STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G390	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENCHMARK HUMAN SERVICES	825 MENDLESON DR RICHMOND, IN 47374

(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	A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 10/01/14 Facility Number: 000904 Provider Number: 15G390 AIM Number: 100233320 Surveyor: Mark Bugni, Life Safety Code Specialist 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. 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.	K010000		

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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	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 3.36. Quality Review by Dennis Austill, Life Safety Code Specialist on 10/07/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010130	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 8 of 9 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	K010130	**Corrective action for resident(s) found to have beenaffected** 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. **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.	10/23/2014

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	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. Findings include: Based on observation during a tour of the facility with the regional director on 10/01/14 from 10:40 a.m. to 11:50 a.m., service and inspection tags for the portable fire extinguishers located in the garage 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 January 2014. Based on interview at the time of observation, the regional director 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 February, March, April, May, June, July, August, and September 2014. This was verified by the regional director at the time of observation and acknowledged at the exit conference on 10/01/14 at 11:55		**Measures or systemic changes facility put in place toensure no recurrence** The RD will monitorthe monthly CQA to ensure QIDP and the GHM has documented that they checked thefire extinguisher. **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 checked the fire extinguisher. The RD will make random checks at leastquarterly to ensure the GHM and QIDP are checking the fire extinguishers.	

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	a.m.			
K01S017	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The separation walls of sleeping rooms are capable of resisting fire for not less than ½ hour, 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 1¾ 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 8.2.3.2.2 or are wired glass not exceeding 1296 sq. in. each in area and installed in approved frames. 33.2.3.6.1, 33.2.3.6.2. Exception No. 1: In prompt evacuation facilities, all sleeping rooms are separated from the escape route by smoke partitions in accordance with 8.2.4. Door closing is regulated by 33.2.3.6.4. Exception No. 2: This requirement does not apply to corridor walls that are smoke partitions in accordance with 8.2.4 and that are protected by automatic sprinklers in accordance with 33.2.3.5 on both sides of the wall and door. In such instances, there is no limitation on the type or size of glass panels. Door closing is regulated by 33.2.3.6.4. Exception No. 3: Sleeping arrangements that are not located in sleeping rooms are permitted for nonresident staff members, provided that the audibility of the alarm in the sleeping area is sufficient to awaken			

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	staff that might be sleeping. Exception No. 4: 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 are separated from escape routes by walls and doors that are smoke resistant. No louvers or operable transoms or other air passages penetrate the wall, except properly installed heating and utility installations other than transfer grilles. Transfer grilles are prohibited. Based on observation and interview, the facility failed to ensure 1 of 5 sleeping room wall was separated with smoke partitions from the common spaces and corridors in accordance with 8.2.4. This deficient practice could affect 2 clients who reside in bedroom #2. Findings include: Based on observation with the regional director on 10/01/14 at 11:10 a.m., bedroom #2 north wall near the exit door had a two inch circular area of drywall missing. This was verified by the regional director at the time of observation and acknowledged at the exit conference on 10/01/14 at 11:55 a.m.	K01S017	**Correctiveactionforresident(s)foundtohavebeenaffected** Maintenance work orders were submitted to the maintenancedepartment on 10/9/14 to fix the hole on the north wall in the south mostbedroom. The maintenance department issecuring the material and will have the hole repaired no later than 10/23/14. **Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasurestaken** All residentscould be affected andcorrective action willaddress the needsof all clients. **Measuresorsystemicchangesfacilityputinplacetoensurenorecurrence** The maintenance departmentwill write the fix on the maintenance word order and submit it to the GHM whowill place it in the work order binder as proof of the date the hole	10/23/2014

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			wasfixed. **Howcorrectiveactionswillbemonitoredtoensurenorecurrence** The QIDP and GHMwill be retrained by the RD to ensure a thorough and complete walk throughmonthly of the home and will document all findings on the CQA. Every CQA is turned into the RD each monthfor tracking and then forwarded to the AWS compliance department.	
K01S046	483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1 Based on observation and interview, the facility failed to ensure 1 of 4 electric outlets in bedroom #2 was provided with a cover plate. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, the National Electrical Code. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. Article 370-25, Covers and Canopies, states "In completed installations each box shall have a cover, faceplate or fixture canopy." This deficient practice could affect one client who resides in the first floor northeast sleeping room. Findings include:	K01S046	**Correctiveactionforresident(s)foundtohavebeenaffected** Maintenance work orders were submitted to the maintenancedepartment on 10/9/14 to fix the outlet cover plate on the north wall in thesouth most bedroom. The maintenancedepartment is securing the material and will have the outlet cover platerepaired no later than 10/23/14. **Howfacilitywillidentifyotherresidentspotentiallyaffectedandwhatmeasurestaken** All residentscould be affected andcorrective action willaddress the needsof all clients. **Measuresorsystemicchangesfacilityputinplacetoensurenorecurrence** The maintenancedepartment will write the fix on the maintenance wor	10/23/2014

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	Based on observation with the regional director on 10/014 at 11:20 a.m., the one electric outlet on the north wall near the exit door was missing the cover plate which exposed the electric wiring for the electric outlet. This was verified by the regional director at the time of observation and acknowledged at the exit conference on 10/01/14 at 11:55 a.m.		order and submit it tothe GHM who will place it in the work order binder as proof of the date theoutlet plate was fixed. **Howcorrectiveactionswillbemonitoredtoensurenorecurrence** The QIDP and GHMwill be retrained by the RD to ensure a thorough and complete walk throughmonthly of the home and will document all findings on the CQA. Alto they will be retrained on facilitymaintenance and following up on ensuring all repairs are completed and trackedin the Maintenance Work Order Binder housed in the GHM office. Every CQA is turned into the RD each monthfor tracking and then forwarded to the AWS compliance department.	