

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534
---	---

(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: 12/11/13</p> <p>Facility Number: 001005 Provider Number: 15G491 AIM Number: 100245050</p> <p>Surveyors: Dennis Austill, Life Safety Code Specialist, Libby Fruth, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Pathfinder Services, Inc. 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 fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, in client sleeping rooms and in common living areas. The facility has a capacity of 8</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: 15G491	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534
---	---

(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
K01S149	<p>and had a census of 8 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 Slow with an E-Score of 2.2.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/23/13.</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 Where smoking is permitted, noncombustible safety type ashtrays or receptacles are provided in convenient locations. 32.7.4.2, 33.7.4.2 Based on observation and interview, the facility failed to ensure staff and clients appropriately used 1 of 1 smoking areas provided with noncombustible safety type ashtrays or receptacles in a convenient location. This deficient practice could affect clients around the front entrance to the facility.</p>	K01S149	K 0149 The improper astray has been replace by one that meets the requirements. Monthly inspections will assure that the proper type of ashtray is being used. Person Responsible: Residential Manager	01/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G491		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 12/11/2013	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534			
(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>Findings include:</p> <p>Based on observation on 12/11/13 at 12:30 p.m. with the Residential Manager, a coffee can was being used as an ashtray on a table under the carport which was the designated smoking area. Additionally, cigarette butts and discarded cigarette packages were mixed together in the coffee can. Based on interview at the time of observation, the Residential Manager acknowledged the aforementioned condition.</p>						