

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  10/15/2012
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NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534
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K0000	<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: 10/15/12</p> <p>Facility Number: 001005 Provider Number: 15G491 AIM Number: 100245050</p> <p>Surveyor: W. Chris Greeney, 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 fire alarm system with smoke detection in the corridors, client 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>	K0000		

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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	<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 3.1</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/16/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0130	<p>Based on observation and interview, the facility failed to ensure the monthly fire extinguisher inspections were documented, including the date and initials of the person performing the inspections for 2 of 3 portable fire extinguishers. LSC 101, 4.5.7 states any device, equipment or system required for compliance with this 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 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 inspection shall be recorded. This deficient practice could affect all clients, staff and visitors in the vicinity of the east bedroom hallway and the living room.</p> <p>Findings include:</p> <p>Based on observation of fire extinguisher inspection/maintenance tags on 10/15/12 between 11:15 a.m. and 11:45 a.m. during a tour of facility with the Community Supports Assistant Director</p>	K0130	<p>K 130</p> <p>Fire extinguishers are checked monthly. According to the manager the fire extinguishers had been check during the months noted but had not been dated and initialed. That is consistent with the fact that one of the extinguishers in the home had been initialed and dated for those months as well as a monthly checklist had been completed that indicated that all fire extinguishers had been checked. A reminder to initial and date will be included on the monthly checklist to initial and date the tags on the fire extinguishers.</p> <p>Completion Date: November 17, 2012</p> <p>Person Responsible: Residential Manager</p>	11/17/2012			

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	(CSAD), a portable fire extinguisher located in the east bedroom corridor and a portable fire extinguisher located in the living room had a monthly inspection tag. The last date on each tag was 7/31/12. with blank spaces for the months of August and September. Interview with the CSAD during the observation indicated there was no other evidence the facility had conducted the monthly inspection of those two extinguishers.				

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KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD</p> <p>The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review and interview, the facility administration failed to ensure all employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan for special staff response, including fire protection procedures needed to ensure the safety of 8 of 8 clients which is amended, or revised, whenever any resident with unusual needs is admitted to the home. Such instruction is reviewed by the staff at least every two months. This deficient practice could affect all clients.</p> <p>Findings include:</p>	KS147	<p>K 147</p> <p>Training had been provided to staff each 2 months as requires. Record of training was not available at the time of the survey. Training records will be added to the list of items to make available for LSC survey.</p> <p>Completion Date: November 17, 2012 Person Responsible: Community Supports Assistant Director</p>	11/17/2012	

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	Based on review of Fire Drill records with the Community Supports Assistant Director (CSAD) on 10/15/12 at 10:35 a.m., lapses in staff fire safety training times were more than the two months allowed as evidenced by the lack of any record of fire drills for the afternoon/evening shift during first quarter of 2012. The records reflect a lapse in training for the afternoon/evening shift between December 2011 and April 2012. The CSAD indicated there was no other fire drill documentation or other fire safety staff training documentation available for this time frame.				

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KS152	<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 ensure fire and evacuation drills were provided for each shift for 1 of 4 quarters. This deficient practice affects all occupants.</p> <p>Findings include:  Based on a review of Fire Drill records on 10/15/12 at 10:35 a.m. with the</p>	KS152	<p>K 152  Fire drills will be run at least once each quarter on each shift. A system to prompt the supervisor that the drill needs to be run and on which shift will be sent at the beginning of each month. A prompt later in the month will be sent to check to make sure that the appropriate drill has been run.</p>	11/17/2012	

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	Community Supports Assistant Director (CSAD), documentation of fire drills was not found for the afternoon/evening shift during the first quarter (January through March) of 2012. The CSAD indicated no other fire drill records for that quarter could be located.		Completion Date: November 17, 2012 Person Responsible: QMRP		