

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 10/17/2012	
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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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: October 9, 10, 11, 12, 16, and 17, 2012.</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>Provider Number: 15G491 AIM Number: 100245050 Facility Number: 001005</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC9.</p> <p>Quality Review was completed on 10/19/12 by Tim Shebel, Medical Surveyor III.</p>	W0000					

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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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7, and #8) who lived in the group home, the governing body failed exercise operating direction over the facility to complete maintenance and repairs at the group home.</p> <p>Findings include:</p> <p>On 10/9/12 from 3:35pm until 6:55pm, and on 10/10/12 from 5:35am until 7:30am, clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home and the following was observed along with Group Home Staff (GHS) #1 and GHS #2:</p> <p>-At 3:35pm, Client #1 and GHS #1 showed client #1's bedroom and the closet did not have a closet door. GHS #1 indicated client #1 had asked for the door to be removed and no barrier was present to divide the closet from client #1's bedroom.</p> <p>-On 10/9/12 from 3:35pm until 6:55pm and on 10/10/12 from 5:35am until 7:30am, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked into and out of the kitchen area of the facility. The kitchen floor tile</p>	W0104	<p>The client requested that the closet door be removed as noted in the report. The request was made with involvement of the parents. This was the client's choice and no deficiency exists.</p> <p>The threshold repair has been completed.</p> <p>Bids are being taken for the countertop and the floor coverings.</p> <p>A section will be added to a monthly checklist to assure that all maintenance items are noted and acted upon.</p> <p>Person Responsible: Community Supports Assistant Director</p>	11/16/2012			

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	<p>was on a lower level than the carpeted surfaced dining room, the connecting threshold plate which connected the two floor levels was not anchored to the floor, and the two floor levels were not even. GHS #2 stated clients #1, #2, #3, #5, #6, and #8 had "trouble with their gaits (an even independent walking motion)" when walking from one surface to another surface safety.</p> <p>-On 10/9/12 from 3:35pm until 6:55pm and on 10/10/12 from 5:35am until 7:30am, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked into and out of the kitchen area of the facility. During both observation periods the kitchen counter tops were worn, damaged, and discolored. At 5:35am, GHS #2 stated the kitchen counter tops were worn, had "rough spots," were stained, and needed replaced.</p> <p>-On 10/9/12 from 3:35pm until 6:55pm and on 10/10/12 from 5:35am until 7:30am, clients #1, #2, #3, #4, #5, #6, #7, and #8 walked into and out of the kitchen area of the facility. At 5:35am, GHS #2 indicated the kitchen floor was "approximately" ten feet by ten feet (10' x 10') and the dining room floor were "worn," was discolored, damaged, and had been requested to be replaced.</p> <p>On 10/11/12 at 2pm, an interview with</p>						

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	<p>the QDP (Qualified Developmental Professional) and Community Supports Assistant Director (CSAD) was conducted. The CSAD provided a "Capital Budget FY'13 (For Year 2013)" indicated "...Countertop...." The CSAD indicated client #1's bedroom closet door had been requested to be removed by client #1 and no barrier for the closet was replaced for the closet door. The CSAD stated the kitchen floor and the dining room carpet was not level in the group home, the kitchen floor was worn, and the living room carpet had "all" been requested for the "Capital Budget." The CSAD indicated the kitchen counter tops had been requested for replacement on the "Capital Budget" and needed replaced. The CSAD stated "the Capital (Budget) had been submitted but not approved."</p> <p>9-3-1(a)</p>						

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled clients (client #2) and one additional client (client #6) who had money skills goals implemented, the facility failed to encourage and teach the use of United States currency during times of opportunity.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/09/12 at 4:40pm, GHS (Group Home Staff) #3 with clients #2 and #6 sat near the desk in the dining room. At 4:40pm, GHS #3 removed pre-cut pieces of green paper labeled on each was a \$1.00 bill, \$5.00 bill, \$10.00 bill, and laid the pile on the desk. No United States currency was observed used or encouraged. GHS #3 prompted clients #2 and #6 to select each identified bill GHS #3 requested. GHS #3 stated "I'm not sure why we don't use real money." Client #6 stated she was "not sure if we can spend it or not."</p>	W0126	<p>Money training will be done with money. During periodic visit and at least monthly, observations by managerial and professional staff will observe the money training to assure that real money is being used and make corrections if needed.</p> <p>Person Responsible: QDDP</p>	11/16/2012

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	<p>Client #2's records were reviewed on 10/11/12 at 9:15am. Client #2's 4/12/12 ISP (Individual Support Plan) indicated client #2's goal was to count enough change for one (1) quarter.</p> <p>On 10/11/12 at 2pm, an interview with the QDP (Qualified Developmental Professional) was conducted. The QDP indicated client #6 could not recognize United States currency. The QDP indicated play replica money was not the same as using United States bills and coins. The QDP indicated United States bills and coins should have been used at each opportunity for clients #1, #2, #3, #4, #5, #6, #7, and #8 living in the group home.</p> <p>9-3-2(a)</p>				

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W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, for 1 of 3 sampled clients (client #1) who had psychotropic medication prescribed, the facility's specially constituted Human Rights Committee (HRC) failed to approve client #1's psychotropic medication behavior plan prior to implementation.</p> <p>Findings include:</p> <p>Client #1's records were reviewed on 10/11/12 at 10:10am. Client #2's 9/11/12 "Physician's Order" indicated "Zoloft" 100mg (milligrams) an anti psychotic medication for behaviors every day for Anxiety Disorder and Impulse Control Disorder. Client #1's 10/14/2009 BSP (Behavior Support Plan) indicated client #1 had targeted behaviors of talking under her breath and lying. Client #1's BSP did not indicate client #1's psychotropic medication use was reviewed by the facility's HRC. Client #1's 8/26/11 Medication Reduction Plan for her Zoloft psychotic medication was blank for HRC review. No HRC reviews were available</p>	W0262	A new reduction plan has been approved by the Human Rights Committee. A checklist will be used to assure that all signatures are obtained before use of a psychotropic medication including Human Rights Committee approval.. Person Responsible: QDDP	11/16/2012	

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	<p>for review from 8/29/11 and 8/26/10 for the use of client #1's Zoloft psychotropic medication for behaviors.</p> <p>The Qualified Developmental Professional (QDP) was interviewed on 10/17/12 at 1:05pm. The QDP indicated the HRC had not reviewed and approved client #1's medications for behaviors of Zoloft before the email the QDP sent out on 10/11/12 after it had been identified. The QDP stated "it was an oversight."</p> <p>9-3-4(a)</p>				

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 3 sample client (client #2) who had prescribed eye glasses and prescribed hearing aids, the facility failed to teach and encourage client #2 to wear her prescribed hearing aids and eye glasses. The facility failed to have client #2's eye glasses available.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/9/12 from 3:35pm until 6:55pm, and on 10/10/12 from 5:35am until 7:35am, and on 10/10/12 from 12:25pm until 12:45pm at day services site #2. During the three observation periods client #2 did not wear her prescribed hearing aids and was not prompted for their use.</p> <p>Client #2's record was reviewed on 10/11/12 at 9:15 AM. Client #2's 5/10/11 hearing assessment indicated client #2 had prescribed hearing aids for her right and left ears. Client #2's 2/8/12 and 10/5/12 ISP (Individual Support Plan) did</p>	W0436	<p>The client is wearing glasses regularly. An objective has been implemented to teach the client to use hearing aids. Managerial and Professional staff at least monthly on visits to the site will note that clients are using identified devices and make corrections if needed.</p> <p>Person Responsible: QDDP</p>	11/16/2012			

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	<p>not indicate a goal/objective to wear her prescribed right and left hearing aids.</p> <p>On 10/11/12 at 11 AM, an interview was conducted with the QDP (Qualified Developmental Professional) and the Agency Registered Nurse (RN). The QDP and RN both indicated client #2 had prescribed hearing aids for her right and left ears. The QDP indicated client #2 did not have a formal goal to teach client #2 to wear her prescribed hearing aids. The QDP indicated client #2 should have been taught and encouraged to wear her prescribed hearing aids.</p> <p>2. Observations were conducted at the group home on 10/9/12 from 3:35pm until 6:55pm, client #2 did not wear her prescribed eye glasses and was not prompted for their use. Observations were conducted on 10/10/12 from 12:25pm until 12:45pm at day services site #2, and client #2 did not wear her prescribed eye glasses and was not prompted for their use.</p> <p>Client #2's record was reviewed on 10/11/12 at 9:15 AM. Client #2's 9/7/11 vision assessment indicated client #2 had prescribed eye glasses and a recommendation for "constant wear." Client #2's 2/8/12 and 10/5/12 ISP (Individual Support Plan) did not indicate</p>						

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	<p>a goal/objective to wear her prescribed eye glasses.</p> <p>On 10/11/12 at 11 AM, an interview was conducted with the QDP (Qualified Developmental Professional) and the Agency Registered Nurse (RN). The QDP and RN both indicated client #2 had prescribed eye glasses. The QDP indicated client #2 had been ill, was in another healthcare facility and client #2's eye glasses were "lost" by the other facility. The QDP stated the other facility was "financially responsible" for client #2's prescribed eye glasses. The QDP indicated client #2 did not have a formal goal to teach client #2 to wear her eye glasses. The QDP indicated client #2 should have been taught and encouraged to wear her prescribed eye glasses.</p> <p>9-3-7(a)</p>				

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on interview and record review, for 4 of 4 sample clients (clients #1, #2, #3, and #4) and for four additional clients (clients #5, #6, #7, and #8) living in the group home, the facility failed to ensure evacuation drills were conducted every ninety (90) days for each shift of personnel.</p> <p>Findings include:</p> <p>The facility evacuation drills for clients #1, #2, #3, #4, #5, #6, #7, and #8 were reviewed on 10/9/12 at 2:55pm, and indicated the following: Evacuation drills from 10/2011 through 10/2012 for the 5pm until 10pm (second) shift personnel- on 4/26/12 at 5pm, and no evacuation drills were available for review before 4/26/12.</p> <p>On 10/11/12 at 2pm, an interview with the QDP (Qualified Developmental Professional) and Community Supports Assistant Director (CSAD) was conducted. The CSAD indicated the second shift of personnel was 5 PM until</p>	W0440	<p>Fire drills will be run at least once each quarter on each shift. A system to prompt the supervisor that the drill needs to be run and on which shift will be sent at the beginning of each month. A prompt later in the month will be sent to check to make sure that the appropriate drill has been run.</p> <p>Person Responsible: QDDP</p>	11/16/2012			

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	10 PM. The CSAD indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 lived in the group home and no additional exit drills were available for review. 9-3-7(a)				