

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534		
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 6, 7, 12, and 22,2013.</p> <p>Facility number: 001005 Provider number: 15G491 AIM number: 100245050</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 2, 2013 by Dotty Walton, QIDP.</p>	W000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#3), the client's interdisciplinary teams failed to address the client's identified need in regard to a recommended augmented speech evaluation.</p> <p>Findings include:</p> <p>On 11/6/13 between 3:56 PM and 5:25 PM, group home observations were conducted. At 3:56 PM, the clients arrived at the group home from their day service program. At 4:18 PM, Client #3 was trying to communicate by pointing toward the television and window area while attempting to verbalize. Client #7 indicated she thought Client #3 was trying to say "it's dark outside" but indicated she wasn't sure "because I can't understand him." At 4:24 PM, Client #3 continued to attempt to communicate using utterances and gestures. Client #1 could not understand Client #3 and stated "What, what, what?" DSP (Direct Support Professional) #1 indicated Client #3 was trying to say "Thanksgiving" and "Turkey." At 4:32 PM, Client #3 attempted to communicate by gesturing as if he was writing on paper and pointing to his room. It was unclear what Client #3 was communicating.</p> <p>On 11/12/13 at 10:22 AM, record review indicated Client #3 had diagnoses which included, but were not limited to, profound intellectual disabilities, cerebral palsy, constipation, mild cataracts, spastic</p>	W000227	<p>The augmented speech evaluation has been scheduled. Future efforts to schedule such evaluation will include setting up a reminder system to prompt for additional follow up if initial efforts are not successful in setting up the evaluation. Person Responsible: QDDP W 227 1 The augmented speech evaluation has been completed. 2 Other people with speech issues have been reviewed to determine their need for augmentative communication evaluations. 3 Future efforts to schedule such evaluation will include setting up a reminder system to prompt for additional follow up if initial efforts are not successful in setting up the evaluation. 4 To assure that evaluations have been obtained the need for evaluations will be reviewed at quarterly review time. Person Responsible: QDDP</p>	12/22/2013			

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	<p>quadriplegia, hypertension, physical disabilities, and visual impairment. Client #3's ISP (Individual Support Plan) dated 5/7/13 indicated no communication goal. Client #3's functional assessment dated 5/7/13 indicated Client #3 had strengths which included, but were not limited to, "uses gestural prompts and sign language, identifies persons by name, makes and responds to verbal and gestural greetings and farewells, uses appropriate gestures to communicate meaning, uses appropriate facial expressions to communicate meaning...". Client #3's functional assessment indicated his weakness in part as "speak clearly, speak in whole sentences, imitate sounds for certain phonemes (smallest language units with meaning), speak faster...".</p> <p>Record review indicated Client #3 had an order for "Augmentative Communication Evaluation" dated 1/7/11. QIDP (Qualified Intellectual Disabilities Professional) notes indicated the QIDP called the Augmentative Communication Specialist and left messages on 1/31/13, 2/20/13, 5/7/13, and 7/1/13.</p> <p>During an interview on 11/12/13 at 12:23 PM, the QIDP indicated the facility has been unable to make an appointment for Client #3 to have an augmentative communication evaluation as the specialist has not called back. The QIDP indicated she hasn't attempted to make an appointment in "maybe six months." The QIDP indicated Client #3 needed to have the evaluation completed and his ISP should address his communication needs.</p> <p>9-3-4(a)</p>				

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W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (#1) and 1 additional client (#8), the facility failed to implement the clients' training objectives when formal and/or informal opportunities existed in regards to medication administration.</p> <p>Findings include:</p> <p>1) On 11/6/13 between 4:03 PM and 5:15 PM, medication administration was observed. At 5:13 PM, DSP (Direct Support Professional) #2 was observed to assist Client #8 with medication administration. DSP #2 prepared all the medications before Client #8 came to the medication room. When Client #8 entered the medication area, DSP #2 prompted her to use alcohol gel on her hands. DSP #2 handed Client #8 her medications which Client #8 took. DSP #2 then handed Client #8 a cup of water. Client #8 did not participate in training or teaching during her medication administration. DSP #2 did not name</p>	W000249	<p>W 249 Staff will be provided training in the need to implement training during informal opportunities. The manger will make periodic observations at least monthly to assure that such informal training is being done. Person Responsible: Residential Manager W 249 1 Staff will be provided training in the need to implement training during informal opportunities. 2. Other people will be observed during the day to assure that they are receiving training during informal opportunities. 3 The manger will observe clients during the day to assure that training is done at informal opportunities at least twice weekly. 4 The manger will maintain a checklist of the observations of informal training opportunities that will be reviewed at least monthly. Person Responsible: Residential Manager</p>	12/22/2013			

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	<p>Client #8's medication or prompt her to identify them herself.</p> <p>Record review on 11/12/13 at 1:12 PM, indicated Client #8 had diagnoses which included, but were not limited to, severe intellectual disabilities, bi-polar, seizure disorder, and visual impairment. Client #8's ISP (Individual Support Plan) dated 4/4/13 indicated a self-medication goal of "with staff supervision, once daily in the evening, [Client #8] will state the names of 3 medications that she takes...".</p> <p>2) On 11/6/13 at 4:10 PM, DSP #2 was observed to assist Client #1 with medication administration. DSP #2 prepared all of Client #1's medications before he entered the medication area. When Client #1 entered the medication area, DSP #2 verbally prompted Client #1 to use alcohol gel on his hands which he did. DSP #2 handed Client #1 his medications in a cup which he took independently. DSP #2 handed Client #1 a cup of water. Client #1 did not participate in any training or teaching of self-medication administration skills.</p> <p>On 11/12/13 at 1:34 PM, record review indicated Client #1 had diagnoses which included, but were not limited to, moderate intellectual disabilities, obsessive compulsive disorder, anxiety,</p>				

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	<p>hypertension, partial hip replacement, and history of constipation. Client #1's ISP (Individual Support Plan) dated 3/13/13 indicated Client #1 had a self-medication skill goal of "with staff supervision, when taking evening medications once daily, [Client #1] will state 2 side effects of 2 medications, independently 95% of the time...".</p> <p>During an interview on 11/12/13 at 12:23 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated client medication goals are written to be done once daily but should be done at "every opportunity." The QIDP indicated the clients should be encouraged to independently complete each task of medication administration as their skill level allows.</p> <p>9-3-4(a)</p>						

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W000455	<p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based upon observation, interview, and record review, the facility failed to ensure proper hand washing and infection control procedures were implemented during medication administration for 1 additional client (#5).</p> <p>Findings include:</p> <p>On 11/6/13 between 4:03 PM and 5:15 PM, medication administration was observed. At 4:03 PM, DSP (Direct Support Professional) #2 assisted Client #5 with medication administration. DSP #2 wore gloves. DSP #2 dropped a bottle of medication on the floor and picked the bottle up with her gloved hands. DSP #2 did not wash her hands or switch gloves. DSP #2 administered eye drops into Client #5's eyes by opening her eyes further using the same gloves.</p> <p>On 11/12/13 at 12:23 PM, the facility nurse was interviewed. The nurse indicated it was not a proper infection control method to pick up a medication bottle from the floor with gloves and then administer eye drops to a client without switching gloves or washing hands.</p> <p>The facility procedure on "Universal Precautions/Infection Control" received from the QIDP (Qualified Intellectual Disabilities Professional) on 11/22/13 at 1:22 PM indicated "gloves shall be removed and discarded after contact with each individual, fluid, item or surface. Hands should be washed immediately after gloves are removed."</p>	W000455	Staff will be provided additional training regarding removing gloves and washing hands in the identified circumstances. The manager will make periodic observations and at least monthly to assure that the procedure is being followed properly. Person Responsible: Residential Manager W 455 1 Staff will be provided additional training regarding removing gloves and washing hands in the identified circumstances. 2. Staff people will be observed different time when performing task requiring gloves and hand washing to assure that the proper procedure is being followed. 3 The manager will observe staff during those procedures to assure that they are being properly performed at least twice weekly. 4 The manager will maintain a checklist of the observations of informal training opportunities that will be reviewed at least monthly. Person Responsible: Residential Manager	12/22/2013			

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, the facility failed to encourage clients to function with as much independence to the extent possible in regards to meal preparation and dining clean up.</p> <p>Findings include:</p> <p>On 11/6/13 between 3:56 PM and 5:25 PM, group home observations were conducted. At 3:56 PM, the clients (#1, #2, #3, #4, #5, #6, #7, #8) returned to the group home from their day program. At 3:56 PM, the salad was already made, vegetables were in a pot cooking on the stove. At 4:00 PM, DSP (Direct Support Professional) #3 was in the kitchen cooking chicken on the stove in two separate pans. DSP #4 assisted Client #2 in putting napkins on the table. DSP #3 was in the kitchen stirring the food and indicated one pot of the meat was done and ready to eat. At 4:10 PM, DSP #4 assisted Client #2 in placing silverware on the table. DSP #3 was in the kitchen cutting more chicken for cooking without any client assistance. At 4:18 PM, Client #1 assisted by putting dishes on the table. DSP #3 put butter in the pan of green beans on the stove without clients present. At 4:32 PM, DSP #3 was in the kitchen pureeing a portion of the food without client assistance. DSP #3 brought out the chicken Alfredo and broccoli in a family style serving dish without client assistance.</p> <p>Between 4:37 PM and 5:25 PM, dinner was observed. At 4:51 PM, DSP #3 brought Client #3</p>	W000488	<p>Clients will participate in the meal process with regards to meal preparation and clean up. Staff will be provided training in the need to involve clients in the process. The manager will make periodic observations at least weekly to assure that this is being done. Person Responsible: Residential Manager W 488 1</p> <p>Staff will be provided training in the need to involve clients in the process of meal preparation and clean up. 2. Other clients will be observed during meal preparation and clean up to assure that they are participating in the process. 3 The manager will observe clients during meal preparation and clean up to assure that they are participating in the process. at least twice weekly. 4 The manger will maintain a checklist of the observations which will be reviewed at least monthly. Person Responsible: Residential Manager</p>	12/22/2013			

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	<p>applesauce already served into a dish. At 4:56 PM, Client #4 took her own dishes to the sink and placed them in the dishwasher. At 5:05, DSP #4 assisted Client #2 from the dining room table to assist her in using the restroom. Client #2 did not come back to clean any portion of her dinnerware. At 5:06 PM, DSP #3 was in the kitchen cleaning up dinner pots and pans without client assistance. At 5:09 PM, Client #7 self-ambulated her wheelchair with her drinking glasses and took them to the kitchen. Client #7 left her dishes at the dining room table and also did not wipe off her spot. DSP #2 assisted Client #6 in getting her walker and Client #6 got up from the dining room table without cleaning any portion of her dining area. Client #1 took his own dishes to the kitchen and put them on the sink. DSP #3 put Client #1's dishes into the dishwasher for him. At 5:11 PM, Client #8 left the table without cleaning up any portion of her dinner area. At 5:19 PM, Client #3 put his tea cup into the sink. At 5:23 PM, no clients remained at the dining room table. The clients were involved in other activities and no one was sitting at the dining room table. Left on the table were 2 salad dressings, 10 cups, 6 dessert dishes, 6 dishes, and one serving dish. DSP #3 was in the kitchen cleaning. At 5:23 PM, Client #1 turned on the television. At 5:25 PM, Client #1 asked DSP #3 if he could help with the plates. DSP #3 indicated he could help and Client #1 took the plates into the kitchen.</p> <p>During an interview on 11/12/13 at 12:23 PM, the QIDP (Qualified Intellectual Disabilities Professional) indicated a client should be assisting in the kitchen during meal preparation during each meal. The QIDP indicated each client (#1, #2, #3, #4, #5, #6, #7 and #8) was capable in assisting in meal preparation and meal clean up based on their individual skill levels.</p>						

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