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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G764	A. BUILDING 01 B. WING	05/04/2022

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

(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
K 0000 Bldg. 01	An investigation of Complaint Number IN00379372 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Complaint Number IN00379372 was unsubstantiated, due to lack of sufficient evidence. One Federal Tag was cited that was unrelated to the complaint. Survey Date: 05/04/22 Facility Number: 012371 Provider Number: 15G764 AIM Number: 200986870 At this Complaint investigation, 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 8 at the time of this survey. Quality Review completed on 05/09/22	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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	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 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)			
	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. Findings include: Based on observation with the Residential Manager on 5/04/22 at 2:00 p.m., the exit door	K S222	The sleeping room exit door in bedroom #1 had a client dresser in front of it blocking egress. The client in this room put the dresser in front of the door. The dresser was removed from in front of the door to allow the door to be used by both clients to enter and exit	05/20/2022

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	to the outside in 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 will develop a plan to ensure the exit is not blocked. The finding was reviewed with the Quality Insurance, Director of Compliance, Maintenance Director, and the House Manager during exit conference. This federal tag was not related to complaint number IN00379372.		freely. The clients verbalized an understanding of the regulation for safety in case of an emergency to keep any items from blocking windows and doors. The residential Director did a pop in visit on 5/9/22 and 5/17/22 and there were no doors or windows obstructed in the entire group home. All staff were also retrained on ensuring no exits/doors or windows are obstructed due to potential emergency situation. The manager will continue to monitor to ensure that no exits are blocked/obstructed by monitoring 2 times weekly for 2 months.	