

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G717	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/12/2015
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2405 S CR 200 N NORTH VERNON, IN 47265
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W 0000 Bldg. 00	<p>This visit was for an investigation of complaint #IN00185491.</p> <p>Complaint #IN00185491: Substantiated, Federal/state deficiencies related to the allegation are cited at W149 and W249.</p> <p>Survey date: November 12, 2015.</p> <p>Facility number: 004132 Provider number: 15G717 AIM number: 200494750</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/23/15.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 1 investigation reviewed affecting 1 of 2 sampled clients (A), the facility neglected to implement its policies and procedures to ensure client safety from</p>	W 0149	All staff at the Day Program and Group Home will receive re-training regarding the correct implementation of each client's dining plan. Monitoring will occur five times weekly for 2 months to	12/12/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>choking by failing to ensure proper implementation of the client's diet order and his dining program.</p> <p>Findings include:</p> <p>A review (11/12/15 at 1:00 PM) of reportable incident reports indicated the following:</p> <p>A BDDS/Bureau of Developmental Disabilities Services report dated 10/26/2015 indicated an incident of choking with client A during the noon meal at the agency operated day program. The BDDS report indicated on 10/26/15 at 11:30 AM:</p> <p>"...[Client A] is on a pureed diet with thickened fluids. He is not able to feed himself. On 10-26-15 at 11:30 am staff was feeding [client A] his lunch. [Client A] started to choke and staff stopped and used finger to sweep food from his mouth. His face was turning purple. Staff started the Heimlich maneuver while he was in his wheelchair with no improvements. A staff put [client A] on the floor and did more finger swipes. More Heimlich (sic) were done and face remained purple. A staff started compressions and 911 was called. Benchmark nurse arrived in the building. [Client A] took a breath and was sit (sic) up and he spit out some of his food and</p>		<p>ensure dining plans are being implemented correctly. Monitoring will be provided by the Residential Manager, QDDP, Day Program Supervisor, and Nurse and will be documented on a dining monitoring checklist. All checklists will be sent to the Benchmark Director to verify that monitoring is occurring. After the 2 month period, the dining monitoring checklist will be completed one time weekly to ensure dining plans are continuing to be implemented correctly.</p>		

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	<p>his color returned to his face and was (sic) breathing normally. Ambulance arrived and took [client A] to ER (Emergency Room) at [name of hospital]. At the ER, [client A] was awake and color (sic) was back to normal. ER physician ordered chest x-ray and had monitor for heart rate and blood pressure and O2 (oxygen) saturation. All were normal and chest x-ray was normal. Benchmark nurse asked about antibiotics and ER physician did not feel that it was needed. No new orders were written from ER physician." The BDDS report's "Plan to Resolve" indicated: "Benchmark nurse instructed staff to take [client A's] temperature every shift for 3 days and report any changes to the nurse."</p> <p>A BDDS follow-up report dated 10/27/15 indicated client A choked on chicken. Client A was being observed for signs/symptoms of aspiration. The client's food textures would be evaluated before meals for the correct puree consistency. The staff were going to "take their time feeding" the client. Retraining would be done with staff to reinforce food textures. The agency's nurse evaluated the food that was being used during the meal when [client A] choked.</p>			

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	<p>The nurse felt the chicken could have been more moist. The agency's team (interdisciplinary team) felt "pureed food can sometimes absorb the moisture of the puree before the food is eaten." The staff would evaluate the food's consistency before the meal was served. No changes were made to client A's dining plan. The nurse would get a referral for a speech evaluation to determine the food consistency needed for client A.</p> <p>Review of client #2's record on 11/12/15 at 12:00 PM indicated he had a risk plan for Dysphagia (choking risk)/Care Dining Plan dated 5/17/15. The risk plan indicated client #2 was at risk for choking. His diet was a pureed/soft consistency with nectar thick liquids. Client #2's plan indicated he was to be given time to swallow between bites of food. Client #2's mouth was to be clear before he was to be offered additional food bites. "Offer bites slowly, do not feed him to (sic) fast." Food and fluids were to be alternated at every meal. Added to the dining plan (date unknown) was the following: "All foods fld(fluids) should be re-evaluated for texture before (offering) food to client. Food is prepared the evening before." Review of an undated "Choking with Intervention Debriefing Checklist" compiled by QIDP/Qualified Intellectual</p>			

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	<p>Disabilities Professional #1 indicated a review of client A's food consistency: "...Client choked on chicken wick (sic) RN feels was finely chopped (and) dry but not pureed (and) moist. Client is on puree (with) nectar thick liquids."</p> <p>An interview was conducted (11/12/15 at 10:45 AM) with day program team leader/TL #1, who was feeding client A on the day he choked. The interview indicated client A's food came from the group home to day program already pureed. On 10/26/15, client A's meal consisted of chicken that was not completely pureed. TL #1 stated the chicken was more "chopped" than pureed. TL #1 indicated she using a utensil and water to further modify the chicken. No blender was available in the area for use by staff.</p> <p>Interview with QIDP #1 and Residential Manager/RM #1 on 11/12/15 at 1:50 PM indicated client A had choked on chicken on 10/26/15 because the chicken had not been processed to a true pureed consistency as specified in his dining plan.</p> <p>A review of the facility's Abuse and Neglect policy, with revision date of 3/26/15, was conducted on 11/12/15 at</p>			

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	<p>1:45 PM. The policy indicated, in part,</p> <p>"...Benchmark maintains a zero tolerance policy with regard to abuse, neglect or exploitation in any form by any person. The following definitions of abuse, neglect and exploitation of individuals receiving services...</p> <p>Neglect includes failure to provide appropriate care, food, medical care or supervision...."</p> <p>This federal tag refers to complaint #IN00185491.</p> <p>9-3-2(a)</p>				
W 0249 Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan,</p>				

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	<p>each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on interview and record review for 1 of 2 sampled clients (#2), the facility failed to implement the client's dining program correctly to prevent choking.</p> <p>Findings include:</p> <p>A review (11/12/15 at 1:00 PM) of reportable incident reports indicated the following:</p> <p>A BDDS/Bureau of Developmental Disabilities Services report dated 10/26/2015 indicated an incident of choking with client A during the noon meal at the agency operated day program. The BDDS report indicated on 10/26/15 at 11:30 AM:</p> <p>"...[Client A] is on a pureed diet with thickened fluids. He is not able to feed himself. On 10-26-15 at 11:30 am staff was feeding [client A] his lunch. [Client A] started to choke and staff stopped and used finger to sweep food from his mouth. His face was turning purple. Staff started the Heimlich maneuver while he was in his wheelchair with no improvements. A staff put [client A] on the floor and did more finger swipes.</p>	W 0249	<p>All staff at the Day Program and Group Home will receive re-training regarding the correct implementation of each client's dining plan. Monitoring will occur five times weekly for 2 months to ensure dining plans are being implemented correctly. Monitoring will be provided by the Residential Manager, QDDP, Day Program Supervisor, and Nurse and will be documented on a dining monitoring checklist. All checklists will be sent to the Benchmark Director to verify that monitoring is occurring. After the 2 month period, the dining monitoring checklist will be completed one time weekly to ensure dining plans are continuing to be implemented correctly.</p>	12/12/2015

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	<p>More Heimlich (sic) were done and face remained purple. A staff started compressions and 911 was called. Benchmark nurse arrived in the building. [Client A] took a breath and was sit (sic) up and he spit out some of his food and his color returned to his face and was (sic) breathing normally. Ambulance arrived and took [client A] to ER (Emergency Room) at [name of hospital]. At the ER, [client A] was awake and color (sic) was back to normal. ER physician ordered chest x-ray and had monitor for heart rate and blood pressure and O2 (oxygen) saturation. All were normal and chest x-ray was normal. Benchmark nurse asked about antibiotics and ER physician did not feel that it was needed. No new orders were written from ER physician."</p> <p>The BDDS report's "Plan to Resolve" indicated: "Benchmark nurse instructed staff to take [client A's] temperature every shift for 3 days and report any changes to the nurse."</p> <p>A BDDS follow-up report dated 10/27/15 indicated client A choked on chicken. Client A was being observed for signs/symptoms of aspiration. The client's food textures would be evaluated before meals for the correct puree</p>			

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	<p>consistency. The staff were going to "take their time feeding" the client.</p> <p>Review of client #2's record on 11/12/15 at 12:00 PM indicated he had a risk plan for Dysphagia (choking risk)/Care Dining Plan dated 5/17/15. The risk plan indicated client #2 was at risk for choking. His diet was a pureed/soft consistency with nectar thick liquids. Client #2's plan indicated he was to be given time to swallow between bites of food. Client #2's mouth was to be clear before he was to be offered additional food bites. "Offer bites slowly, do not feed him to (sic) fast." Food and fluids were to be alternated at every meal. Review of an undated "Choking with Intervention Debriefing Checklist" compiled by QIDP/Qualified Intellectual Disabilities Professional #1 indicated a review of client A's food consistency: "...Client choked on chicken wick (sic) RN feels was finely chopped (and) dry but not pureed (and) moist. Client is on puree (with) nectar thick liquids."</p> <p>An interview was conducted (11/12/15 at 10:45 AM) with day program team leader/TL #1, who was feeding client A on the day he choked. The interview indicated client A's food came from the group home to day program already pureed. On 10/26/15, client A's meal</p>			

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

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