

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G792	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2022
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 9285 W CR 950 N ELIZABETHTOWN, IN 47232
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E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 01/26/22</p> <p>Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060</p> <p>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.</p> <p>The facility has 4 certified beds. All 4 beds are certified for Medicaid. At the time of the survey, the census was 3.</p> <p>Quality Review completed on 01/27/22</p>	E 0000		
K 0000  Bldg. 01	<p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 01/26/22</p> <p>Facility Number: 012528 Provider Number: 15G792 AIM Number: 201017060</p> <p>At this Life Safety Code survey, Benchmark</p>	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 that other safeguards 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 S100 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>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 3 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 0.6.</p> <p>Quality Review completed on 01/27/22</p> <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 EXISTING</p> <p>List in the REMARKS section any LSC Section 33.1 or 33.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>Based on observation and interview, the facility failed to document 1 of 3 portable fire extinguishers had the date of 6-year maintenance documented in accordance with NFPA 10. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition,</p>	K S100	K100- This deficiency could affect all clients living in the home. Fire Extinguisher Company #1 has been contacted and a work order submitted to have the necessary service completed on the fire extinguisher in the garage of the	02/25/2022

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	<p>arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Residential Manager and the Team Leader during a tour of the facility from 12:05 p.m. to 12:25 p.m. on 01/26/22, the ABC type portable fire extinguisher located in the garage was manufactured in 2012. The extinguisher had an</p>		<p>home. The director completed an Environmental check at the home on 1/31/22 to ensure all areas were within compliance. This extinguisher was noted to need serviced. Monthly environmental checklists will be completed by the manager and reviewed by the Director. The Manager and TL will receive retraining to ensure their checks are inclusive of the extinguisher in the garage. This will be monitored by the Environmental Checklist and reviewed by the director for compliance. Documentation of the repair will be included in the homes Life Safety binder for review.</p>	

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K S362 Bldg. 01	<p>affixed sticker indicating 6-year maintenance was performed June 2018. The verification of service collar located around the neck of the container indicated the month and year of the agency performing the maintenance or recharge was November 2012. Based on interview at the time of the observations, the Team Leader agreed the verification of service collar for the portable fire extinguisher located in the garage did not have the 6-year maintenance properly documented on the container.</p> <p>This finding was reviewed with the Residential Manager and the Team Leader during the exit conference.</p> <p>NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING (Prompt) Unless otherwise indicated below, corridor walls shall meet all of the following: * Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. * Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. * Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic</p>				

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	<p>sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels.</p> <p>In Prompt Evacuation facilities, all sleeping rooms shall be separated from the escape route by smoke partitions in accordance with 8.2.4.</p> <p>Sleeping arrangements that are not located in sleeping rooms shall be permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken staff that might be sleeping.</p> <p>In previously approved facilities, where the group achieves an E-score of three or less using the board and care methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety, sleeping rooms shall be separated from escape routes by walls and doors that are smoke resistant.</p> <p>33.2.3.6</p> <p>Based on observation and interview, the facility failed to ensure corridor doors to 2 of 4 client bedrooms would resist the passage of smoke. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Residential Manager and the Team Leader during a tour of the facility from 12:05 p.m. to 12:25 p.m. on 01/26/22, a one half inch gap was noted in between the door and the door frame above and below the latching mechanism to the corridor door to the south bedroom by the dining room when the door was in the closed and latched position. In addition, a five inch in diameter hole was noted near the bottom of the corridor door</p>	K S362	K362- A work order had previously been completed by the manager to Inside Out for repair of the doors. The director completed an Environmental check at the home on 1/31/22 to ensure all areas were within compliance. The doors were noted to need repaired/replaced. Monthly environmental checklists will be completed by the manager and reviewed by the Director. The contractor has been contacted by the Director and the door will be replaced as soon as the replacement door is received. The door with the gap will be leveled by the contractor	02/25/2022

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	<p>to the northwest bedroom. Based on interview at the time of the observations, the Residential Manager stated a work order has been submitted to replace the northwest bedroom door but agreed the corridor door for each bedroom would not resist the passage of smoke.</p> <p>This finding was reviewed with the Residential Manager and the Team Leader during the exit conference.</p>		<p>immediately. Doors will be monitored by the Environmental Checklist and reviewed by the director for compliance. Documentation of the repair will be included in the homes Life Safety binder for review. The Manager and TL will receive retraining to ensure their checks are inclusive of doors being occlusive to prevent smoke from entering sleeping areas.</p>	