

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/22/2013
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
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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: 05/22/12</p> <p>Facility Number: 001004 Provider Number: 15G490 AIM Number: 100245030</p> <p>Surveyor: Amy Kelley, 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>The one story facility was not sprinklered. 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 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K010000		
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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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	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 1.5.</p> <p>Quality Review by Dennis Austill, Life Safety Code Supervisor on 05/24/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K01S147	<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 written emergency plans were available to protect 6 of 6 clients. This deficient practice affects all clients in the facility.</p> <p>Findings include:</p> <p>During the record review process with the Residential Manager on 05/22/13 from 11:25 a.m. to 11:56 a.m., the facility was unable to provide the written emergency plans. Based on an interview with the Residential Manager at 11:56 a.m., she was unable to provide the documentation.</p>	K01S147	<p>1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>- The written plan was in the group home, but the manager was unable to locate it at the time of survey. All group home staff and the manager were trained on 6/4/13 on the proper location of fire safety documents. They were shown the red, Emergency Management book and it was explained to everyone that this book is where the written emergency plans are located.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective</p>	06/21/2013	

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			<p>action will be taken? - All clients could be affected if their staff did not know where the written emergency plans are located. All group home staff and the manager were trained on 6/4/13 on the proper location of fire safety documents. They were shown the red, Emergency Management book and it was explained to everyone that this book is where the written emergency plans are located.3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?- Once a year the Manager will review the Emergency Management book with staff at a house meeting.4. How will action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? - The Manager will review the Emergency Management book annually in June and the QDDP will review the book as well.</p>		

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K01S152	<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 1 of the last 4 calendar quarters. This deficient practice could affect all clients.</p> <p>Findings include: Based on record review of the "Fire Drill Report" with the Residential Manager on</p>	K01S152	<p>1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? - A 3rd shift drill will be completed by 6/21/13. A Fire Drill Signature Page has been created for more accountability.2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</p>	06/21/2013			

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	05/22/13 at 11:53 a.m., a third shift fire drill was not conducted for the fourth quarter of 2012. This was acknowledged by the Residential Manager at the time of record review.		taken? - All clients can be affected. A 3rd shift drill will be completed and a new Fire Drill Signature page has been created. It will list what drill is due each month and the time frame in which it should be done.3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?- A Fire Drill Signature Page has been created for more accountability. The Manager will print this page out each month and fill in the information regarding what shift should be done for the month and the time frame in which it should be done.4. How will action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? - The Administrative Assistance will review the Fire Drill Signature Page each month and will also check the fire drill itself to ensure the correct shift is being completed.		

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K01S155	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to protect 8 of 8 clients by providing a written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on record review with the Residential Manager on 05/22/13 at 11:57 a.m., the facility did have written policy and procedure for an impaired fire alarm system but the policy did not state the designated person conducting the fire watch shall be properly trained in the duties and responsibilities prior to conducting the fire watch. Based on an interview with the Residential Manager at the time of record review, it was acknowledged the fire watch policy documentation lacked a statement</p>	K01S155	<p>1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? - Staff were trained on 6/4/13 on the procedure to be followed in the event fire alarm system is out of order for 4 hrs to 24 hrs. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? - All residents will be safe because staff are trained and prepared in dealing with this situation of the fire alarm being disabled if it ever comes up. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?- Staff were trained on 6/4/13 on the procedure to follow in the event the fire alarm system is disabled for 4 hrs to 24 hrs. 4. How will action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? - Staff signed training sheet on 6/4/13 and training</p>	06/21/2013			

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	indicating the person conducting the fire watch shall be properly trained prior to conducting a fire watch.		regarding fire alarm system outage will be completed annually by house mgr.		