

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G765	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/22/2015
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2033 DUNCAN DR HUNTINGTON, IN 46750
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(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
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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: 07/22/15</p> <p>Facility Number: 012373 Provider Number: 15G765 AIM Number: 200993530</p> <p>At this Life Safety Code survey, Pathfinder 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 nonsprinklered. The facility has a fire alarm system with smoke detection in the corridors, sleeping rooms and common living areas. The facility has a capacity of 4 and had a census of 4 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 S018 Bldg. 01	<p>Alternative Approaches to Life Safety, Chapter 6 rated the facility Prompt with an E-score of 0.4.</p> <p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Doors are provided with latches or other mechanisms suitable for keeping the doors closed. No doors are arranged to prevent the occupant from closing the door. 32.2.3.6.3, 32.2.3.6.4, 33.2.3.6.3, 33.2.3.6.4</p> <p>Doors are self-closing or automatic closing in accordance with 7.2.1.8</p> <p>Exception: Door closing devices are not required in buildings protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5.1 and 33.2.3.5.2.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 client sleeping room doors would self close and latch into the door frame in accordance with 7.2.1.8. This deficient practice affects 1 client in the facility.</p> <p>findings include:</p> <p>Based on observation during a tour of the facility on 07/22/15 at 12:02 p.m. with the Community Support Assistant Director, self closing devices had been provided on the client doors for this nonsprinklered facility but the self closing device on the door of Back Single Room #1 failed to operate. Based on interview at the time of observation, this</p>	K S018	<p>A Maintenance request has been completed to have the door repaired so that it self closes. All other doors were checked and currently do self close. A reminder has been sent to all staff to monitor bedroom doors and at any time if they do not self close, to complete a Maint. Request for repair. We have a Monthly Inspection checklist where checking the doors is a set task to be completed monthly in all group homes. All group home staff will be reminded to always be aware of these doors and to complete a Maint. Request as needed if they do not perform as needed. The Q's and Coord., are in the homes weekly and will also check bedroom doors on their visits.</p>	08/21/2015

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K S149 Bldg. 01	<p>was acknowledged by the Community Support Assistant Director.</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 1 of 1 smoking areas was provided with a noncombustible safety type ashtrays or receptacles in a convenient location. This deficient practice could affect all clients in the event of a fire emergency.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Community Support Assistant Director on 07/22/15 at 12:10 p.m., a metal coffee can with a plastic lid was being used as an ashtray dump on the back deck, and the ashtray provided was an open plastic ashtray. Based on interview, this was acknowledged by the Community Support Assistant Director at the time of observation.</p>	K S149	<p>The coffee can and ash tray have been disposed of. A smoker's outpost has been put into place at the house. All staff have been trained on what is the proper receptacle for smoking. All group homes have been checked with to make sure they also have the proper container for smoking and these are in place. The containers will be maintained and replaced as needed. The Q's and Coord. will check the smoking container on their visits to the group home which is on a weekly basis.</p>	08/21/2015