

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G013	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/23/2014
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NAME OF PROVIDER OR SUPPLIER  BENCHMARK HUMAN SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 817 MENDLESON DR RICHMOND, IN 47374
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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: 09/23/14</p> <p>Facility Number: 000588 Provider Number: 15G013 AIM Number: 100233310</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, AWS 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 33, Existing Residential Board and Care Occupancies.</p> <p>This one story facility was not sprinkled. The facility has a fire alarm system with smoke detection in the corridors common living areas, and hard wired smoke detectors in all client sleeping rooms. The facility has a capacity of 8 and had a census of 7 at the time of this survey.</p>	K010000		
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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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K010130	<p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.52.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 09/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 portable fire extinguishers were inspected at least monthly and the inspections were documented for 10 of 10 months since the last annual inspection date, including the date and initials of the person performing the inspection. LSC 4.6, General Requirements at 4.6.12.2 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition</p>	K010130	<p><b>Corrective action for resident(s) found to have beenaffected</b> All fireextinguishers will be checked and initialed on 10-15-14 by the RD. The QIDP and the GHMwill be retrained by the RD on 10-15-14 on the requirement to check and initialeach file extinguisher monthly. This ispart of the monthly CQA that the GHM and/or the QIDP are required to complete.</p> <p><b>How facility will identify other residents potentiallyaffected and what measures taken</b> All residents couldpotentially be affected and corrective action will address the needs of allclients.</p> <p><b>Measures or systemic changes</b></p>	10/23/2014

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K01S150	<p>NFPA 10, 4-2.1 defines inspection as a quick check an extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the social worker on 09/23/14 from 11:40 a.m. to 12:50 p.m., service and inspection tags for the portable fire extinguishers located in the kitchen and the furnace room each bore a service inspection tag indicating the most recent annual inspection was 01/21/14, but no monthly check was documented on the inspection tags for July 2014.</p> <p>Based on interview at the time of observation, the social worker stated there is no written documentation of monthly fire extinguisher inspections for the facility other than the service inspection tags and the home manager missed the monthly inspection for July 2014. This was verified by the social worker at the exit conference on 09/23/14 at 1:10 p.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD New draperies, curtains, and other similar</p>		<p><b>facility put in place to ensure no recurrence</b></p> <p>The RD will monitor the monthly CQA to ensure QIDP and the GHM has documented that they checked the fire extinguisher.</p> <p><b>How corrective actions will be monitored to ensure no recurrence</b></p> <p>The RD will monitor the monthly CQA to ensure QIDP and the GHM has documented that they checked the fire extinguisher. The RD will make random checks at least quarterly to ensure the GHM and QIDP are checking the fire extinguishers.</p>				

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	<p>loosely hanging furnishings and decorations in board and care facilities are in accordance with provisions of 10.3.1. 32.7.5.1, 33.7.5.1</p> <p>Based on record review, interview and observation, the facility failed to ensure new draperies and curtains were flame resistant for 4 of 12 rooms. LSC Section 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect all clients in the facility.</p> <p>Findings include</p> <p>Based on an interview with the social worker on 09/23/14 at 11:40 a.m. during record review, there was no record of fire rated documentation on window curtains throughout the facility and the facility bought new window curtains over the past year. Based on observations during a tour of the facility with the social worker on 09/23/14 from 11:40 a.m. to 12:50 a.m., the staff office window curtain, the northwest client sleeping room two window curtains, the southwest client sleeping room window curtain, and the south client sleeping room window curtains did not have a fire resistance</p>	K01S150	<p><b>Correctiveactionforresident(s)foundedtohavebeenaffected</b> Maintenance work orders were submitted to the maintenancedepartment on 10/8/14 to spray all curtains in the home with flameretardant. The maintenance department issecuring the material and will have the curtains sprayed by 10/23/14.</p> <p><b>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasuresstaken</b> All residentscould be affected andcorrective action willaddress the needsof all clients.</p> <p><b>Measuresorsystemicchangesfacilityputinplacetoensurenorecurrence</b> A letter will bemaintained in the emergency binder documenting that all curtains were sprayedwith approved flame retardant. The flameretardant used will be retained for audit.</p> <p><b>Howcorrectiveactionswillbemonitoredtoensurenorecurrence</b> The QIDP and GHMwill be retrained by the RD to ensure any new curtains purchased are sprayedwith flame retardant and it is documented in the emergency binder.</p>	10/23/2014			

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	label attached to each set of curtains. The lack of flame resistance documentation for the window curtains was verified by the social worker at the time of record review and observation and at the exit conference on 09/23/14 at 1:10 p.m.				