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	08/12/2021

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

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 08/12/21 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 7 certified beds. All 7 beds are certified for Medicaid. At the time of the survey, the census was 6. Quality Review completed on 08/17/21	E 0000		
E 0039 Bldg. --	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) EP Testing Requirements §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). *[For ASCs at §416.54, CORFs at §485.68,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of 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 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. (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 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			

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[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 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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct			

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	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. (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. *[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:			

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	(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. (ii) Conduct an [additional] annual exercise or and 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[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			

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	(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 the PACE's emergency plan, as needed. *[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			

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	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. *[For ICF/IIDs at §483.475(d)]: (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: (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.			

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	(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. (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 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 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. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan,			

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	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. (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 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 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise 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			

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	required testing exercise following the onset of the emergency event. (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. *[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 accessible, conduct an annual individual, facility-based functional exercise. 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.	E 0039	Corrective Actions: A county wide table top exercise was attended by Pathfinder Coordinator on 8/12/2020. How The Corrective Actions Will Be Monitored: Assistant Director of GH Supports will implement a schedule for conduction exercises. Assistant Director of GH supports will implement routine exercises to test emergency plan. Assistant Director of GH supports will keep record of all exercises in future to ensure compliance. See Attached.	09/03/2021

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	(ii) Conduct an additional 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. b. A mock disaster drill; or 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. (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. Findings include: Based on record review and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 10:30 a.m. and 12:25 p.m., The COVID 19 Pandemic was being used as the full-scale exercise. However, no documentation of an additional/second exercise of choice was available for review to show the required exercise was conducted within the past 12 months. Based on interview at the time of records review, the Qualified Intellectual Disability Professional stated an additional exercise was not conducted within in the past 12 months. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and again at the exit conference at 1:30 p.m. on 08/12/21.			

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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: 08/12/21 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 smoke detection in the corridors, sleeping rooms and common living areas could not determine if heat detection is present in the attic. The facility has a capacity of 7 and had a census of 6 at the time of this survey. Quality Review completed on 08/17/21	K 0000		
K S100 Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other 2012 NEW 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			

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	NFPA standard citation, should be included on Form CMS-2567. Based on record review and interview; the facility failed to ensure all 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. Findings include: Based on record review and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 10:30 a.m. and 12:25 p.m., documentation of monthly 30 second and 90-minute annual test for the battery-operated emergency lights was not available for review. Based on interview at the time of records review, the Qualified Intellectual Disability Professional stated the documentation for the battery-operated emergency light 90-minute annual test was not in the home and was unable to provide a copy of the testing during the time of survey. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.	K S100	Corrective Actions: Assistant Director of GH Supports will ensure that all monthly forms are completed and put into book at house as well as keeping an copy electronically. Random in house inspections will be done through out the year by Assistant Director of GH Supports to ensure the proper procedures are being followed and implemented.**Emergency lights in the facility need to be maintained in accordance with LSC 7.9.3. Periodic testing will be documented monthly on the Residential Monthly Checklist. This testing will be conducted for 30 seconds at 30 day intervals and an annual test will be conducted on every required battery powered emergency lighting system for not less than a 1.5 hour duration.How the Corrective Action Will Be Monitored: This documentation will be monitored by the Group Home Manager and submitted to Asst. Director of GH Supports for verification monthly.** See attached,	08/26/2021
K S222	NFPA 101 Egress Doors			

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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
Bldg. 02	Egress Doors 2012 NEW Doors and paths of travel to a means of escape shall not be less than 32 inches wide. Bathroom doors shall not be less than 24 inches wide. In conversions (see 32.1.1.6), 28 inches doors are permitted. Doors shall be swinging or sliding. Every closet door latch shall be readily opened from the inside. Every bathroom door shall be designed to allow opening from the outside during an emergency when locked. No door in any means of escape shall be locked against egress when the building is occupied. Delayed egress locks complying with 7.2.1.6.1 shall be permitted on exterior doors. Access-control egress locks complying with 7.2.1.6.2 shall be permitted. Force to open doors shall comply with 7.2.1.4.5. Door latching devices shall comply with 7.2.1.5.10. Corridor doors are provided with positive latching hardware, and roller latches are prohibited. Floor levels at doors shall comply with 7.2.1.3. Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15. 32.2.2.5.1 through 32.2.2.5.8, 32.7.7, 42 CFR 483.470(j)(1)(ii)			
	Based on observation and interview, the facility failed to ensure 3 of 3 exterior exit doors were provided with only one latching mechanism to release the door and open. 33.2.2.5.7 refers to 7.2.1.5.10 which states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf	K S222	/b> All the deadbolt latching mechanisms in the home have been disarmed. The deadbolt plates are still there, but they're unable to be locked. **Identifying other residents**	08/26/2021

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	with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect all occupants in the facility. Findings include: Based on a facility tour and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 12:30 p.m. and 1:05 p.m., the facility (1) Front door, (2) Back door and (3) Man door in the garage were all equipped with two latching devices, a regular door handle with a turn lock and a separate deadbolt lock. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.		**having the potential to be affect by the same deficient practice:** All residents can be affected since the deadbolts were on the doors of their home. **Measures put into place:** All the deadbolt latching mechanisms in the home were disarmed and will no longer be able to be locked. **How the corrective actions will be monitored:** The Manager and QDDP will monitor the doors in the home to ensure no deadbolts are put in again. This will be done through routine monitoring.	
K S253 Bldg. 02	NFPA 101 Number of Exits - Patient Sleeping and Non-Sl Number of Exits - Patient Sleeping and Non-Sleeping Rooms 2012 NEW Every sleeping room and living area shall have access to a primary means of escape located to provide a safe path of travel to the outside. Where sleeping rooms or living areas are			

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	above or below the level of exit discharge, the primary means of escape shall be an interior stair in accordance with 32.2.2.4, an exterior stair, a horizontal exit, or a fire escape stair. In addition to the primary route, sleeping rooms, other than those having a door leading directly to the outside of the building in accordance with 32.2.2.3.2, and living areas in facilities without a sprinkler system installed in accordance with 32.2.3.5 shall have a second means of escape consisting of one of the following: 1. It shall be a door, stairway, passage, or hall providing a way of unobstructed travel to the outside of the dwelling at street or the finished ground level that is independent of and remotely located from the primary means of escape. 2. It shall be a passage through an adjacent nonlockable space, independent of and remotely located from the primary means of escape, to approved means of escape. 3. *It shall be an outside window or door operable from the inside without the use of tools, keys, or special effort that provides a clear opening of not less than 5.7 square feet. The width shall be not less than 20 inches. The height shall be not less than 24 inches. The bottom of the opening shall be not more than 44 inches above the floor. Such means of escape shall be acceptable where one of the following criteria are met: a. The window shall be within 20 feet of the finished ground level. b. The window shall be directly accessible to fire department rescue apparatus as approved by the authority having jurisdiction. c. The window or door shall open onto an			

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	exterior balcony. 4. Windows having a sill height below the adjacent finished ground level are that provided with a window well meet the following criteria: a. The window well allows the window to be fully openable. b. The window is not less than 9 square feet with a length and width of not less than 36 inches. c. Window well deeper than 43 inches has an approved, permanently affixed ladder or steps complying with the following: 1. The ladder or steps do not extend more than 6 inches into the well. 2. The ladder or steps are not obstructed by the window. 5. If the sleeping room has a door leading directly to the outside of the building with access to the finish ground level or to and exterior stairway meeting the requirements of 32.2.2.6.3, that means of escape shall be considered as meeting all the escape requirements for a second means. 32.2.2.3.1, 32.2.2.3.2 Based on observation and interview, the facility failed to ensure 2 of 6 clients sleeping rooms was provided with a secondary means of escape in accordance with 33.2.2.3. LSC 33.2.2.3 requires a secondary egress from each sleeping room with multiple provisions. This deficient practice could affect at least 4 clients. Findings include: Based on a facility tour and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 12:30 p.m. and 1:05 p.m., (1) the bedroom #1 window was obstructed and would not be accessible as a timely means of	K S253	Corrective Actions: Items obstructing window egress have been removed from the area. Window was repaired on 8/14/21. How Corrective Actions Will Be Monitored: The Manager, QIDP and DSPs will monitor all points of exit to ensure they remain clear. Manager, QIDP and staff have received training in submitting maintenance requests for repair.	08/26/2021

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	escape. (2) Bedroom # 6 window contained broken glass and was un-openable. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.			
K S300 Bldg. 02	NFPA 101 Protection - Other Protection - Other 2012 NEW List in the REMARKS section any LSC Section 32.2.3 Protection 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. Based on observation and interview, the facility failed to ensure 1 of 1 smoking areas did not contain flammable gases. LSC 8.7.3.1 states the storage and handling of flammable liquids or gases shall be in accordance with the following applicable standards (1) NFPA 30, Flammable and Combustible Liquids Code. NFPA 30 2012 edition 6.5.1 states precautions shall be taken to prevent the ignition of flammable vapors by sources such as the following: (1) Open flames (2) Lightning (3) Hot surfaces (4) Radiant heat (5) Smoking (6) Cutting and welding (7) Spontaneous ignition (8) Frictional heat or sparks (9) Static electricity (10) Electrical sparks (11) Stray currents (12) Ovens, furnaces, and heating equipment	K S300	Corrective Action: The gas grill has been removed from the area and will be kept separate. How Corrective Actions Will Be Monitored: Manager, QIDP will do random inspections to ensure that flammable gasses are kept separate from smoking areas.	08/26/2021

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	This deficient practice could affect all occupants. Findings include: Based on a facility tour and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 12:30 p.m. and 1:05 p.m., the smoking area, located on the back patio, contained a propane tank, near the gas grill, sitting inside the designated smoking area. Based on interview at the time of observation, the Qualified Intellectual Disability Professional stated the tanks are used for the grill and agreed they were sitting inside the smoking area. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.			
K S345 Bldg. 02	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 1. 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	K S345	Corrective Actions; Shambaugh and Sons repaired and inspected systems in in home on 8/26/21.	08/27/2021

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	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 fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on record review and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 10:30 a.m. and 12:25 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months before the annual fire alarm inspection conducted on 03/29/21. Based on interview at the time of records review, the Qualified Intellectual Disability Professional stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21. 2. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date information in accordance with the requirements of NFPA 101- 2012 edition, Sections 33.3.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections		How Corrective Actions Will Be Monitored: Alarm inspections will be completed every six months to ensure compliance. Fire panels will be visually inspected during each drill by DSP completing drill, monthly by Manager and randomly by Assistant Director of Group Homes to ensure continued compliance. Should any issues arise, Shambaugh and Sons will be contacted to repair.	

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	14.1, 14.1.1. This deficient practice could affect all clients, staff and visitors. Findings include: Based on a facility tour and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 12:30 p.m. and 1:05 p.m., the time on the fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated a time that was 15 minutes slower than the actual local time. Based on interview at the time of observation, the Qualified Intellectual Disability Professional indicated she was unaware of the discrepancy. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.			
K S351 Bldg. 02	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 NEW All new occupancies shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with 32.2.3.5.3 using quick response or residential sprinklers. The system shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and shall initiate the fire alarm system in accordance with 9.6. The adequacy of the water supply shall be documented. In new occupancies up to and including four stories above grade plane, systems in accordance with NFPA 13R, Standard for the Installation of Sprinkler Systems in			

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	Residential Occupancies up to and Including Four Stories in Height, shall be permitted. All habitable areas, closets, roofed porches, roofed decks, and roof balconies shall be sprinklered. In new occupancies, an automatic sprinkler system in accordance with NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, with a 30 minute water supply, shall be permitted. All habitable areas, closets roofed porches, roofed decks, and roof balconies shall be sprinklered. Automatic sprinklers systems in accordance with NFPA 13 and 13R are provided with electrical supervision in accordance with 9.7.2. Automatic sprinkler systems in accordance with NFPA 13D shall be provided with valve supervision by one of these methods: 1. Single listed control valve that shuts off both domestic and sprinkler system, and separate shutoff for domestic system only. 2. Electrical supervision in accordance with 9.7.2. 3. Valve closure that caused the sounding of an audible signal in the facility. Attics used for living purposes, storage, or fuel-fired equipment are sprinkler protected in accordance with 9.7.1.1, by July 5, 2019. Attics not used for living purposes, storage, or fuel-fired equipment meet one of the following: 1. Protected by heat detection system to activate the fire alarm system according to 9.6, by July 5, 2019. 2. Protected by automatic sprinkler system according to 9.7.1.1, by July 5, 2019. 3. Constructed of noncombustible or limited-combustible construction.			

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	4. Constructed of fire-retardant-treated wood according to NFPA 703. 32.2.3.5.1, 32.2.3.5.3, 32.2.3.5.4, 32.2.3.5.5, 32.2.3.5.3.7, 42 CFR 483.470(j)(1)(iv) Based on records review, observation and interview the facility failed to ensure 1 of 1 attics not used for storage, living purposes, or containing fuel-fired equipment had installed heat detection connected to the fire alarm system. Based on records review, observation and interview the facility failed to ensure 1 of 1 attics not used for storage, living purposes, or containing fuel-fired equipment had installed heat detection connected to the fire alarm system. LSC 33.2.3.5.7.1 states where an automatic sprinkler system is installed, attics used for living purposes, storage, or fuel-fired equipment shall be protected with automatic sprinklers that are part of the required, approved automatic sprinkler system in accordance with 9.7.1.1. LSC 33.2.3.5.7.2 states where an automatic sprinkler system is installed, attics not used for living purposes, storage, or fuel-fired equipment shall meet one of the following criteria: (1) Attics shall be protected throughout by a heat detection system arranged to activate the building fire alarm system in accordance with Section 9.6. (2) Attics shall be protected with automatic sprinklers that are part of the required, approved automatic sprinkler system in accordance with 9.7.1.1. (3) Attics shall be of noncombustible or limited-combustible construction. (4) Attics shall be constructed of fire-retardant-treated wood in accordance with NFPA 703, Standard for Fire Retardant- Treated Wood and Fire-Retardant Coatings for Building	K S351	Corrective Actions: Heat Detection equipment was installed in the attic on 8/26/2021. See Attachment	08/26/2021

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	Materials. This deficient practice could affect all clients. Findings include: Based on record review and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 10:30 a.m. and 12:25 p.m., the last annual fire alarm inspection, dated June 19, 2020 did not list heat detectors in the attic and no documentation was available to show heat detection was installed in the attic. Based on interview at the time of records review, the Qualified Intellectual Disability Professional stated the attic is not used for storage, for living purposes, or contained fuel-fired equipment but was unaware if there was heat protection in the attic. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.			
K S353 Bldg. 02	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			

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	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: 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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	unheated portions of the building are inspected, tested and maintained (NFPA 25, section 13.4.4). A. Date sprinkler system last checked and necessary maintenance provided. _____ B. Show who provided the service. _____ C. Note the source of the water supply for the automatic sprinkler system._____ ____ 32.2.3.5.3, 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. 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. Findings include: Based on record review and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 10:30 a.m. and 12:25 p.m., there was no current annual inspection for the	K S353	**Corrective Actions:** Monthly valve checks are in place and will be performed by group home staff and turned into Assistant Director of GH Supports. On this sprinkler gauge and valve checks will include that the wrench is in place. See Attached	08/26/2021

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	15G786	A. BUILDING 02 B. WING	08/12/2021

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

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	sprinkler system available for review. The last annual inspection was dated June 19, 2020. Based on interview at the time of observation, the Qualified Intellectual Disability Professional stated she was unaware if the annual sprinkler inspection was conducted. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21. 2. Based on record review, observation, and interview, the facility failed to maintain monthly inspection documentation for 1 of 1 sprinkler systems in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 3.3.18 states 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. This deficient practice could affect all clients in the facility. Findings include: Based on record review and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 10:30 a.m. and 12:25 p.m., there was no documentation of a monthly gauge			

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	and valve checks for the home's sprinkler system. There were two gauges and one control valve on the sprinkler riser. Based on an interview at the time of records review, the Qualified Intellectual Disability Professional stated she was unaware if the checks were completed. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.			
K S362 Bldg. 02	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 NEW Unless otherwise indicated below, corridor walls shall meet all of the following: o Walls separating sleeping rooms have a minimum 1/2-hour fire resistance rating, which is considered to be achieved if the partitioning is finished on both sides with lath and plaster or materials providing a 15-minute thermal barrier. o Sleeping room doors are substantial doors, such as those of 1-3/4 inch thick, solid-bonded wood-core construction or other construction of equal or greater stability and fire integrity. o Any vision panels are fixed fire window assemblies in accordance with 8.3.4 or are wired glass not exceeding 9 square feet each in area and installed in approved frames. This requirement shall not apply to corridor walls that are smoke partitions in accordance with 8.4 and that are protected by automatic sprinklers in accordance with 32.2.3.5 on both sides of the wall and door. In such instances, there shall be no limitation on the type or size of glass panels. 32.2.3.6			

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	Based on observation and interview, the facility failed to ensure 1 of 6 sleeping room doors were smoke resistant. This deficient practice could affect all clients, staff and visitors. Findings include: Based on a facility tour and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 12:30 p.m. and 1:05 p.m., bedroom door #6 when closed and latched had 1 inch gaps around the top and sides which would allow the passage of smoke. The trim pieces around the door were missing creating the gaps. The Qualified Intellectual Disability Professional stated the resident is hard on the room and likely caused the damage to the door assembly. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.	K S362	Corrective Actions: Trim on door was repaired by facility maintenance on 8/24/2021.	08/26/2021
K S511 Bldg. 02	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 NPFA 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 exposed wiring located in the laundry room was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect all clients at staff.	K S511	Corrective Actions: The light fixture was repaired on 8/24/2021 by facility maintenance. How the corrective actions will be monitored:	08/26/2021

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	Findings include: Based on a facility tour and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 12:30 p.m. and 1:05 p.m., there were exposed electrical wires in the ceiling light in the laundry room. The fixture did not fully conceal the wiring connecting the fixture. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.		Manager will submit any maintenance requests for repair/replacement in a timely fashion.	
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 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.			

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	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 2 of 12 quarterly shift fire drills in accordance with 42 CFR 483.470(i), which states the following: (1) The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to - (i) Ensure that all personnel on all shifts are trained to perform assigned tasks; (ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features. Or, per 2019 Novel Coronavirus Disease (COVID-19) 1135 Waiver allowances, a documented orientation training program related to the current fire plan, which considers current facility conditions. This deficient practice could affect all clients. Findings include: Based on record review of the "Fire Drill Report" and interview with the Qualified Intellectual Disability Professional on 08/12/21 between 10:30 a.m. and 12:25 p.m., the facility could not provide fire drills or allowed training documentation for the First Shift during 1st of 3rd Quarters of 2020 and 2021. Based on interview at the time of record review, the Qualified Intellectual Disability Professional was unsure if the drills or training for the periods previously mentioned were conducted. This finding was reviewed with the Qualified Intellectual Disability Professional at the time of discovery and acknowledged again at the exit conference at 1:30 p.m. on 08/12/21.	K S712	Corrective Actions: **Retraining on Proper drill times will be completed by 9/3/2021. Life/Safety manuals have been updated and are in place in each of the homes.** **How the Corrective Actions Will Be Monitored:** **Documentation will be monitored by Asst. Director of GH monthly to ensure compliance.**	08/26/2021

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