STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G786	A. BUILDING -- B. WING	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PATHFINDER SERVICES INC	1570 JESSUP STREET HUNTINGTON, IN 46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 05/13/24 Facility Number: 012414 Provider Number: 15G786 AIM Number: 200998980 At this Emergency Preparedness survey, Pathfinder Services Inc. was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 05/15/24	E 0000		
E 0004 Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Rogers	ADRS	05/21/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G786	A. BUILDING -- B. WING	05/13/2024

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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility	E 0004	1. The plan of correcting the	05/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	failed to review and update the Emergency Preparedness Plan (EPP) at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Residential Manager on 05/13/24 at 11:43 a.m., the facility failed to review and update the EPP every two years. The provided EPP had a revision date listed on the cover page of 2019. Based on an interview during records review, the Residential Manager agreed the listed date of review was 2019 and stated there is an updated copy but it was not in the home during the survey. The finding was reviewed with the Residential Manager during the exit conference.		specific deficiency. The plan should address the processes that led to the deficiency cited. The Emergency Preparedness Plan was last updated on 5/9/24 and has been distributed to all group homes. 2/3/4. The procedure for implementing the acceptable PoC for the specific deficiency cited. The monitoring procedure to ensure that the PoC is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible for implementing the acceptable PoC. The EPP is reviewed and updated at least every other year and is distributed to all homes. The GHM or QIDP will review EPP documents monthly to ensure that the most recent plan is available for review in the home. This will be documented on the Monthly Residential Safety Checklist. 5. The plan sets reasonable completion dates for all deficiencies The EPP was completed and distributed to all group homes on 5/9/24	
E 0013	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b),			

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Bldg. --	484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based			

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	on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the	E 0013	1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The Emergency Preparedness Plan was last updated on 5/9/24 and has been distributed to all group homes. 2/3/4. The procedure for	05/21/2024

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	Residential Manager on 05/13/24 at 11:43 a.m., the facility failed to review and update the EPP Policies and Procedures every two years. The provided EPP Policies and Procedures had a revision date listed on the cover page of 2019. Based on an interview during records review, the Residential Manager agreed the listed date of review was 2019 and stated there is an updated copy but it was not in the home during the survey. The finding was reviewed with the Residential Manager during the exit conference.		implementing the acceptable PoC for the specific deficiency cited. The monitoring procedure to ensure that the PoC is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible for implementing the acceptable PoC. The EPP is reviewed and updated at least every other year and is distributed to all homes. The GHM or QIDP will review EPP documents monthly to ensure that the most recent plan is available for review in the home. This will be documented on the Monthly Residential Safety Checklist. 5. The plan sets reasonable completion dates for all deficiencies The plan was completed and distributed to all group homes on 5/9/24.	
E 0029 Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c),			

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	§494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication Plan at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Residential Manager on 05/13/24 at 11:43 a.m., the facility failed to review and update the EPP Communication Plan every two years. The provided EPP Communication Plan had a revision date listed on the cover page of 2019. Based on an interview during records review, the Residential Manager agreed the listed date of review was 2019 and stated there is an updated copy but it was not in the home during the survey. The finding was reviewed with the Residential Manager during the exit conference.	E 0029	1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The Emergency Preparedness Plan was last updated on 5/9/24 and has been distributed to all group homes. 2/3/4. The procedure for implementing the acceptable PoC for the specific deficiency cited. The monitoring procedure to ensure that the PoC is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible for implementing the acceptable PoC. The EPP is reviewed and updated at least every other year and is distributed to all homes. The GHM or QIDP will review EPP documents monthly to ensure that the most recent plan is available for review in the home. This will be documented on the Monthly Residential Safety Checklist. 5. The plan sets reasonable completion dates for all	05/21/2024

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			deficiencies The plan was completed and distributed to all group homes on 5/9/24.	
E 0036 Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.			

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	*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and			

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	orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training and Testing Program at least every two years in accordance with 42 CFR 483.475(b). This deficient practice could affect all occupants. Findings include: Based on review of the facility's EPP with the Residential Manager on 05/13/24 at 11:43 a.m., the facility failed to review and update the EPP Training and Testing Program every two years. The provided EPP Training and Testing Program had a revision date listed on the cover page of 2019. Based on an interview during records review, the Residential Manager agreed the listed date of review was 2019 and stated there is an updated copy but it was not in the home during the survey. The finding was reviewed with the Residential Manager during the exit conference.	E 0036	1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited. The Emergency Preparedness Plan was last updated on 5/9/24 and has been distributed to all group homes. 2/3/4. The procedure for implementing the acceptable PoC for the specific deficiency cited. The monitoring procedure to ensure that the PoC is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The title of the person responsible for implementing the acceptable PoC. The EPP is reviewed and updated at least every other year and is distributed to all homes. The GHM or QIDP will review EPP documents monthly to ensure that the most recent plan is available for review in the home. This will be documented on the Monthly Residential Safety Checklist.	05/21/2024

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			5. The plan sets reasonable completion dates for all deficiencies	
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency			

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	preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers,			

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	consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.			

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	15G786	A. BUILDING -- B. WING	05/13/2024

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	(ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting			

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	and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure staff were trained in emergency preparedness policies and procedures. The ICF/IID facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least every two years; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures; (v) If the emergency preparedness policies and procedures are	E 0037	p="" paraid="1474714166" paraeid="{0122cc53-f498-49de-8c82-3bb6003186b6}{72}">What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; The facility admits that emergency preparedness annual tests were not completed as required. Staff retraining will be completed by 5/25/24. This will include training on emergency drill completion requirements and proper	05/25/2024

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	significantly updated, the facility must conduct training on the updated policies and procedures in accordance with 42 CFR 483.475(d) (1). This deficient practice could affect all occupants. Findings include: Based on records review with the Residential Manager on 05/13/24 at 11:43 a.m., there was no documentation available for review to indicate all facility staff were trained and demonstrated knowledge of the Emergency Preparedness Program (EPP) initially for new staff and once every two years for existing staff. Based on an interview at the time of records review, the Residential Manager stated staff were trained on the EPP but no documentation for staff training was provided during the survey. The finding was reviewed with the Residential Manager during the exit conference.		documentation of emergency drills. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents could be affected by the deficient practices, but the facility has put steps in place that will ensure that compliance is met. p="" paraid="1474714166" paraeid="{0122cc53-f498-49de-8c82-3bb6003186b6}{72}"> p="" paraid="1474714166" paraeid="{0122cc53-f498-49de-8c82-3bb6003186b6}{72}">Staff are to be trained on EPP procedures and complete their annual testing upon hire and annually thereafter. Facility schedules those tests to be completed by November annually. Facility will complete testing before 5/25/24 and again in November to maintain compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices not recur; QIDP will complete an inspection of each home in November to ensure that all EPP testing has been completed. What is the date by which the systemic changes will be completed. p="" paraid="1474714166" paraeid="{0122cc53-f498-49de-8c82-3bb6003186b6}{72}">5/25/24	

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K 0000 Bldg. 02	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 05/13/24 Facility Number: 012414 Provider Number: 15G786 AIM Number: 200998980 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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies. The one-story facility was sprinklered, and has a fire alarm system with heat detectors in the attic, smoke detection in the corridors, sleeping rooms, and common living areas. The facility has a capacity of 8 and had a census of 6 at the time of this survey. Quality Review completed on 05/15/24	K 0000		
K S712 Bldg. 02	NFPA 101 Fire Drills Fire Drills 1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to: a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are			

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	familiar with the use of the facility's emergency and disaster plans and procedures. 2. The facility must: a. Actually evacuate clients during at least one drill each year on each shift; b. Make special provisions for the evacuation of clients with physical disabilities; c. File a report and evaluation on each drill; d. Investigate all problems with evacuation drills, including accidents and take corrective action; and e. 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. 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. 42 CFR 483.470(i) Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift under varied conditions for 2 of 12 shifts. This deficient practice affects all staff and clients. Findings include: Based on record review with the Residential Manager on 05/13/24 at 12:10 p.m., the facility operates with three shifts. No documentation for a first shift fire drill in the first quarter of 2024 and third quarter of 2023 was available for review. Based on interview at the time of record review, the Residential Manager the staff that were to conduct the first shift fire drill conducted the drill on second shift instead. The finding was reviewed with the Residential	K S712	p="" paraid="1474714166" paraeid="{0122cc53-f498-49de-8c82-3bb6003186b6}{72}">What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; The facility admits that emergency drills were not completed as required. Staff retraining will be completed by 5/25/24. This will include training on emergency drill completion requirements and proper documentation of emergency drills. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All	05/25/2024

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	Manager during the exit conference.		residents could be affected by the deficient practices, but the facility has put steps in place that will ensure that compliance is met. Drill scheduling requirements been added to the drill documentation forms. All staff have access to view scheduled drills. Drill form has been added for review. Group home managers will oversee completion of all drills monthly and submit drills for review with Pathfinder Safety Committee and ADRS. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices not recur; Drill scheduling requirements been added to the drill documentation forms. All staff have access to view scheduled drills. Drill form has been added for review. What is the date by which the systemic changes will be completed. p="" paraid="1474714166" paraeid="{0122cc53-f498-49de-8c82-3bb6003186b6}{72}">5/25/24	