

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 11/28/2022
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP COD 1570 JESSUP STREET HUNTINGTON, IN 46750
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E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475.</p> <p>Survey Date: 11/28/22</p> <p>Facility Number: 012414 Provider Number: 15G786 AIM Number: 200998980</p> <p>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</p> <p>The facility has 8 certified beds. All beds are certified for Medicaid. At the time of the survey, the census was 6.</p> <p>Quality Review completed on 12/05/22</p> <p>42 CFR, Subpart 483.475 is NOT MET as evidenced by:</p>	E 0000		
E 0037 Bldg. --	<p>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)</p> <p>EP Training Program</p> <p>§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),</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Connie Noonan	QIDP	12/22/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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>§491.12(d)(1).</p> <p>*[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:]</p> <p>(1) Training program. The [facility] must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</p> <p>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</p> <p>(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.</p> <p>(ii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iii) Provide emergency preparedness training at least every 2 years.</p> <p>(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out</p>			
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	<p>the procedures necessary to protect patients and others.</p> <p>(v) Maintain documentation of all emergency preparedness training.</p> <p>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</p> <p>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:</p> <p>(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.</p> <p>(ii) After initial training, provide emergency preparedness training every 2 years.</p> <p>(iii) Demonstrate staff knowledge of emergency procedures.</p> <p>(iv) Maintain documentation of all emergency preparedness training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.</p> <p>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Demonstrate staff knowledge of</p>			

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	<p>emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.</p> <p>(iv) Maintain documentation of all training.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.</p> <p>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least annually.</p> <p>(iii) Maintain documentation of all emergency preparedness training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:</p> <p>(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.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(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</p>			
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	<p>instruction in the location and use of alarm systems and signals and firefighting equipment.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.</p> <p>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:</p> <p>(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 and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.</p> <p>(ii) Provide emergency preparedness training at least every 2 years.</p> <p>(iii) Maintain documentation of the training.</p> <p>(iv) Demonstrate staff knowledge of emergency procedures.</p> <p>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.</p> <p>*[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</p>			

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	<p>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 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.</p> <p>Findings include:</p> <p>Based on records review with the Qualified Intellectual Disabilities Professional (QIDP) on 11/28/22 at 11:40 a.m., there was no documentation available for review to indicate all facility staff were trained and demonstrate knowledge of the Emergency Preparedness Program (EPP) initially for new staff and every two years for existing staff. Based on an interview at the time of records review, the QIDP stated no documentation for staff training could not be found during the survey.</p> <p>The findings were reviewed with the QIDP during the exit conference.</p>	E 0037	<p>POC for tag 0037</p> <p>-Staff will be trained upon hire and annually in September on emergency preparedness policies and procedures and documentation will be maintained and updated as required. Staff convened 12/21/2022 and were trained on emergency preparedness policies and procedures.</p> <p>-Documentation at all group homes will be reviewed to ensure it is current.</p> <p>-Group Home Manager will review staff trainings are current monthly and addressed/completed as required</p> <p>-Oversight on documentation to be completed quarterly by QIDP or ADRS</p>	12/22/2022

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E 0039 Bldg. --	<p>403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2)</p> <p>EP Testing Requirements</p> <p>§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).</p> <p>*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:</p> <p>(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:</p> <p>(i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2) (i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is</p>			

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	<p>community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.</p> <p>*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based</p>			
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	<p>functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p>			

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	<p>(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.</p> <p>*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the [facility's] response to and maintain documentation of all drills,</p>			

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	<p>tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.</p> <p>*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise</p>			
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	<p>the PACE's emergency plan, as needed.</p> <p>*[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.</p>			
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
	<p>*[For ICF/IIDs at §483.475(d)]:</p> <p>(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:</p> <p>(i) Participate in an annual full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or</p> <p>(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional annual exercise that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.</p> <p>*[For HHAs at §484.102]</p> <p>(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the</p>				

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	<p>following:</p> <p>(i) Participate in a full-scale exercise that is community-based; or</p> <p>(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.</p> <p>(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.</p> <p>(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:</p> <p>(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or</p> <p>(B) A mock disaster drill; or</p> <p>(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.</p> <p>*[For OPOs at §486.360]</p> <p>(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:</p> <p>(i) Conduct a paper-based, tabletop exercise</p>			
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	<p>or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.</p> <p>(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.</p> <p>*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The ICF/IID facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not</p>	E 0039	<p>POC for tag 0039 A: If there is no emergency related event, staff will conduct an annual exercise per emergency preparedness policies and procedures every May and documentation will be maintained</p>	12/29/2022	

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	<p>accessible, conduct an annual individual, facility-based functional exercise.</p> <p>b. If the ICF/IID facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.</p> <p>(ii) Conduct an additional exercise that may include, but is not limited to the following:</p> <p>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.</p> <p>b. A mock disaster drill; or</p> <p>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</p> <p>(iii) Analyze the ICF/IID facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID facility's emergency plan, as needed in accordance with 42 CFR 483.475(d)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Qualified Intellectual Disabilities Professional (QIDP) on 11/82/22 at 12:05 p.m., the following was not available for review:</p> <p>a) No documentation of an annual full-scale exercise that is community-based, a facility-based functional exercise when a community-based exercise is not accessible, or an actual natural or man-made emergency.</p>		<p>and updated as required</p> <p>-Documentation at all group homes will be reviewed to ensure it is current. Any documentation not in compliance will be updated as required</p> <p>- Group Home Manager will review staff trainings are current monthly and addressed at staff meeting</p> <p>-Oversight on documentation to be completed quarterly by QIDP or ADRS</p> <p>B. -Staff will conduct an annual exercise of choice per emergency preparedness policies and procedures every September and documentation will be maintained and updated as required</p> <p>-A tabletop exercise was completed on 12/21/21 but was not available at this site during the time that survey occurred. Please see submitted documentation for review.</p> <p>-Staff will ensure documentation of emergency preparedness trainings are available upon request.</p> <p>-Documentation at all group homes will be reviewed to ensure it is current. Any documentation not in compliance will be updated as required</p> <p>-Group Home Manager will review staff trainings are current monthly and filed properly</p> <p>-Oversight on documentation to be completed quarterly by QIDP or ADRS</p>	

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K 0000 Bldg. 02	<p>b) No documentation of an additional annual exercise of choice: a second full-scale exercise that is community-based, a facility-based functional exercise, a mock disaster drill, a tabletop exercise, or a workshop.</p> <p>Based on interview at the time of records review, the QIDP stated the documentation for a community-based exercise or actual event could not be found and documentation of a second exercise of choice could not be found.</p> <p>This finding was reviewed with the QIDP during the exit conference.</p> <p>A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 11/28/22</p> <p>Facility Number: 012414 Provider Number: 15G786 AIM Number: 200998980</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 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 32, New Residential Board and Care Occupancies.</p> <p>This one-story facility was fully sprinkled. The facility has a fire alarm system with heat detection in the attic; smoke detection in the corridors, all living areas and in client sleeping rooms. The</p>	K 0000		

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K S100 Bldg. 02	<p>facility has a capacity of 8 and had census of 6 at the time of this survey.</p> <p>Quality Review completed on 12/05/22</p> <p>NFPA 101 General Requirements - Other General Requirements - Other 2012 NEW</p> <p>List in the REMARKS section any LSC Section 32.1 or 32.2 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.</p> <p>1. Based on record review and interview; the facility failed to ensure 3 of 3 battery operated emergency lights in the facility were maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30-day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review with the Qualified Intellectual Disabilities Professional (QIDP) on 11/28/22 at 12:02 p.m., documentation of a 90-minute annual test for the three battery operated emergency lights was not available for review. Based on interview at the time of</p>	K S100	<p>POC for tag S100</p> <p>A. -Staff will be trained to conduct and document the 90-minute annual test for the emergency lights per emergency preparedness policies and procedures every July. -Documentation at all group homes will be reviewed to ensure the 90-minute annual test for the emergency lights has been completed. -Group Home Manager will schedule the 90-minute annual test for the emergency lights and document it's completion on Emergency Lighting Test form. The Emergency Lighting Test Form has been submitted for review. -Oversight on documentation to be completed quarterly by QIDP or ADRS</p>	12/18/2022

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	<p>observation, the QIDP stated the emergency lights have not been tested annually within the last 12 months.</p> <p>This finding was reviewed with the QIDP at the exit conference.</p> <p>2. Based on observation, records review, and interview, the facility failed to ensure all portable fire extinguisher located in the facility were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.3 requires existing LSC features obvious to the public, such as fire extinguishers, to be either maintained or removed. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept demonstrating that at least the last 12 monthly inspections have been performed. This deficient practice could affect all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disabilities Professional (QIDP) on 11/28/22 at 12:05 p.m., 2 of 3 fire extinguisher in the</p>		<p>B. -Staff to be trained to conduct and document the fire extinguisher inspections per emergency preparedness policies and procedures every September</p> <p>-Documentation at all group homes will be reviewed to ensure the fire extinguisher inspections have been completed</p> <p>-Group Home Manager will ensure all fire extinguisher inspections have been completed monthly</p> <p>-Oversight on documentation to be completed quarterly by QIDP or ADRS</p>	

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K S345 Bldg. 02	<p>facility had an affixed inspection and maintenance tag but all the monthly check boxes were blank. A Fire extinguisher in the kitchen was inspected on 9/22 and 10/22 only. No other documentation was provided to show the fire extinguishers had been inspected monthly. Based on interview at the time of observation and records review, the QIDP stated the monthly checks of the fire extinguishers in the facility were not conducted.</p> <p>This finding was reviewed with the QIDP during the exit conference.</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 NEW A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual</p>	K S345	<p>POC for tag S345 -Staff will ensure semi-annual visual inspections are completed per emergency preparedness policies and procedures -Documentation at all group homes will be reviewed to ensure semi-annual visual inspections have been completed. Please see submitted form for review. -Facility and Property Management department will alert Group Home Managers when</p>	12/18/2022

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K S353 Bldg. 02	<p>fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants.</p> <p>Findings include:</p> <p>Based on records review with the Qualified Intellectual Disabilities Professional (QIDP) on 11/28/22 at 12:05 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 05/17/22. Based on interview at the time of records review, the QIDP stated she did not know if a visual inspection of the fire alarm system six months after the annual fire alarm inspection was conducted.</p> <p>This finding was reviewed with the QIDP at the exit conference.</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 2012 NEW NFPA 13 and 13R Systems All sprinkler systems installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies Up To and Including Four Stories in Height, are inspected, tested and maintained in accordance with NFPA 25, Standard for Inspection, Testing and Maintenance of Water Based Fire Protection System. NFPA 13D Systems Sprinkler systems installed in accordance</p>		<p>semi-annual visual inspections are scheduled to ensure completion and compliance -Oversight on documentation to be completed quarterly by QIDP or ADRS</p>	

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	<p>with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, are inspected, tested and maintained in accordance with the following requirements of NFPA 25:</p> <ol style="list-style-type: none"> 1. Control valves inspected monthly (NFPA 25, section 13.3.2). 2. Gauges inspected monthly (NFPA 25, section 13.2.71). 3. Alarm devices inspected quarterly (NFPA 25, section 5.2.6). 4. Alarm devices tested semiannually (NFPA 25, section 5.3.3). 5. Valve supervisory switches tested semiannually (NFPA 25, section 13.3.3.5). 6. Visible sprinklers inspected annually ((NFPA 25, section 5.2.1). 7. Visible pipe inspected annually (NFPA 25, section 5.2.2). 8. Visible pipe hangers inspected annually (NFPA 25, section 5.2.3). 9. Buildings inspected annually prior to freezing weather for adequate heat for water filled piping (NFPA 25, section 5.2.5). 10. A representative sample of fast response sprinklers are tested at 20 years (NFPA 25, section 5.3.1.1.1.2). 11. A representative sample of dry pendant sprinklers are tested at 10 years (NFPA 25, section 5.3.1.1.15). 12. Antifreeze solutions are tested annually (NFPA 25, section 5.3.4). 13. Control valves are operated through their full range and returned to normal annually (NFPA 25, section 13.3.3.1). 14. Operating stems of OS&Y valves are lubricated annually (NFPA 25, section 13.3.4). 15. Dry pipe systems extending into 			
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	<p>unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4).</p> <p>A. Date sprinkler system last checked and necessary maintenance provided.</p> <p>_____</p> <p>B. Show who provided the service.</p> <p>_____</p> <p>C. Note the source of the water supply for the automatic sprinkler system. _____</p> <p>_____</p> <p>32.2.3.5.3, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler systems were tested and/or inspected in accordance with NFPA 25. NFPA 25, Section 5.2.5 states, waterflow alarm and supervisory alarm devices shall be inspected quarterly to verify that they are free of physical damage. An inspection is defined as a visual examination of a system or a portion thereof to verify that it appears to be in operating condition and is free of physical damage. Section 5.3.3.2 states vane-type and pressure switch-type water flow alarm devices shall be tested semiannually. A test is defined as a procedure used to determine the operational status of a component or system by conducting periodic physical checks, such as waterflow tests, fire pump tests, alarm tests, and trip tests of dry pipe, deluge, or preaction valves. This deficient practice could affect all clients and staff.</p> <p>Findings include:</p> <p>Based on record review with the Qualified Intellectual Disability Professional (QIDP) on 11/28/2022 at 11:45 a.m., there was no third quarter inspections for the water flow alarm device available for review. Based on interview at the</p>	K S353	<p>POC for tag S353</p> <p>-Staff will ensure quarterly water flow alarm device inspections are completed per emergency preparedness policies and procedures</p> <p>-Documentation at all group homes will be reviewed to ensure quarterly water flow alarm device inspections have been completed</p> <p>-Facility and Property Management department will alert Group Home Managers when quarterly water flow alarm device inspections are scheduled to ensure completion and compliance</p> <p>-Oversight on documentation to be completed quarterly by QIDP or ADRS</p>	12/18/2022

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K S363 Bldg. 02	<p>time of observation, the RM stated that it must not have been done.</p> <p>The finding was reviewed with the QIDP during the exit conference.</p> <p>NFPA 101 Corridor - Doors Corridor - Doors Doors shall meet all of the following requirements: 1. Doors shall be provided with latches or other mechanisms suitable for keeping the door closed. 2. No doors shall be arranged to prevent the occupant from closing the door. 3. Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 in buildings other than those protected throughout by an approved automatic sprinkler system in accordance with 32.2.3.5. Door assemblies with leaves required to swing in the direction of egress travel are inspected and tested annually per 7.2.1.15. 33.2.3.6.4, 32.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 clients sleeping rooms were provided with a door which would latch securely in the door frame. This deficient practice could affect 1 client.</p> <p>Findings include:</p> <p>Based on observation with the Qualified Intellectual Disabilities Professional (QIDP) on 11/28/22 at 11:55 a.m., sleeping room door #2 did not latch into the frame when tested. Based on interview at the time of observation, the QIDP confirmed the door did not securely latch into the door frame.</p>	K S363	<p>POC for tag S363 A maintenance request was submitted for repair of the latch on sleeping room door #2 -All group home sleeping room doors will be checked to ensure they latch into the frame. Maintenance requests will be submitted with high priority upon noting any deficiencies -Group Home Managers will review the monthly safety checklist to ensure all sleeping room doors latch into the frames before submitting monthly documentation</p>	12/22/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/28/2022
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1570 JESSUP STREET HUNTINGTON, IN 46750
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K S511 Bldg. 02	<p>The finding was reviewed with the QIDP during the exit conference.</p> <p>NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. 32.2.5.1, 33.2.5.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 multi-plug adaptors was not used as a substitute for fixed wiring according to LSC 32.2.5.1 which states utilities shall comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, 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 could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the QIDP on 11/28/22 at 11:57 a.m., in the kitchen, electrical equipment was plugged into and powered by a multi-plug adaptor. Based on interview at the time of observation, the QIDP agreed electrical equipment was plugged into a multi-plug adaptor and did unplug the adaptor.</p> <p>The finding was reviewed with the QIDP during the exit conference.</p>	K S511	<p>-Oversight on documentation to be completed quarterly by QIDP or ADRS</p> <p>POC for tag S511 -The multi-plug adaptor that was being used for electrical equipment in the kitchen has been removed -All group homes will be inspected to ensure no multi-plug adaptors are in use. Any multi-plug adaptors in use will be removed immediately -Group Home Managers will review the completed monthly safety checklist and ensure no multi-plug adaptors are in use. -Oversight on documentation to be completed quarterly by the QIDP or ADRS</p>	12/22/2022
K S712	<p>NFPA 101 Fire Drills</p>			

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Bldg. 02	<p>Fire Drills</p> <p>1. The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to:</p> <ul style="list-style-type: none"> a. Ensure that all personnel on all shifts are trained to perform assigned tasks; b. Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures. <p>2. The facility must:</p> <ul style="list-style-type: none"> 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. <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. 42 CFR 483.470(i)</p> <p>Based on record review and interview, the facility failed to conduct evacuation/fire drills at least quarterly for each shift of personnel and under varied conditions for 10 of 12 shifts. This deficient practice affects all staff and clients.</p> <p>Findings include:</p> <p>Based on records review with the Qualified Intellectual Disability Professional (QIDP) on 11/28/2022 at 11:56 a.m., the following shifts were missing fire drills:</p>	K S712	<p>POC for tag S712</p> <p>-Staff will be trained upon hire and annually in September on conducting evacuation/fire drills per the emergency preparedness policies and procedures. A calendar email reminder has been implemented monthly to remind all group home staff to schedule and complete the evacuation/fire drills per shift per quarter going forward</p> <p>-Documentation at all group</p>	12/22/2022
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP COD 1570 JESSUP STREET HUNTINGTON, IN 46750		
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	<p>a) There was no documentation for a third shift fire drill in the first quarter of 2022</p> <p>b) There was no documentation for a first, second, or third shift fire drill in the second quarter of 2022</p> <p>c) There was no documentation for a first, second, or third shift fire drill in the third quarter of 2022</p> <p>d) There was no documentation for a first, second, or third shift fire drill in the fourth quarter of 2021 or 2022</p> <p>Based on interview at the time of record review, the QIDP stated documentation of the missing fire drills could not be found.</p> <p>The finding was reviewed with the QIDP during the exit conference.</p>		<p>homes of evacuation/fire drills will be reviewed to ensure it is current. Any documentation not in compliance will be updated as required</p> <p>-Group Home Managers will review the monthly safety checklist to ensure all evacuation/fire drills have been completed for the month before submitting documentation</p> <p>-Oversight on documentation to be completed quarterly by the QIDP or ADRS</p>		