

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G013	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2015
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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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K 0000 Bldg. 01	<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: 08/24/15</p> <p>Facility Number: 000588 Provider Number: 15G013 AIM Number: 100233310</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 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> <p>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A,</p>	K 0000		
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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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K 0130 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.20.</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 6 of 6 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 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 home manager on 08/24/15 from 10:20 a.m. to 11:50 a.m.,</p>	K 0130	<p>Corrective action for resident(s) found to have beenaffected All fireextinguishers have been checked and initialed by the GHM. The AssistantDirector, QIDP and the GHM will be retrained by the RD on 9/9/15 on therequirement to check and initial each file extinguisher monthly. This is also documented as part of themonthly CQA that the GHM and/or the QIDP are required to complete.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken All residents couldpotentially be affected and corrective action will address the needs of allclients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence The RD will monitorthemonthly CQA to ensure QIDP and the GHM has documented that they checked thefire extinguisher.</p> <p>How corrective actions will be monitored to ensure norecurrence The RD will monitor the monthly CQA to ensure QIDP and the GHM hasdocumented that they</p>	09/11/2015	

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K S029 Bldg. 01	<p>service and inspection tags for the portable fire extinguishers located in the furnace room and the kitchen utility room each bore a service inspection tag indicating the most recent annual inspection was 01/29/15, but no monthly check was documented on the inspection tags for February, March, April, May, June, and July of 2015. Based on interview at the time of observation, the home manager stated there is no written documentation of monthly fire extinguisher inspections for the facility other than the service inspection tags and the home manager indicated monthly inspections were missed from February through July 2015. This was verified by the home manager at the exit conference on 08/24/15 at 11:50 a.m.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Any hazardous area that is on the same floor as, and is in or abuts, a primary means of escape or a sleeping room is protected by one of the following means:</p> <p>(a) Protection is an enclosure with a fire resistance rating of not less than 1 hour, with a self-closing or automatic closing fire door in accordance with 7.2.1.8 that has a fire protection rating of not less than ¾ hour.</p>				checked the fire extinguisher. The RD will make random checks to ensure theGHM and/or QIDP are checking and initialing the fire extinguishers.		

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	<p>(b) Protection is automatic sprinkler protection, in accordance with 32.2.3.5, and a smoke partition, in accordance with 8.2.4, located between the hazardous area and the sleeping area or primary escape route. Any doors in such separation is self-closing or automatic closing in accordance with 7.2.1.8. 33.2.3.2.2.</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 hazardous area storage room used for storage of combustible items, was provided with a 3/4 hour self closing door in a non sprinklered facility. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation on 08/24/15 at 11:40 a.m. with the home manager, the finished garage, which measured eleven hundred ten square feet, had sixty seven cardboard boxes of holiday decorations, clothing, paper products, and food. Furthermore, the door leading from the home to the garage was not labeled with a fire resistance rating and lacked a self closing device. Based on an interview with the home manager on 08/24/15 at 11:45 a.m., the garage was converted to a storage room due to a lack of storage in the home. The lack of a 3/4 hour rated self closing door leading into the garage storage room was acknowledged by the</p>	K S029	<p>Correctiveactionforresident(s)foundtohavebeenaffected The heat sensor in the garage was replaced on 9/2/15 with a smoke detector that is hard wired in to the house alarm system. In the case of a fire in the garage, all alarms will sound and the fire door will be released. A 3/4 hour self closing door has been ordered and will be installed on 9/18/15</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwh atmeasurestaken All residents could be affected andcorrective action will address the needs of all clients.</p> <p>Measuresorsystemicchangesfa cilityputinplacetoensurenorecu rrence The GHM ensured the non compliant heat sensor was removed. Once the alarm was replaced the citation was completed and the hard wired smoke detector will remain in place. The 3/4 hour self closing door has been ordered and will be installed on 9/18/15</p> <p>Howcorrectiveactionswillbemo nitoredtoensurenorecurrence The hard wired smoke detector and 3/4 hour self closing door will remain in place.</p>	09/15/2015

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K S046 Bldg. 01	<p>home manager at the exit conference on 08/24/15 at 11:50 a.m.</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 record review and interview, the facility failed to maintain an electrical outlet in 1 of 5 client sleeping rooms. LSC 9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice could affect 2 clients who reside in client room #1.</p> <p>Findings include:</p> <p>Based on observation on 08/24/15 at 11:20 a.m. with the home manager, client sleeping room #1 had an electrical outlet behind the door with no cover plate with electrical wires exposed. This was verified by the home manager at the time of observation and acknowledged at the exit conference on 08/24/15 at 11:50 a.m.</p>	K S046	<p>Correctiveactionforresident(s)foundedtohavebeenaffected Maintenance work order was submitted to the maintenancedepartment on 8/24/15 to fix the outlet cover plate in Client #1 bedroom. This outlet cover plate was fixed on 8/25/15.</p> <p>Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasuresstaken All residentscould be affected andcorrective action willaddress the needsof all clients.</p> <p>Measuresorsystemicchangesfacilityputinplacetoensurenorecurrence The GHM and/or QIDPwill be retrained to check all outlet covers as well as all other qualityassurance items monthly on the CQA. TheCQA is turned in to the Regional Director as well as the corporate compliancedepartment.</p> <p>Howcorrectiveactionswillbemonitoredtoensurenorecurrence The QIDP and GHMwill be retrained by the Regional Director to ensure a thorough and completewalk through monthly of the home and will document all findings on theCQA. Every CQA is turned into the</p>	09/11/2015

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K S152 Bldg. 01	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD (1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.</p> <p>(2) The facility must - (i) Actually evacuate clients during at least one drill each year on each shift; (ii) Make special provisions for the evacuation of clients with physical disabilities: (iii) File a report and evaluation on each drill: (iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and (v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.</p> <p>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize. Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 2 of the last 4 calendar quarters and 2 of 3 shifts over the past year. This deficient practice could affect all clients.</p>			K S152	<p>RegionalDirector each month for tracking and then forwarded to the corporate compliance department.</p> <p>Corrective action for resident(s) found to have beenaffected An annual emergencydrill calendar has been designed and will be implemented which includes drillson each shift quarterly. GHM and QIDPwill post this annual calendar and mark on the monthly calendar</p>		09/11/2015

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	<p>Findings include:</p> <p>Based on a review of Residential Safety Drill Reports on 08/24/15 with the home manager at 10:40 a.m., there was no record of a fire drill conducted on third shift for the first quarter of the year 2015, and first shift for the second quarter of the year 2015. This was verified by the home manager at the time of record review and there were no other records to indicate the missed fire drills were conducted at the exit conference on 08/24/15 at 11:50 a.m.</p>		<p>the dates andtimes drills are due to be completed. Team Leaders will check the next day to ensure the drills were completedand will turn the drill into the QIDP for tracking.</p> <p>The GHM and QIDPwere retrained on the need for all drills to be completed and filed. This retraining was done by the RegionalDirector on 9/9/15.</p> <p>How facility will identify other residents potentiallyaffected and what measures taken</p> <p>All residents couldpotentially be affected and corrective action will address the needs of allclients.</p> <p>Measures or systemic changes facility put in place toensure no recurrence</p> <p>An annual emergencydrill calendar has been designed and implemented. This annual schedule will include drills tobe conducted on each shift quarterly. Supervisors will post this calendar and mark on the monthly calendar thedates and times drills are to be conducted. The Supervisors will pick up the drill the following day to ensure itwas completed and will turn it into the QIDP for tracking.</p> <p>How corrective actions will be monitored to ensure norecurrence</p> <p>Supervisors were trainedto follow emergency drill calendar by the RD on 9-9-15. Supervisors will check the following day toensure drills are</p>		

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			being completed as scheduled. A member of management will check monthly during the environmental quality assessment to ensure drills are being completed as scheduled. The Regional Director will review the monthly environmental quality checks to ensure compliance.		