

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

PRINTED: 03/29/2021

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 03/09/2021
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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/09/21 Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870 At this Emergency Preparedness survey, Benchmark Human Services was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 03/12/21	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/09/21 Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870 At this Life Safety Code survey, Benchmark	K 0000		

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 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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K S222 Bldg. 01	<p>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 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.8.</p> <p>Quality Review completed on 03/12/21</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 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</p>						

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K S741	<p>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 living room closet doors can be readily opened from the inside if locked. LSC 33.2.2.5.3 states every closet door latch shall be readily opened from the inside. This deficient practice affects all clients.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Residential Coordinator and the Qualified Intellectual Disabilities Professional (QIDP) on 03/09/21 at 11:35 a.m., the closet door located in the living room had a padlock on the outside of the door; allowing someone to be locked inside the closet with no means of escape. Based on interview at the time of the observation, the QIDP stated there was a padlock on the living room closet door, and the door could not be opened from the inside if locked.</p> <p>The finding was reviewed with the Residential Coordinator and QIDP during the exit conference.</p> <p>NFPA 101 Smoking Regulations</p>	K S222	The pad lock was removed from the closet door in the living room. All staff were trained on ensuring that no locks were put on doors to prevent the possibility of someone being locked inside with no means of escape. All other doors at this group home were evaluated to ensure that there were not locks or issues with egress. An audit was also completed at other group homes to ensure that Benchmark was following this regulation. To ensure that no locks are on doors that could prevent egress/escape, the management will complete monitoring 3 times a week for a month and then 1 time weekly for 2 months to ensure compliance with the training. These forms will be turned into the residential director for compliance.	04/08/2021

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Bldg. 01	<p>Smoking Regulations Smoking regulations shall be adopted by the administration of board and care occupancies. Where smoking is permitted, noncombustible safety type ashtrays or receptacles shall be provided in convenient locations. 32.7.4.1, 32.7.4.2, 33.7.4.1, 33.7.4.2 Based on observation, records review, and interview; the facility failed to ensure smoking took place in 1 of 1 designated smoking areas. This deficient practice could affect up to all clients and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with Residential Coordinator and the Qualified Intellectual Disabilities Professional (QIDP) on 03/09/21 at 11:30 a.m., in the garage there was a cup of water with cigarette butts in it and there was a smell of cigarette smoke in the garage. Based on records review at 11:20 am, the Benchmark smoking policy stated the designated smoking is located on the back patio. Based on interview at the time of observation, the QIDP agreed there were cigarette butts in a cup, the garage smelled like cigarette smoke, smoking is not allowed in the garage, and the designated smoking area is outside on the back patio.</p> <p>The finding was reviewed with the Residential Coordinator and QIDP during the exit conference.</p>	K S741	All staff and clients were retained that the designated smoking area at Old Lantern is located on the back patio. There was a new "butt hut" receptacle purchased for the patio as well for proper disposal of cigarette butts. Staff and clients were retrained that there is only 1 designated smoking area on the back porch. To ensure that the training was effective, the management will monitor to be sure the clients/staff are only smoking in the designated areas. This will monitoring 3 times a week for a month and then 1 time weekly for 2 months to ensure compliance with the training. These forms will be turned into the residential director for compliance. The managers will also monitor the garage for any signs of smoking/smell or cigarette butts improperly place there. This will be documented on the motioning form as well.	04/08/2021
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