

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(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
W0000	<p>This visit was for the fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: April 30, May 1, 2, 3, 4, 7, and 9, 2012.</p> <p>Facility Number: 001004 Provider Number: 15G490 AIMS Number: 100245030</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/16/12 by Ruth Shackelford, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, the governing body failed to exercise operating direction over the facility to provide financial oversight of personal expenditures for 1 of 4 sample clients (client #3).</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 5/2/12 at 11:40am. Client #3's 9/30/11 QMRP (Qualified Mental Retardation Professional) quarterly review indicated of client #3's ISP (Individual Support Plan) that client #3 had a guardian. Client #3's 10/30/11 quarterly review indicated "Medical Appointments: Optometrist: [name of doctor] 10/21/11 Office visit, [Client #3] was measured for Bi-focals on 10/4/11. Trust Fund Check \$125.00 was used for down payment on 10/5/11. (Later will make payment for) remainder of balance \$195.00 on glasses." Client #3's record indicated an 8/23/11 entry for doctor visits "Optometrist [name of doctor]. Had [client #3's] glasses repaired due to broken at nose piece. Requested information re: Flexon frames. Obtained approval from Q (Qualified Mental</p>	W0104	<p>A check request of \$320 has been sent to the accounting dept and client #3 will be reimbursed the total amount for his glasses. The client has had an adaptive equipment goal to care for his glasses for the past year and this goal will continue. The QDDP will ensure that no medical needs/equipment will ever be purchased with a client's trust fund. All requests are approved through the QDDP, so the QDDP will monitor this closely to ensure it does not happen again.</p>	06/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
	<p>Retardation Professional) for trust funds to purchase sturdier glasses (sic)...."</p> <p>On 5/4/12 at 10:15am, client #3's personal funds financial record was reviewed and indicated the following: -A 10/21/11 ledger entry withdrawal expense indicated the name of the Optometrist for "\$195.00" for eye glasses.</p> <p>On 5/4/12 at 10:45am, client #3's personal funds financial record for 9/2011, 8/2011, and 7/2011 was requested for review and was not available.</p> <p>On 5/4/12 at 10:45am, an interview with the QMRP was conducted. The QMRP stated client #3 had broken his prescribed eye glasses "several times." The QMRP indicated client #3 had a personal trust fund at the local bank and client #3 paid for his new prescribed eye glasses. The QMRP indicated client #3 had not paid for the repairs to his old broken eye glasses. The QMRP indicated client #3 now had special frames which were more expensive and she thought client #3 could pay for these. The QMRP indicated client #3 had a guardian and no documentation was available for review to indicate client #3's guardian was consulted before the expenditure.</p> <p>9-3-1(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
W0112	<p>483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records.</p> <p>Based on observation, record review, and interview for 1 of 4 sample clients (client #3), the facility failed to keep client #3's medical and personal information confidential by posting information on the dining room bulletin board.</p> <p>Findings include:</p> <p>On 4/30/12 from 3:35pm until 7:30pm, and on 5/1/12 from 5:40am until 7:35am, observation and interviews were completed at the group home. During both observations, posted on the dining room bulletin board was client #3's 4/12/12 "Dysphagia/Dining Protocol for: [client #3]." The dining protocol indicated, "Difficulty swallowing is called Dysphagia. It is usually a sign of a problem with the throat or esophagus...Dysphagia Warning signs: Coughing w/(with) signs of struggle...Coughing vs. Choking...Proactive preventative supports and strategies to manage the risk: ST (Speech Therapy) recommendations from 3/26/12 positioning; 1:1 (one on one) supervision/assistance, upright for All</p>	W0112	Client #3's dysphagia plan was removed immediately. All staff will be re-trained prior to 6/8/12 regarding the importance of client privacy and not posting personal information in public areas of the home. All clients could be affected since all clients have high risk plans and other personal information. The manager will conduct a quarterly check of the home to ensure all personal/private information regarding clients is not posted.	06/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992		
(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	
	<p>oral intake and 20 minutes after. Presentation Precautions: Solid/liquids in 1 tsp. (teaspoon) amounts. Use regulated straw or present liquids in small amount in cup so when [client #3] uses straw he gets approximately 1 tsp. per swallow...diet changed to Mechanical Soft with moist ground meat and regular consistency liquids..." Client #3's full name was identified in bold print on each of the two page "Dysphagia/Dining Protocol" document. On 4/30/12 at 7:30pm, GHS (Group Home Staff) #1 indicated client #3's full name was posted on the document with client #3's personal medical information.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 5/4/12 at 10:45am. At 10:45am, the QMRP indicated client #3's Dysphagia/Dining Protocol and personal information should not have been posted on the group home dining room bulletin board where visitors to the home had access.</p> <p>9-3-1(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
W0368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to administer prescribed medications per physician's orders to 3 of 8 clients living at the group home (clients #3, #7, and #8).</p> <p>Findings include:</p> <p>The facility's incident reports from 4/30/11 to 4/30/12 were reviewed on 4/30/12 at 10:10am.</p> <p>1. "Incident Date: 11/2/11 at 6pm, Client: [Client #3], Narrative: Staff failed to give [Client #3] Tamsulosin 0.4mg (milligrams) for urinary flow at 6pm on 11/2/11. Staff re educated on avoiding distractions and following rules of Medication pass."</p> <p>2. "Incident Date: 9/6/11 at 8am, Client: [Client #7], Narrative: 3 (three) staff involved in medication error. [Client #7's] Sertraline (a medication given for depression) discontinued on 8/24/11 and was taken off of Aug (August) and Sept. (September) MAR's (Medication Administration Records) but pharmacy had sent medication and it was put into</p>	W0368	<p>Corrective actions include: All staff will be trained on the new Medication Administration Handbook. All clients have the potential to be affected by the same deficient practice since all clients take medications. All the client's staff will be trained on the new Medication Administration Handbook. Systemic changes: Nurse will observe staff on a quarterly basis to ensure all staff are administering medications properly. Corrective actions will be monitored quarterly by the nurse.</p>	06/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
	<p>time slot for [Client #7]. All three staff failed to follow rules of medication pass and hence gave medication. This staff who found medication errors was following medication rules and pulled medication from time slot for this client. Staff involved have written medication errors and have to write a consequence paper. Staff re educated on medication rules by nurse."</p> <p>3. "Incident Date: 8/11/11 at 6pm, Client [Client #8], Narrative: Client was receiving Antibiotic Cipro for urinary tract infection. Medication was for 20 (twenty) doses (over) 10 (ten) days, MAR was bracketed and stop date given. Staff gave one more extra dose and though she (the staff person) questioned it to self did not call nurse and gave [Client #8] medication. Pharmacy sent extra doses. Staff education on following policy and anytime she is questioning a med (medication) to call nurse."</p> <p>4. "Incident Date: 6/7/11 at 6am, Client [Client #7], Narrative: Staff forgot to give 6am medications to this client. Staff had given 5am medication without food or other medications per orders and then she had passed all other medications to other clients but forgot to come back and give [client #7] her 6am medications. Medications missed were Aspirin 81mg</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
	<p>(for blood thinner for Coronary Artery Disease), Daily Vitamin (for nutritional health), liquid tears (for macular degeneration of the eyes), Metformin 500mg (for diabetes mellitus), Metoprolol (for hypertension/high blood pressure) 25mg, (and) Zoloft 150mg (for depression). After staff passes medication second staff will review medication administration record to ensure all medications were given."</p> <p>5. "Incident Date: 5/27/11 at 8:30pm, Client [Client #8], Narrative: Staff had gotten medications ready for another client and was distracted by another staff member. Staff handed the medications that she had gotten ready for another client to [Client #8] (and client #8 took the wrong medications). [Client #8] received wrong medications of Dilantin and Primidone. Dr. (Doctor) updated no new orders. Staff monitoring client for side effects of medications. Staff to pass medications by herself with no distractions."</p> <p>Client #3's 1/26/12 physician orders were reviewed on 5/2/12 at 11:40am. The review indicated the following orders: "Tamsulosin Cap (Capsule) 0.4mg (milligrams) 1 cap daily at 6pm (for urinary flow)."</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
	<p>Client #7's 1/26/12 physician orders were reviewed on 5/2/12 at 11:50am. The review indicated the following orders: daily at 6am: "Aspirin 81mg (for blood thinner for Coronary Artery Disease), Daily Vitamin (for nutritional health), liquid tears (for macular degeneration of the eyes), Metformin 500mg (for diabetes mellitus), Metoprolol (for hypertension/high blood pressure) 25mg, (and) Zoloft (also known as Sertraline) 150mg (for depression)." Client #7's record indicated "Sertraline (also known as Zoloft) 100mg tab 1 x (one time) dly (daily), Sertraline 50mg tab 1 x dly, Aspirin 81mg tab 1 x dly, Daily Vit. (Vitamin) 1 tab dly, Refresh eye drops 1 (one) drop ea (each) eye every 2 (two) hrs (hours) (for macular degeneration), Metformin 500mg 1 tab 2 x's (two times) dly, (and) Metoprolol 25mg 1 tab 2 x's dly." Client #7's records indicated she did not receive 8am medications.</p> <p>Client #8's record and client #8's 1/26/12 physician orders were reviewed on 5/2/12 at 12:15pm. The review indicated client #8 was on an Antibiotic Cipro for urinary tract infection in 7/2011 and until 8/10/11 stop date for the medication. Client #8 did not have a physician order for Dilantin (for seizures) and Primidone (for seizures). Client #8's record did not indicate he had seizure activity.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/09/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(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
	<p>The Agency Nurse was interviewed on 5/4/12 at 10:45am. The Agency Nurse stated continued medication administration errors were the result of "staff committing med errors." The Agency Nurse further indicated she followed up on each medication error and stated "medication errors happened."</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
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, interview, and record review, for 1 of 4 sample clients (client #1) and for 2 additional clients (clients #6 and #8), the facility failed to provide client #1's hearing aid in good repair and clients #6 and #8's wheelchair arm rests in good repair.</p> <p>Findings include:</p> <p>1. On 4/30/12 from 3:35pm until 7:30pm, and on 5/1/12 from 5:40am until 7:35am, client #1 did not wear a hearing aid and staff did not encourage client #1 to wear his hearing aid.</p> <p>Client #1's record was reviewed on 5/2/12 at 10:45am. Client #1's 12/21/11 Hearing assessment indicated he wore a left hearing aid. Client #1's 1/26/12 Physician Order indicated client #1 wore a hearing aid in his left ear. Client #1's ISP (Individual Support Plan) monthly reviews for 12/2011, 11/2011, and 10/2011 indicated client #1's hearing aid</p>	W0436	<p>Client #1's hearing aid had already been sent in to be repaired, but it hadn't been returned. It was picked up on 5/7/12. Also, client #6 got his wheelchair armrest repaired on 5/7/12 and client #8 got his armrests repaired on 5/3/12. Clients who have adaptive equipment could be affected by the same deficient practice. A section will be added to the Monthly Safety Checklist to ensure that the adaptive equipment is being monitored. Systemic changes include: The checklist will be reviewed monthly by the Res. Mgr. and will be turned into the Nurse and QDDP monthly. All parties will review and initial the checklist to ensure any adaptive equipment has been repaired in a timely manner. The corrective actions will be monitored by the Res. Mgr, Nurse, and QDDP.</p>	06/08/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992		
(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	
	<p>was "broken." Client #1's 5/5/11 ISP indicated an objective to keep his hearing aid in his ear and not in his pocket.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 5/4/12 at 10:45am. At 10:45am, the QMRP indicated client #1 wore a hearing aid in his left ear and staff should have prompted client #1 to wear his hearing aid. The QMRP indicated client #1 had left his hearing aid in his shirt pocket and the aid was damaged or broken as the result. The QMRP indicated client #1 had a goal developed to teach client #1 to care for his hearing aid. The QMRP indicated no information was available for review to determine if client #1 had his hearing aid or if client #1's hearing aid was "broken."</p> <p>2. On 4/30/12 from 3:35pm until 7:30pm, and on 5/1/12 from 5:40am until 7:35am, client #6 propelled himself throughout the group home and his right wheelchair arm rest vinyl was worn, torn, and exposed the wheelchair arm rest padding.</p> <p>3. On 4/30/12 from 3:35pm until 7:30pm, and on 5/1/12 from 5:40am until 7:35am, client #8 propelled himself throughout the group home and his wheelchair did not have arm rests. Client #8 rested his right and left arms on the metal portion of the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/09/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(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			
	<p>wheelchair frame where the right and left arm rests pads were missing from the wheelchair. On 5/1/12 at 7:18am, client #8 indicated his wheelchair arm rest had come off his wheelchair. Client #8 propelled his wheelchair to his bedroom, opened his lower drawer of his chest of drawers, and pulled out two new arm rest pads. Client #8 indicated the screws were missing and he had no way to attached the new arm rest pads to his wheel chair.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 5/4/12 at 10:45am. At 10:45am, the QMRP indicated she was not aware client #6 and #8's arm rests were damaged. The QMRP indicated clients #6 and #8 required daily use of their wheelchairs for independent mobility.</p> <p>9-3-7(a)</p>						