

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G033	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 456 W MARKET 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: 05/22/13</p> <p>Facility Number: 000593 Provider Number: 15G033 AIM Number: 100233370</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 with a basement was not sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, sleeping rooms and common living areas. The facility has a capacity of 7 and had a census of 6 at the time of this survey.</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>Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.4.</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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K01S043	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD No door in any means of escape is locked against egress when the building is occupied.</p> <p>Exception: Delayed egress locks complying with 7.2.1.6.1 are permitted on exterior doors. 32.2.2.5.5, 33.2.2.5.5.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 3 exit doors was provided with a releasing device having a obvious method of operation and readily operated under all lighting conditions. LSC 33.2.2.5.7 requires compliance with LSC 7.2.1.5.4. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one that is familiar to the average person. Generally, a two-step release, such as a knob and independent dead-bolt, is not acceptable. In most occupancies, it is important a single action unlatch the door. This deficient practice could affect all clients.</p> <p>Findings include:</p> <p>Based on observation with the Residential Manager on 05/22/13 at 12:51 p.m., the front exit door had a lockable door knob and an independent dead-bolt. Based on an interview with the Residential</p>	K01S043	<p>1. What corrective action will be accomplished for these residents found to have been affected by the deficient practice? * Maintenance will plug the dead bolt hole so it is not functioning anymore. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?*</p> <p>All residents in the house will have the same ease in leaving the home by the front door by having only one door knob lock to unlock in case of a fire or emergency because of the dead</p>	06/21/2013

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	Manager at the time of observation, the door was installed last summer and she wasn't aware the front door could not have an independent dead bolt.		<p>bolt being disabled. 3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practices does not recur?* The front door dead bolt will be disabled so it will be non-functioning and leaving only one lock to be used.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? *Dead bolt will be disabled and so they will not be any issue of it being locked. QDDP will ensure that no dead bolt will be installed on any doors in the home. 5. What date will the systematic changes will be completed? *6/21/13</p>		

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K01S046	<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 flexible cords, such as an extension cord were not used as a substitute for fixed wiring. LSC 33.2.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice was not in a resident care care but indirectly affect all clients in the house in the event of a fire emergency in the basement.</p> <p>Findings include:</p> <p>Based on observation with the Residential Manager on 05/22/13 at 12:46 p.m., there was an extension cord was in use and providing power to a dehumidifier in the basement. At the time of observation, the Residential Manager acknowledged the extension cord was in use and providing power to a dehumidifier in the basement.</p>	K01S046	<p>1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? *Maintenance will inspect the wiring and upgrade the electric wiring to the de-humidifier if needed. 6/21/13</p> <p>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 in the house will be safe from potential harm from the electrical cord going to the de-humidifier.</p> <p>3. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? * House staff will be in-serviced/instructed to never you a extension cord when using the de-humidifier.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur? *House Manager and QDDP will ensure that extension cord will not be used with de-humidifier.</p> <p>5. What is the date by which systemic changes will be completed?*6/21/13</p>	06/21/2013	

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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 6 of 6 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 12:34 p.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?</p> <p>*Staff will be in-serviced/trained on the procedure to be followed in the event fire alarm system is out of order for 4 hrs to 24 hrs.</p> <p>2. How will you identify other</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.		<p>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.</p> <p>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 will be in-serviced/trained on procedure to</p>		

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			<p>follow in the event the fire alarm system is disabled for 4 hrs to 24 hrs.</p> <p>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 will sign training paper and training will be reviewed yearly by house mgr. &amp; QDDP.</p> <p>5. What is the date by which the systemic changes will be completed? * 6/21/13</p>	