STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G792	A. BUILDING -- B. WING	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BENCHMARK HUMAN SERVICES	9285 W CR 950 N ELIZABETHTOWN, IN 47232

(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: 09/05/2024 Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060 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 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 09/06/24	E 0000		
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. 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 the training; (iv)	E 0037	The facility does have an EPP Staff training and testing procedure. These trainings occur initially at hire and annually thereafter. All staff will receiving re-training on the EPP. This training will be kept in the Life Safety binder. Director will monitor training to ensure compliance.	10/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kim Bolen	Residential Director	09/25/2024

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	Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.475(d)(1). This deficient practice could affect all occupants. Findings include: Based on record review on 09/05/2024 between 10:45 AM and 1:00 PM and 1:30 PM and 2:30 PM with the Program Coordinator, no documentation regarding emergency preparedness testing of new hires or ongoing staff was available for review. Based in interview at the time of record review, the Program Coordinator reported the company is in the process of going paperless so all the testing and training records for staff regarding emergency preparedness was out of date. This finding was reviewed with the Program Coordinator at the exit conference.		Addendum: All staff will receive retraining on the EPP. The management staff will receive training on completing EPP training packets with all new employees and during the Staff Annual Training to ensure that training on the EPP is completed at hire and annually. The training will also include keeping a copy of the EPP trainings in the home Life Safety binder along with turning in the original document to the Director to ensure compliance with completing the training. Director will complete a file audit annually to ensure that all training for the EPP is completed. Corrections will be completed by 10/4/24.	
E 0039 Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements 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 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 community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.	E 0039	Additional training will be provided to management staff regarding the requirement to complete at least two exercises to test the emergency plan on an annual basis. Management staff are also being trained to document all community wide drills, table top discussions and natural emergency events. Management staff will complete the required emergency preparedness drills by 10/4/24. These drill will be documented on the emergency preparedness drill forms and turned into the director to ensure	10/04/2024

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	(ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or 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. (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. Findings include: Based on record review on 09/05/2024 between 10:45 AM and 1:00 PM and 1:30 PM and 2:30 PM with the Program Coordinator, the facility was unable to provide documentation of a full-scale community-based exercise and a secondary exercise. Based on interview at the time of record review, the Program Coordinator agreed there was not documentation available for the full-scale community-based exercise or the secondary exercise. This finding was reviewed with the Program Coordinator at the exit conference.		compliance. Addendum: All management staff will be trained to conduct Emergency Preparedness drills twice per year. A copy of the drills will be kept in the home Life Safety binder and the original to be turned into the director for review. Management staff will complete and document the required EP drills by 10/4/24 and turn into the director to ensure compliance. The director will schedule the required drills annually and add to the Group Home Drill Schedule. The director will complete a file audit annually to ensure that all EPP drills and documentation are completed. Corrections will be completed by 10/4/24.	
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was	K 0000		

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	conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 09/05/2024 Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060 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. This one story building was determined to be fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, bedrooms and all living areas. The facility has a capacity of 4 and had a census of 4 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 0.7. Quality Review completed on 09/06/24			
K S200 Bldg. 01	NFPA 101 Means of Egress Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 1 egress exterior gates near the smoking areas, swung in the direction of egress travel. LSC 7.2.1.4.2 states door leaves required to be of the side-hinged or pivoted-swinging type shall swing in the direction	K S200	A work order to repair the egress exterior gate has been completed. This also includes replacing the keyed lock with a passcode non-keyed lock to ensure ready accessibility in case	10/04/2024

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	of egress travel. This deficient practice could affect staff, residents, and visitors while exiting this area through the gate. Findings include: Based on observation on 09/05/2024 between 1:00 PM and 1:30 PM with the Direct Support Professional, the egress gate in the fenced in yard swung into the fenced in area instead of swinging in the direction of egress to the driveway outside the gate. Additionally, the gate was equipped with a key padlock and the key was kept inside, not near the key padlock. Based on interview at the time of the observation, the Direct Support Professional agreed the gate swung into the fenced in area and the key to the padlock was not kept readily accessible at the padlock in case of emergency. This finding was reviewed with the Program Coordinator at the exit conference.		of emergency. The repairs are scheduled to be completed by 10/4/24. All staff will be trained on use of locking mechanism and egress gate. The director will follow up with the contractor to ensure timely completion.	
K S222 Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure 1 of 1 med room doors, 1 of 1 med room doors to the bathroom, and 1 of 1 room 4 doors to the bathroom were arranged so that no door in any means of escape was locked against egress when the building is occupied Findings include: Based on observation with the Direct Support Professional on 09/05/2024 between 1:00 PM and 1:30 PM, the med room door to the bathroom and the room 4 door to the bathroom were both equipped with chain locks and the med room door	K S222	A work order was completed to replace the locks on med room and bathroom doors to ensure egress doors can be opened from the inside. The repairs are scheduled to be completed by 10/4/24. The director will follow up with the contractor to ensure timely completion.	10/04/2024

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	was equipped with a slide lock, preventing exiting if occupied. Based on interview at the time of each observation, the Direct Support Professional agreed there were locks on the outside of the doors in the aforementioned locations which could not be opened from the interior of the med room or bathroom. This finding was reviewed with the Program Director at the exit conference.			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate date information in accordance with the requirements of NFPA 101-2012 edition, Sections 33.3.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all clients, staff and visitors. Findings include: Based on observation during a tour of the facility with the Direct Support Professional on 09/05/2024 between 1:00 PM and 1:30 PM, the fire panel display indicated the date was 09/04/2024. Based on interview at the time of observation, the Director Support Professional agreed the date on the fire panel was incorrect. This finding was reviewed with the Program Coordinator at the exit conference. 2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states	K S345	Priority One, the vendor that services the fire system, was contacted to complete the annual inspection which includes correcting the date on the fire panel. This is scheduled to be completed by 10/11/24. A semi-annual visual inspection of the fire system was completed on 9/23/24 and findings were within normal limits. The house manager has received training on completing the semi-annual visual inspection of the fire system. If any abnormalities are found the vendor will be contacted and necessary maintenance completed for compliance. The semi-annual inspections are scheduled to be completed in March by the house manager and will be sent to the director for review and placed in the Life Safety binder. Addendum: The director will follow	10/14/2024

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	that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on record review on 09/05/2024 between 10:45 AM and 1:00 PM and 1:30 PM and 2:30 PM with the Program Coordinator, no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months, furthermore, there was no documentation of an annual fire alarm system inspection during the past 12 months. Based on interview at the time of record review, the Program Coordinator agreed there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review. This finding was reviewed with the Program Coordinator at the exit conference.		up with Priority One to ensure the scheduled inspections are completed by 10/11/24. The director will receive the inspection report by email and will place a copy of the report in the house Life Safety binder. The director will complete a file audit annually to ensure all fire system inspections have been completed and in the Life Safety binder. The completion date is 10/14/24.	
K S353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review, observation, and interview, the facility failed to maintain monthly sprinkler systems inspection documentation for 5	K S353	The backflow prevention device was tested on 4/5/24 by VFP, the vendor that services the sprinkler	10/05/2024

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	of 12 months in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states an inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. This deficient practice could affect all clients in the facility. Findings include: During record review and interview with the Program Coordinator on 09/05/2024 between 10:45 AM and 1:00 PM and 1:30 PM and 2:30 PM, there was no documentation of monthly valve and gauge checks for the months of September, October, November, and December 2023 and January 2024. The Program Coordinator stated her current system would not allow her to go further back than February 2024. This finding was reviewed with the Program Coordinator at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with a special sprinkler wrench in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of		system. A copy of this report is being submitted with the POC. The monthly sprinkler system inspections to check the gauge and valves was completed during the management staffs house walk through. This walk through was documented on the Health and Welfare Assessment. A home check sheet will be used to document the monthly sprinkler system inspections and will remain in the home. The manager is being re-trained on the requirement for completing the monthly visual inspection of the sprinkler system and documenting on the home checksheet. The monthly inspections include monitoring for leaks, actual pressure of gauges, and wrenches present. If any abnormalities are found the vendor will be contacted and necessary maintenance completed for compliance. VFP was contacted for replacement sprinkler wrench. The monthly inspection will be documented on the Health and Welfare Assessments and turned into the director for review. The director will monitor the monthly reports to ensure compliance.	

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	Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all clients and staff in the facility. Findings include: Based on observation during a tour of the facility on 09/05/2024 between 1:00 PM and 1:30 PM with the Direct Support Professional, no special sprinkler wrench was present in the sprinkler cabinet. Based on interview at the time of observation, the Direct Support Professional agreed there was no special sprinkler wrench present. This finding was reviewed with the Direct Support Professional at the exit conference. 3. Based on record review and interview, the facility failed to maintain 1 of 1 backflow prevention devices. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property			

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	owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 09/05/2024 between 10:45 AM and 1:00 PM and 1:30 PM and 2:30 PM with the Program Coordinator, the facility's backflow device annual testing/inspection was last completed on 08/15/2023. Based on interview at the time of record review, the Program Coordinator agreed the backflow device annual testing/inspection was more than 1 year old. This finding was reviewed with the Program Coordinator at the exit conference.			
K S363 Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 room 1 doors and 1 of 1 doors to the garage were able to self-close and latch securely in the door frame without any hindrance. This deficient practice could affect all clients. Findings include: Based on observation during a tour of the facility	K S363	K-S363 Inside Out Contracting has completed the adjustment to the door hinge/latch mechanism to ensure that the bedroom door and garage door latched into the frame. The door has been checked and is functioning appropriately. The Benchmark Health and Wellness Assessment will be completed by the house manager	10/05/2024

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	on 09/05/2024 between 1:00 PM and 1:30 PM with the Direct Support Professional, the door to room 1 did not close and latch into the frame. Additionally, the door to the garage was equipped with a self-closer and would not latch into the frame when allowed to swing freely. Based on interview at the time of observation, the Direct Support Professional stated the door to room 1 was slammed repeatedly and so would not latch and agreed the door to the garage would not latch. This finding was reviewed with the Program Coordinator at the exit conference.		which making sure doors are in working order. The checks are to be completed by the 20th of the month and will be reviewed by the director after the 20th of the month. In order to ensure compliance, the director will monitor the monthly reports and include the life safety check in the Life Safety Binder for review.	