STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G532	A. BUILDING -- B. WING	12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PATHFINDER SERVICES INC	107 BINKLEY KNOX, IN 46534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.475. Survey Date: 12/18/2020 Facility Number: 001046 Provider Number: 15G532 AIM Number: 100245310 At this Emergency Preparedness survey, Patherfinder Services, Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 8 certified beds. All 8 beds are certified for Medicaid. At the time of the survey, the census was 8. Quality Review completed on 12/22/20	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.470(j). Survey Date: 12/18/2020 Facility Number: 001046 Provider Number: 15G532 AIM Number: 100245310 At this Life Safety Code survey, Pathfinder	K 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 33, Existing Residential Board and Care Occupancies. This one story facility was fully sprinklered. The facility has a monitored fire alarm system with smoke detection in the corridors, client sleeping rooms and common living areas. The attic is not used for living purposes, storage, or fuel-fired equipment and is protected by a heat detection system. The facility has a capacity of 8 and had a census of 8 at the time of this survey. Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 2.7. Quality Review completed on 12/22/20			
K S345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance 2012 EXISTING (Prompt) 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, observation and interview; the facility failed to properly document	K S345	=”” p=””> =”” p=”>	01/13/2021

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	fire alarm system testing in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all clients, staff, and visitors. Findings include: During record review with the Manager on 12/18/2020 at 10:40 a.m. the facility was unable to provide documentation of an annual fire alarm test and inspection. The last documented annual test and inspection was on 07/10/2019. Based on interview, the Manager advised that the vendor did come to the facility in approximately July, 2020, however could not provide any documentation. This deficient finding was reviewed with the Manager at the time of exit. 2) 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 Sections 33.3.3.4.1 and 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		="" p="">What corrective actions(s) will be accomplished for these residents found to have been affected by the deficient practice?: Testing of the fire alarm system was conducted on January 13, 2020 by Nobe, before the survey. Because the staff at the home misplaced the test results, the Annual Fire Alarm System Test Result was not available for the surveyor to review, Anita Kline, Community Supports Coordinator, had given a copy of the test results to Jennifer McKee, House Manager upon receiving them. All future test results will be sent by Anita Kline to Jennifer McKee as soon as the test results are received. Jennifer McKee is to put the test results in a folder labeled Life Safety Inspection. This will ensure that a copy of the test is in the home and it was placed in a Folder labeled Life Safety and place it in the file cabinet. Anita Kline, Coordinator will schedule and oversee that testing will be completed annually in January each year. Anita Kline will ask to see the copy of the test result each quarter when visiting the home, to ensure that the tests are there and up to date. A back up copy of the test results will also be sent to Jennifer via email so that she will be able to save it to the computer and print if needed. How will you identify other	

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	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: During record review with the Manager on 12/18/2020 at 10:45 a.m. the facility was unable to provide documentation of a semi-annual fire alarm visual inspection. The last documented annual test and inspection was on 07/10/2019. No documentation of a subsequent semi-annual fire alarm visual inspection could be provided. Based on interview, the Manager advised that she was unaware of a semi-annual fire alarm visual inspection. This deficient finding was reviewed with the Manager at the time of exit.		residents having the potential to be affected by the same deficient practice and what corrective action will be taken?Since the test results were not available in the home, all residents living in the home were at risk and there was no proof that their home had been inspected. If there are not test results in a home with a fire alarm system, then all residents living there are assumed to be at risk of having a faulty alarm system. All homes with that have a fire alarm system are required to have annual testing of the fire alarm system. Anita Kline, Coordinator will schedule and oversee that testing will be completed annually in January. Anita Kline will ask to see the copy of the test result each quarter when visiting the home to ensure that they are present and up to date. Jennifer McKee, House Manager will keep a copy of the test result in the folder Labeled Life Safety. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not occur?Jennifer McKee, House Manager, will keep a Life Safety Inspection folder in the home. The folder is to contain copies of fire drills, F1s and Fire Alarm System inspections and test results. When in the home Anita Kline, Community Supports Coordinator, will look through the folder to make sure the test	

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			results are current and in the folder. This will be done quarterly. If the test results are not in the folder, Anita Kline will obtain a copy and place it in the home's folder. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Anita Kline, will schedule annual Fire Alarm System Testing each December so that testing will be completed each January. Anita Kline will review the Life Safety Inspection folder kept in the home, at least quarterly, to ensure test results are up to date and in the home. If test results are missing from the folder, Anita will replace the missing copy. Both Anita and Jennifer will keep back up copies of the test result on their computers so that it can be printed if the folder is miss placed at the time of the survey. What is the date by which the systemic changes will be completed? January 13, 2020.	