

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G787	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 5515 TOMAHAWK TR FORT WAYNE, IN 46804
--	---

(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
--------------------	--	---------------	---	----------------------

K010000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 10/20/14</p> <p>Facility Number: 012483 Provider Number: 15G787 AIM Number: 201011380A</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>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 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies.</p> <p>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.</p>	K010000		
---------	--	---------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G787	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 5515 TOMAHAWK TR FORT WAYNE, IN 46804
--	---

(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
K010130	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.4.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 10/27/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 4 portable fire extinguishers was provided maintenance no more than one year apart. LSC Section 4.5.7 states any device, equipment, system required for compliance with the Code shall thereafter be maintained unless the code exempts such maintenance. NFPA 10, Standard for Portable Fire Extinguishers, 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. NFPA 10, 4-3.4.3 requires records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file,</p>	K010130	<p>The Fire Extinguisher has already beenserviced by Priority One on 11/6/14.</p> <p>AWS/Benchmark has a monthly maintenancewalk through that the manager completes monthly (Environmental CQA)that will check for and ensure maintenance no more than one yearapart and monthly Fire Extinguisher inspections. This walk through(Environmental CQA) will be reviewed by the Director to ensurecompliance.</p>	11/19/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G787	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  10/20/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 5515 TOMAHAWK TR FORT WAYNE, IN 46804
--	---

(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
	<p>or in an electronic system that provides a permanent record. This deficient practice would affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation and interview, the Qualified Developmental Disability Professional (QDDP) on 10/20/14 at 1:15 p.m., she acknowledged the last annual inspection on the portable fire extinguisher located in the garage was 2012.</p> <p>2. Based on observation and interview the facility failed to ensure a monthly fire extinguisher inspections was documented, including the date and initials of the person performing the inspections for 1 of 4 portable fire extinguishers. NFPA 101, Section 4.5.7 states any device, equipment, system required for compliance with the Code shall thereafter be maintained unless the code exempts such maintenance. NFPA 10, Standard for Portable Fire Extinguishers, 4-3.1 requires extinguishers shall be inspected monthly. NFPA 10, 4-2.1 defines inspection as a quick check that an extinguisher is available and will operate. NFPA 10, 4-3.4.2 requires at least monthly, the date the inspection was performed and the initials of the person performing the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G787		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/20/2014	
NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 5515 TOMAHAWK TR FORT WAYNE, IN 46804			
(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			
K01S046	<p>inspection shall be recorded. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation and interview, the Qualified Developmental Disability Professional (QDDP) on 10/20/14 at 1:16 p.m., she acknowledged the inspection tag on the garage fire extinguishers lacked initials and a date of a monthly inspection from October 2013 to August 2014.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 master bathroom wet location client care areas was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the</p>	K01S046	<p>A work order was sent to Byall Homeson 10/22/2014. The contractor is scheduled to preform the work and to have it completed before 11/19/14. All other wet locations have been checked to ensure that they are GFCI protected. A walk through has been completed by the contractor to ensure that all other wet locations have GFCI protected receptacles and the director will also complete a walk through to ensure compliance.</p>	11/19/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G787		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  10/20/2014	
NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES				STREET ADDRESS, CITY, STATE, ZIP CODE 5515 TOMAHAWK TR FORT WAYNE, IN 46804			
(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			
	<p>countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice affects 2 of 8 clients.</p> <p>Findings include:</p> <p>Based on observation and interview, the Qualified Developmental Disability Professional (QDDP) on 10/20/14 at 1:20 p.m., she acknowledged the master bathroom had a GFCI receptacle on the wall within two feet of the hand sink. When the test button was pressed on the GFCI testing device power was not interrupted indicating the GFCI receptacle was wired improperly.</p>						