

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/30/2013
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783
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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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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: 01/30/13</p> <p>Facility Number: 001057 Provider Number: 15G543 AIM Number: 100245390</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 fully sprinklered. The facility has a fire alarm system with smoke</p>	K0000		
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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>detection in the corridors and common living areas. The facility has a capacity of 7 and had a census of 7 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 4.8.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/04/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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KS046	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 propane tanks was stored outside of the building. Section 9.1.1 refers to NFPA 58, Liquefied Petroleum Gas Code which at 3-2.2.1 states LP gas containers shall be located outside of buildings. This deficient practice could affect all clients in the facility.</p> <p>Findings include:</p> <p>Based on observation with the Community Support Coordinator on 01/30/12 at 11:55 a.m., a small gas barbeque grill type propane tank was stored near the front door in the living room. Based on an interview with the Community Support Coordinator at the time of observation, she stated the propane tank should not be in the house.</p>	KS046	<p>There was an empty propane tank that was noticed while walking through our Roanoke Group Home during the Life and Safety Code Inspection on 01/30/2013. As soon as it was pointed out to the Residential Coordinator, Lisa Pape, it was removed from inside the home and placed on the front porch, as was witnessed by Amy Kelley. An email was sent to all of the staff of the home on 02/01/2013 to let them know that this was discovered and that it is not acceptable and that anything made to hold flammable materials needs to stay outside at all times. A copy of said email is attached. An email was sent to all Group Home staff at all of our homes on 02/11/2013 requesting that they check the homes for any such gas containers and requesting they be removed immediately if noticed. A copy of said email is attached. An email has also sent to all Group Home Managers on 02/11/2013 requesting that at least once monthly they do a thorough walk through of each room within the home checking for any such containers. If any are found, they should be removed immediately, and then they need to investigate how they got there and by whom to assure the protection of our clients. Their</p>	02/15/2013	

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			findings will then be reported to the Residential Coordinator. Once again, said email is attached. With the Group Home Managers being in the home at least 5 times per week, they will readily be able to notice any such containers being within the home and will be able to get them removed very quickly for the protection of our clients. Their first thorough walk through will be done by 02/15/2013.		