STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING -- B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	1726 OLD LANTERN TR FORT WAYNE, IN 46845

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 03/03/25 Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870 At this Emergency Preparedness survey, Benchmark Human Services was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds, at the time of the survey, the census was 7. Quality Review completed on 03/04/25	E 0000		
E 0006 Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an emergency preparedness plan (EPP) that was based on and includes a documented facility-based and community-based risk assessment utilizing an all-hazards approach including missing clients and strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.475(a) (1) and 42 CFR 483.475(a) (2). This deficient practice could affect all occupants. Findings include:	E 0006	E006 The facility failed to maintain an Emergency Preparedness Plan (EPP) that was based on and includes on and includes a documented facility-based and community-based risk assessment utilizing an all-hazards approach including missing clients and strategies for addressing emergency events identified by the risk assessment	03/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Eldridge	Residential Director	03/17/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	Based on review of the facility's EPP with the Residential Manager on 03/03/25 at 1:30 p.m., no documentation was available to show that the EPP was based on and included a documented facility-based and community-based risk assessment utilizing an all-hazards approach including missing clients and strategies for addressing emergency events identified by the risk assessment. Based on an interview at the time of records review, the Residential Manager stated documentation for a risk assessment was not in the home during the survey. This finding was reviewed with the Residential Manager during the exit conference.		in accordance. 1.The Emergency Preparedness Program is based on identified situations that would constitute an emergency, as evidenced by annual hazard vulnerability assessments that are both facility and community-based (for our individuals). The top combined hazards are identified below in alphabetical order and special procedures have been incorporated into this policy: 1.Active Shooter 2.Bomb Threat 3.Epidemic (i.e. widespread disease in the community) 4.Fire 5.Inclement Weather (including Tornado) 6.Information Technology System Outage All of this information is located in the Emergency Preparedness book under the section of the EPP Policy. Special Instruction Section A. On 3/14/25 Residential Manager and staff have been retrained on this section of the EPP Book. To ensure that all training was understood, staff and management team completed a Record of Training form. Management team will ensure that EPP Book is accessible to all staff and Individuals served. This will be monitored annually when everyone who works in the home completes	

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			their annual Staff Annual Training, yearly.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 03/03/25 Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870 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. 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 7 at the time of this survey. 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 0.4. Quality Review completed on 03/04/25	K 0000		

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K S363 Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of 6 clients sleeping rooms were provided with a door which would latch securely in the door frame. This deficient practice could affect 3 clients. Findings include: Based on observation with the Residential Manager on 03/03/25 at 1:48 p.m., male sleeping room door #2 and female sleeping room door #3 did not latch into the frame when tested. Based on an interview at the time of observation, the Residential Manager confirmed the doors did not securely latch into the door frames. This finding was reviewed with the Residential Manager during the exit conference.	K S363	K363 The facility failed to ensure 2 out of 6 clients sleeping rooms are provided with a door which would latch securely in the door frame. This deficient practice could affect 3 clients. Male sleeping room door #2 and female sleeping room door #3 did not latch into the frame when tested. Both deficiencies have been corrected on 3/14/25 by Talon Custom Construction. The male sleeping room door #2 was replaced. A new door was ordered the day after the incident. The door arrived on the 3/13/25. Talon replaced the old door with the new door 3/14/25. The deficiency of the female sleeping door #3 not latching when tested, has been repaired on 3/14/25 by Talon Custom Construction. Talon came out and fixed the latches for the door. Now all 3 doors latch appropriately and securely. Management will continue to monitor and check for deficiencies on the monthly Health and Wellness Assessment. This Assessment is completed by my management monthly, on or before the 15th of the month. This	03/14/2025

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			Assessment is sent to the director each month. These checks of compliance will continue to be monitored monthly through the Health & Wellness Assessment by Management and the Director	