM and 12:30 AM times listed for the Levalbuterol on 3/7/16 and 3/8/16 were blank. "Encourage [client A] to drink fluids at least 3 oz (ounces) every hour. Avoid milk." The 3-11 (PM) on 3/7/16</p>			
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	<p>and 11-7 (11:00 PM until 7:00 AM) on 3/8/16 listed times to document fluids were blank.</p> <p>An Emergency Department Chart dated 3/8/16 started at 8:04 AM indicated client A was brought by ambulance with "diminished mental status. Hypotensive blood pressure in the 60s and route (sic). Low grade fever. Cough...." Vital signs/Data indicated client A's vitals at 8:07 AM indicated a temperature of 98.3, pulse of 114 per minute and 98% pulse oximetry (measure of oxygen in the blood). The chart indicated client A was confirmed to have pneumonia and sepsis on 3/8/16 at 9:29 AM. "Procedure and consent for picc (line for medications) line placement signed by [relative]. Per [relative's] request to have patient sedated....." Client A's breathing was assisted with a breathing device and the picc line procedure was halted when client A's breathing deteriorated. Attempts at reviving client A failed and he was pronounced dead at 11:07 AM. A physician's note indicated client A's cardiac arrest was due to "overwhelming sepsis." Client A was also diagnosed with influenza and pneumonia.</p> <p>A death certificate dated 3/15/16 indicated cause of death was influenza and sepsis.</p>			

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	<p>Statements by staff #4 dated 3/28/16 and #5 dated 3/28/16 indicated they had encouraged client A to drink fluids every hour. Staff #5 indicated she had provided a 12:00 AM breathing treatment and had taken client A's pulse on 3/8/16.</p> <p>The group home nurse and the Residential Director were interviewed on 3/31/16 at 3:11 PM. The nurse indicated she had not indicated in writing parameters for staff to follow to monitor client A's status including his temperature or oxygen level after being diagnosed with the flu on 3/7/16. When asked if a count of medication had been completed to ensure client A had received his breathing treatments as ordered, the nurse indicated since his medication was as needed, it was not able to be tracked. She indicated there was not a system in place to keep track of client A's Xopenex medication. The Residential Director indicated staff statements had been taken to ensure medications had been administered and fluids encouraged after it was noticed there was a lack of documentation of client A's breathing treatment on 3/8/16 at 12:00 AM and of encouraging client A to consume fluids.</p> <p>Client A's Xopenex medication box was inspected on 3/31/16 at 3:22 PM and</p>			

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	<p>indicated there were 25 vials sent in each package. The label indicated spaces to indicate Date Opened, but the date was blank.</p> <p>The group home nurse was interviewed again on 3/31/16 at 3:22 PM and indicated the vials had not been counted or compared to client A's MAR to determine how many vials had been used.</p> <p>Staff #4 was interviewed on 3/31/16 at 5:11 PM. Staff #4 indicated he had failed to document encouraging client A to drink fluids, but had done so during his shift on 3/7/16 from 3:00 to 11:00 PM. He indicated he had been in contact with client A's relative and had personally gone to the store to purchase a drink and flavor client A liked to encourage him to drink fluids. He stated it was "chaotic" in the house due to staff taking care of and monitoring client A while providing care to the other clients and he had forgotten to document client A's fluids.</p> <p>Staff #5 was interviewed on 4/1/16 at 10:10 AM and indicated she had provided client A with his breathing treatment as ordered and had encouraged client A to drink fluids every hour, but had forgotten to document it on client A's MAR. Staff #5 indicated she had checked on client A every 15 minutes throughout</p>			

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	<p>the night. Staff #5 indicated she had not noticed a difference in client A's color or a changed status in his condition prior to ending her shift.</p> <p>This federal tag relates to complaint #IN00195367.</p> <p>9-3-6(a)</p>			