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	11/01/2024

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. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 09/05/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 11/01/2024 Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060 At this PSR survey to the 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 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 4. Quality Review completed on 11/07/24	E 0000		
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 at least two exercises to test the emergency plan on an annual basis using the emergency procedures. The ICF/IID facility must do all of 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	E 0039	E-0039 Another 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	11/25/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alexandria Allender	Director	11/21/2024

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	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. (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 with the Manager from 10:35 a.m. to 11:15 a.m. on 11/01/24, documentation of at least two exercises to test the emergency plan using the emergency procedures within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Manager agreed the facility has not documented emergency preparedness exercises conducted within the most recent twelve month period and agreed testing documentation was not available for review at the time of the survey.		staff will complete the required emergency preparedness drills by 11/25/2024. and Documentation will be kept in the home EP binder for review. The director will complete a file audit annually to ensure that all EPP drills and documentation are completed quarterly.	

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	15G792	A. BUILDING -- B. WING	11/01/2024

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	These findings were reviewed with the Residential Director during a telephone conversation at 11:17 a.m. on 11/01/24 and with the Manager during the exit conference. This deficiency was cited on 09/05/24. The facility failed to implement a systemic plan of correction to prevent recurrence.			
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification Survey conducted on 09/05/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 11/01/24 Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060 At this PSR 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 heat detection in the attic. The facility has a capacity of 4 and had a census of 4 at the time of this survey.	K 0000		

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	15G792	A. BUILDING 01 B. WING	11/01/2024

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	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 11/07/24			
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 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 observations with the Manager during a tour of the facility from 11:15 a.m. to 11:30 a.m. on 11/01/24, the med room door to the bathroom and the Room 1 door to the bathroom were both equipped with chain locks. The med room door was equipped with a slide lock, preventing exiting if occupied. Based on interview at the time of each observation, the Manager 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. These findings were reviewed with the Manager during the exit conference. This deficiency was cited on 09/05/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	K S222	K-S 222 A miscommunication between benchmark and the contractor occurred, which caused the wrong door to have adjusted locks. A new 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 11/25/2024. The director will follow up with the contractor to ensure completion.	11/25/2024

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	15G792	A. BUILDING 01 B. WING	11/01/2024

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K S363 Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 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 observations with the Manager during a tour of the facility from 11:15 a.m. to 11:30 a.m. on 11/01/24, the door to the garage from the family room near the front entrance was equipped with a self-closing device but the door failed to fully self close and latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Manager agreed the garage door failed to fully self close and latch into the door frame when tested to close multiple times. These findings were reviewed with the Manager during the exit conference. This deficiency was cited on 09/05/24. The facility failed to implement a systemic plan of correction to prevent recurrence.	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 and the repair has been made. The door was checked and was functioning appropriately. The door began not latching again on the 30th of Oct. The Benchmark Health and Wellness Assessment will be completed by the house manager 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.	11/25/2024