

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

PRINTED: 12/20/2023

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G764	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 11/21/2023
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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP COD 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 11/21/23</p> <p>Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870</p> <p>At this Emergency Preparedness survey, Benchmark Human Services was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475</p> <p>The facility has 8 certified beds, at the time of the survey, the census was 6.</p> <p>Quality Review completed on 11/27/23</p>	E 0000		
E 0037 Bldg. --	<p>403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1)</p> <p>EP Training Program</p> <p>§403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).</p> <p>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Eldridge	Residential Director	12/16/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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>HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p>				

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	<p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p>			

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	<p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies</p>			

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	<p>and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <ul style="list-style-type: none"> (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. <p>*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility</p>	E 0037	It is Benchmark Policy that all	12/20/2023

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E 0039 Bldg. --	<p>failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Residential Manager on 11/21/23 at 11:50 a.m., there was no documentation available for review to indicate 5 of 6 facility staff members were trained and could demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Only one staff member had a completed training form dated July of 2022. Based on an interview at the time of records review, the Residential Manager stated all staff were trained on the EPP but the training documentation for 5 staff members could not be found during the survey.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2),</p>		<p>staff members working in the homes must be trained on the Emergency Preparedness Book. That all staff members must keep their training current. Staff members and managers attended a annual staff training where they are retrained on the Emergency Preparedness Book.</p> <p>Fire and tornado drills for the homes and what to do in emergency situations. (Flood, power outages, snowstorms, icy weather, etc.) Any changes or updates to emergency plans or policies. Management will make sure staff are trained and current on any changes. Staff and management will be retrianed by 12/20/23.</p>		

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	<p>485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or</p>			

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	<p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):]</p> <p>(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:</p> <p>(i) Participate in a full-scale exercise that is community based every 2 years; or</p> <p>(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is</p>			
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	<p>led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or</p> <p>(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or a facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise</p>			
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	<p>the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p>			
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	<p>*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):]</p>			
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	<p>(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.</p> <p>(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p> <p>*[For ICF/IIDs at §483.475(d):</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least</p>			
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	<p>twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p>				

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	<p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically</p>			

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	<p>relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.</p> <p>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the ICF/IID facility experiences an actual</p>	E 0039	Manager will be retrained on how and when to conduct full scale community-based exercises, and also mock disaster drills by 12/20/23. Those exercises are conducted twice a year. Preferably one in the wintertime. The other in the summer or warmer months. Benchmark understands the importance of these exercises.	12/20/2023	

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	<p>natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Residential Manager on 11/21/23 at 11:45 a.m., the following was not available for review:</p> <p>a) No documentation was provided of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency.</p> <p>b) No documentation was provided of an additional annual exercise of choice: a second full-scale exercise that is community-based, a facility-based functional exercise, a mock disaster</p>		<p>Also, that managers and staff understand the importance of completing such exercises. Staff and management will be reminded of past severe weather events that has happened. Also, the possibilities of severe weather events that can happen and how we can keep the individuals we serve safe.</p> <p>Management will monitor and keep the discussion in staff meetings, Emergency Preparedness book, and monthly trainings within the home.</p>		

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K 0000 Bldg. 01	<p>drill, a tabletop exercise, or a workshop. Based on interview at the time of records review, the Residential Manager stated the documentation for both exercises could not be found during the survey.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 11/21/23</p> <p>Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870</p> <p>At this Life Safety Code survey, Benchmark Human Services was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>The one-story facility was not sprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms and common living areas. The facility has a capacity of 8 and had a census of 6 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101 A, Alternative</p>	K 0000		

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K S100 Bldg. 01	<p>Approaches to Life Safety, Chapter 6, could not be determined at this time because no F-1 forms were provided. LSC Chapter 32.2.1.2.2 states where such documentation is not furnished, the evacuation capability shall be classified as Impractical.</p> <p>Quality Review completed on 11/27/23</p> <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING</p> <p>List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on records review and interview, the facility failed to provide 6 of 6 F-1 work sheets to the authority having jurisdiction to be able to determine an evacuation assistance score in accordance with LSC 33.2.1.2.2 which states that facility management shall furnish to the authority having jurisdiction, upon request, an evacuation capability determination using a procedure acceptable to the authority having jurisdiction; where such documentation is not furnished, the evacuation capability shall be classified as impractical. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Residential Manager on 11/21/23 at 11:51 a.m., the non-sprinklered facility was unable to provide F1 worksheets used to rate the residents' evacuation</p>	K S100	Current F1 sheets were submitted to surveyor later. Manager will make sure all that information is in the Emergency Preparedness Book. That managers and staff have access and be privy to that information. To be able to conduct a more thorough safety exercise. All staff will be retrained on the Emergency Preparedness Book, during their yearly Staff Annual Training classes, by 12/20/23. All staff members current signatures will be in the book. Management will continue to monitor and train current staff members. It is Benchmark policy that new staff members are to be trained on the Emergency Preparedness Book with management. During training	12/20/2023

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K S169 Bldg. 01	<p>score and determine the residents' overall need for assistance during an emergency evacuation. Based on interview at the time of records review, the Residential Manager stated the F-1 work sheets were not in the home during the survey.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING (Impractical) In Impractical Evacuation Capability facilities, nonsprinklered buildings shall be of any construction type in accordance with 8.2.1 other than Type II (000), Type III (200), or Type V (000) construction. Buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5 shall be permitted to be of any type of construction. 33.2.1.3.3 Based on record review, observation, and interview, the facility failed to ensure 1 of 1 non-sprinklered home with an Impractical Evacuation Capability was of any construction type other than Type II (000), Type III (200), or Type V (000) construction for non-sprinklered homes. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K S169	<p>in the homes. Management will continue to discuss the importance of the Emergency Preparedness Book, when they conduct monthly house meetings. Management and staff will understand the importance of the F1's when it comes to being able to get all individuals out of the home, or in designated safety areas safely. F1's help staff understand what assistance is needed personally, for each individual served within the home.</p> <p>Current F1 sheets were submitted to surveyor later, that day. Manager will make sure all that information is in the Emergency Preparedness Book. That managers and staff have access and be privy to that information. To be able to conduct a more thorough safety exercises.</p> <p>All staff will be retrained on the</p>	12/20/2023

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K S222 Bldg. 01	<p>Based on records review with the Residential Manager on 11/21/23 at 11:51 a.m., the non-sprinklered facility was unable to provide the F1 worksheets used to rate the resident and determine the resident's overall need for assistance when requested. Due to the lack of furnished F1 forms, the facility was classified as "Impractical." Based on observation at 11:41 a.m., the construction type of the home could not be determined. Based on interview at the time of observation and records review, the Residential Manager acknowledged the building type could not be determined.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>NFPA 101 Egress Doors Egress Doors 2012 EXISTING (Prompt) Doors and paths of travel to a means of escape shall not be less than 28 inches. Bathroom doors shall not be less than 24 inches. Doors are swinging or sliding. Every closet door latch shall be readily opened from the inside in case of an emergency. Every bathroom door shall be designed to allow opening from the outside during an</p>		<p>Emergency Preparedness Book, during their yearly Staff Annual Training classes, by 12/20/23. All staff members current signatures will be in the book. Management will continue to monitor and train current staff members. It is Benchmark policy that new staff members are to be trained on the Emergency Preparedness Book with management. During training in the homes. Management will continue to discuss the importance of the Emergency Preparedness Book, when they conduct monthly house meetings.</p> <p>Individuals served should know the building type and proper ways to evacuate the home safely. Due to the house not having a sprinkler system, all individuals and staff should be aware of alternative evacuation routes. Management will be retained on the importance of the F1's and why we do them.</p>	

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	<p>emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors only. Access-controlled egress locks complying with 7.2.1.6.2 shall be permitted. Forces to open doors shall comply with 7.2.1.4.5. Door-latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 33.2.2.5.1 through 33.2.2.5.7, 33.7.7, 42 CFR 483.470(j)(1)(ii)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 sleeping room exit doors to the outside was not obstructed. This deficient practice could affect 2 clients.</p> <p>Findings include:</p> <p>Based on observation with the Residential Manager on 11/21/23 at 12:00 p.m., the exit door in the double male sleeping room #1 was completely blocked by a dresser that was pushed up against the door. Based on interview at the time of observation, the Residential Manager stated the client in the room likes the door blocked and keeps moving the dresser back in front of the door.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>Note: This deficient practice was cited on</p>	K S222	<p>Management and staff will be retrained on the importance of not blocking doorways and windows for safety reasons. Benchmark understands the importance of our individuals and staff being able to evacuate safely without obstructions. Blocking a door with a dresser is a safety hazard and can be the deciding factor if someone is able to evacuate safely or not be able to get to safety. Dresser has been moved out of the doorway, to another area of the room. Staff and management will do daily observations to make sure dresser is not obstructing doorway. Management will also retrain staff the importance and why we do not block windows or</p>	12/20/2023
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K S253 Bldg. 01	<p>complaint investigation number IN00379372 on 05/05/22</p> <p>NFPA 101 Number of Exits - Patient Sleeping and Non-SI Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Prompt) Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 33.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, each sleeping room shall have a second means of escape that consists of one of the following:</p> <ol style="list-style-type: none"> 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. <p>Such means of escape shall be acceptable where one of the following criteria are met:</p>		doors for safety reasons and a its a fire hazard.	

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	<p>a. The window shall be within 20 feet of finished ground level.</p> <p>b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction.</p> <p>c. The window or door shall open onto an exterior balcony.</p> <p>4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria:</p> <p>a. The window well allows the window to be fully openable.</p> <p>b. The window is not less than 9 square feet with a length and width of not less than 36 inches.</p> <p>c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following:</p> <p>1. The ladder or steps do not extend more than 6 inches into the well.</p> <p>2. The ladder or steps are not obstructed by the window.</p> <p>5. If the sleeping room has a door leading directly to the outside of the building with access to finished ground level or to a stairway that meets the requirements of exterior stairs in 33.2.2.2.2, that means of escape shall be considered as meeting all the escape requirements for the sleeping room.</p> <p>a. A second means of escape from each sleeping room shall not be required where the facility is protected throughout by approved automatic sprinkler system in accordance with 33.2.3.5.</p> <p>b. Existing approved means of escape shall be permitted to continue to be used.</p> <p>33.2.2.2.1, 33.2.2.2, 33.2.2.3.1 through</p>			

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NAME OF PROVIDER OR SUPPLIER BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP COD 1726 OLD LANTERN TR FORT WAYNE, IN 46845
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K S259 Bldg. 01	<p>33.2.2.3.4 Based on observation and interview, the facility failed to ensure 1 of 5 client sleeping rooms were provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect 1 client.</p> <p>Findings include:</p> <p>Based on observation with the Residential Manager on 11/21/23 at 12:20 p.m., the secondary means of escape for the single girl sleeping room was a window, but the window was blocked by a desk. Based on interview at the time of observation, the Residential Manager agreed the window in the sleeping room was the secondary means of escape and was blocked from access.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>NFPA 101 Number of Exits - Patient Sleeping and Non-SI Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 EXISTING (Impractical)</p>	K S253	<p>Desk was moved to another area in the room. Where the desk will not obstruct the window area. Manager immediately helped move the room around to make sure the desk does not obstruct the window. Management and staff will be retrained on the importance of not blocking doorways and windows for safety reasons. Benchmark understands the importance of our individuals and staff being able to evacuate safely without obstructions. Blocking a window with a desk is a safety hazard and can be the deciding factor if someone is able to evacuate safely or not be able to get out of the home safely. Desk has been moved out of the doorway, to another area of the room. Staff and management will do daily observations to make sure desk is not obstructing window. Management will also retrain staff the importance and why we do not block windows or doors for safety reasons and that its a fire hazard. These trainings should be completed by 12/20/23.</p>	12/20/2023

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K S345 Bldg. 01	<p>In Impractical Evacuation Capability facilities, the primary means of escape for each sleeping room shall not be exposed to living areas and kitchens, unless the building is protected by an approved automatic sprinkler system in accordance with 33.2.3.5 utilizing quick-response or residential sprinklers throughout.</p> <p>33.2.2.2.3 Based on observation and interview, the facility failed to ensure 1 of 1 primary means of escape for an impractical rating for all sleeping room was not exposed to living areas and kitchens. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on records review with the Residential Manager on 11/21/23 at 11:51 a.m., the non-sprinklered facility was unable to provide the F1worksheets used to rate the resident and determine the resident's overall need for assistance when requested. Due to the lack of furnished F1 forms, the facility was classified as "Impractical." Based on observation with the Residential Manager at 12:10 p.m., all sleeping rooms primary exit rout were open to the living rooms and the kitchen. Based on an interview at the time of observation, the Residential Manager acknowledged exit routs were exposed to kitchens and living spaces, and stated the F-1s could not be provided during the survey.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and</p>	K S259	<p>It is Benchmark policy that each home has an emergency evacuation plan. The routes, 1st and secondary exits and meeting points. It is Benchmark policy that each home conduct monthly designed dates for fire/tornado drills to be practiced and monitored. Manager and staff will be retrained on evacuation routes and exits, by 12/20/23.</p> <p>It is important our individuals to know the different ways for them to be able to evacuate the home safely and properly. Management and staff will be retrained on the importance of having this information and teaching our individuals. The safest way to exit the home and routes/ alternate routes.</p>	12/20/2023

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K S359 Bldg. 01	<p>Maintenance 2012 EXISTING (Prompt) A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems could be reset promptly after activation in accordance with LSC 9.6. Section 9.6.1.5 refers to NFPA 72. NFPA 72-14.5.4 states all apparatus requiring resetting to maintain normal operation shall be reset as promptly as possible after each test and alarms. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Residential Manager on 11/21/23 at 12:45 p.m., the fire alarm control panel (FACP) showed the system was in silence mode and the Residential Manager had to reset the FACP to put the system back to normal. Based on an interview at the time of observation, the Residential Manager stated the system was activated over the weekend and it was possible the system was left in silence mode.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>NFPA 101 Sprinkler System - Installation Sprinkler System - Installation</p>	K S345	<p>Manager and staff will be retrained on properly operating and resetting the alarm system after emergency drills are executed by 12/20/23. Manager will monitor and do checks to make sure alarm system is functioning and reset properly. Making sure the alarm is working properly, checking for any maintenance issue. Will be useful to everyone in the home, if such an emergency occurs.</p> <p>The safety of our individuals and staff is a priority. Drills are put in put in place to help our individuals and staff obtain knowledge and awareness of the proper way. To evacuate safely. The more we practice in the homes, the better we will be prepared for real life emergencies.</p> <p>Giving our individuals the proper tools to stay safe in emergency conditions.</p>	12/20/2023
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	<p>2012 EXISTING (Impractical)</p> <p>All Impractical Evacuation Capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3.</p> <p>The system shall be in accordance with Section 9.7 and shall initiate the fire alarm system in accordance with 9.6, as modified below. The adequacy of the water supply shall be documented.</p> <p>In Impractical Evacuation Capability Facilities, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in one-and-two-Family Dwellings and Manufactured Homes, with a 30 minute water supply, shall be permitted. All habitable areas and closets shall be sprinklered.</p> <p>Automatic Sprinklers shall not be required in bathrooms not exceeding 55 square feet, provided that such spaces are finished with lath and plaster or materials provided a 15-minute thermal barrier.</p> <p>In Impractical Evacuation Capability Facilities up to and including four stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted.</p> <p>All habitable areas and closets shall be sprinklered. Automatic sprinklers shall not be required in bathrooms not exceeding 55 square feet provided that such spaces are finished with lath and plaster or materials providing a 15-minute thermal barrier.</p> <p>Initiation of the fire alarm system shall not be required for existing installations in accordance with 33.2.3.5.6.</p> <p>Attics used for living purposes, storage, or</p>			

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	<p>fuel-fired equipment are sprinkler protected, by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following:</p> <ol style="list-style-type: none"> 1. Protected by heat detection system to activate the fire alarm system according to 9.6 by July 5, 2019. 2. Protected by automatic sprinkler system according to 9.7, by July 5, 2019. 3. Constructed of noncombustible or limited-combustible construction; or 4. Constructed of fire-retardant-treated wood according to NFPA 703. <p>33.2.3.5.3, 33.2.3.5.3.2, 33.2.3.5.3.5 through 33.2.3.5.3.7, 42 CFR 483.470(j)(1)(ii)</p> <p>Based on record review, observation, and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems were installed for Impractical Evacuation Capability. LSC 33.2.3.5.3.7 states all impractical evacuation capability facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 33.2.3.5.3. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based record review with the Residential Manager on 11/21/23 at 11:51 a.m., the facility was unable to provide the F1 worksheets used to rate the resident and determine the resident's overall need for assistance when requested. Due to the lack of furnished F1 forms, the facility was classified as "Impractical." Based on observation at 12:11 p.m., there was not a sprinkler system in the home. Based on interview at the time of observation and records review, the Residential Manager agreed the E-score for the facility was Impractical and stated the home is not equipped with a sprinkler system.</p>	K S359	<p>Current F1 sheets were submitted to surveyor later that day. Manager will make sure all that information is in the Emergency Preparedness Book. That managers and staff have access and be privy to that information. To be able to conduct a more thorough safety exercise.</p> <p>Management and staff will be retrained on the importance of not blocking doorways and windows for safety reasons. Benchmark understands the importance of our individuals and staff being able to evacuate safely without obstructions. Blocking a door with a dresser is a safety hazard and can be the deciding factor if someone is able to evacuate safely or not be able to get to safety.</p> <p>Management and staff will</p>	12/20/2023
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K S511 Bldg. 01	<p>The finding was reviewed with the Residential Manager during the exit conference.</p> <p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NPFA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could all clients.</p> <p>Findings include:</p>	K S511	<p>understand the importance of the F1's when it comes to being able to get all individuals out of the home, or in designated safety areas safely. F1's help staff understand what assistance is needed personally, for each individual served within the home. Giving our individuals the proper tools for safety.</p> <p>It is Benchmark policy that extension cords and power strips, not approved by Benchmark are not allowed in the homes. Power cord was immediately removed from the home. Manager will retrain staff, Benchmark policies about extension cords and power strips in the homes by 12/20/23.</p> <p>All staff will be retrained on Life Safety protocol. Extension cords and non-medical grade surge protectors are not approved to be in the homes. Medical grade surge protectors have to be approved by</p>	12/20/2023

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K S751 Bldg. 01	<p>Based on observation with the Residential Manager on 11/21/23 at 12:33 p.m., behind the staff desk next to the kitchen had a power strip used to power equipment, was not secured, and was dangling from the desk. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Residential Manager agreed the power strip was dangling, and did attach the power strip on the back of the desk.</p> <p>The findings were review with the Residential Manager during the exit conference.</p> <p>NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics New draperies, curtains, and other similar loosely hanging furnishings and decorations in board and care facilities shall be in accordance with provisions of 10.3.1. In other than common areas, new draperies, curtains and other similar loosely hanging furnishings and decorations are not required to comply with 10.3.1 where building is protected throughout by an approved automatic sprinkler system installed in accordance with 33.2.3.5 for small facilities. 32.7.5.1.1, 32.7.5.2, 33.7.5.1.1, 33.7.5.2 Based on observation, records review, and interview the facility failed to ensure 6 of 6 sets of new curtains were in compliance with LSC 10.3.1., which states where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall meet the flame propagation performance criteria contained in NFPA701. This deficient practice could affect all clients and staff</p>	K S751	<p>IT/ Talon. Will also be installed by Talon, mounted on the wall.</p> <p>Our individuals safety is our priority and concern. Helping prevent shocking or fires, within the home. Teaching our individuals fire safety watching for the wrong power strips and cords. Will help provide a safe environment for everyone in the home.</p> <p>All curtains in the homes will be sprayed with flame propagation by 12/20/23. The house will keep spares of the flame propagation in the home. Treating the curtains and draperies with the proper flame propagation, will add to Benchmark providing a safe home for our individuals we serve.</p>	12/20/2023

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	<p>in the facility.</p> <p>Findings include:</p> <p>Based on observations with the Residential Manager on 11/21/23 at 12:31 p.m., there were six sets of new blackout curtains hanging over the windows in the Movie Living Room and in the Activities Living Room. Based on records review at 12:35 p.m., the labels on the curtains did not provide the flame propagation performance criteria and no other documentation could be provided to show the flame propagation performance criteria. Based on interview at the time of the observation, the Residential Manager stated the curtains were installed in common areas about six months ago and no paperwork could be provided to show the curtains flame propagation performance criteria.</p> <p>The findings were review with the Residential Manager during the exit conference.</p>		<p>Management and staff will be retrained on properly spraying propagation. Also, helping our individuals understand why we take these steps to provide a safe environment for everyone. Understanding that these measures and steps have been taken, will help our individuals feel safer in their home.</p>		