

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 8/19, 8/20, 8/21, 8/22, and 8/25/2014.</p> <p>Facility number: 012414 Provider Number: 15G786 AIMS Number: 200998980</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/9/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000140	<p>483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) who had personal money entrusted to the facility and had personal money kept by staff at the facility owned day services, the facility</p>	W000140	The Personal Account and Petty Cash Guidelines will be updated to further outline the procedure to insure a full and complete accounting of clients personal funds entrusted to the facility on behalf of clients. Staff of this group home will receive training	09/24/2014

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: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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
	<p>failed to ensure a full accounting of client #1 and #2's personal funds and failed to follow their policy and procedure for client finances.</p> <p>Findings include:</p> <p>On 8/20/14 at 6:25am, client #2 verbally reminded GHS (Group Home Staff) #1 that he wanted his money to go to day services today. GHS #1 indicated clients #1 and #2 did not carry wallets. At 7:40am, client #2 asked GHS #1 to make sure he had his day services money from his personal funds. Client #2 showed a folder to GHS #1, GHS #1 retrieved client #2's money from a drawer, removed 4 quarters from the bag, and inserted the 4 quarters into client #2's folder then zipped the folder shut. GHS #1 indicated to client #2 he would have his money for day services. GHS #1 signed the withdrawal slip and placed it inside client #2's bank bag.</p> <p>On 8/20/14 at 4:15pm, clients #1 and #2 indicated they did not carry wallets for their personal use. At 5:00pm, client #1 and #2's personal funds and bank statements were reviewed with the Group Home Manager (GHM). The GHM counted out client #1 and #2's cash from their personal funds accounts in their individual cash bags and cash ledger</p>		<p>in this updated procedure to insure they are aware of the steps to be followed.</p> <p>The updated guidelines will also be provided to all group home staff and training will occur so that they also follow the needed steps. The Community Supports Coordinator will review Personal Accounts of the residents each month as they are turned in and also conduct spot checks on the accounts when visiting the group home.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>records. No pop/canteen money was recorded. The GHM provided client #1 and #2's current monthly receipts which indicated clients #1 and #2 did not sign for authorization of withdrawals for pop money staff took out of their current personal fund money available at the group home.</p> <p>On 8/21/14 at 10:30am, the QIDP (Qualified Intellectual Disabilities Professional) provided client #1 and #2's monthly receipts which indicated the following:</p> <p>Client #1's 8/2014, 7/2014, 6/2014, and 5/2014 ledgers did not indicate access to his personal funds and did not indicate client #1 took or received money for breaks at the facility owned day program.</p> <p>Client #2's monthly ledgers indicated for 8/2014 no record of access to his personal funds and did not indicate client #2 had taken money to the facility owned day program. Client #2's 7/2014, 6/2014, and 5/2014 ledgers indicated money sent to "CI (Community Integration, the facility owned day program)." The receipts and ledger entries indicated on 7/30/14 \$18.25 returned from CI to his account, on 7/30/14 a withdrawal of \$.75, on 7/23/14 a \$25.00 withdrawal to CI, on 6/6/14 a withdrawal of \$20.00, and on</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>5/7/14 a withdrawal of \$15.00. The QIDP stated the facility did not track client #1 and #2's "pop (workshop break)" funds and no records for these funds were available for review. When asked if the facility owned workshop had a record of client #1 and #2's pop/break money, the QIDP stated "No, [clients #1 and #2's] pop/break money was not tracked." The QIDP indicated client #1 and #2's funds from their personal fund accounts were given to the staff at the facility owned workshop by the facility staff from the group home. The QIDP indicated clients #1 and #2 did not carry their money and did not dispense their own money.</p> <p>On 8/21/14 at 10:30am, an interview with the QIDP was conducted. The QIDP indicated clients #1 and #2's pop/break funds were not accounted for by the facility. The QIDP indicated the facility did not follow the agency's policy and procedure to ensure a full accounting of each client's personal funds.</p> <p>On 8/21/14 at 10:30am, the facility's policy and procedure 7/26/2011 "Personal Account and Petty Cash Guidelines" indicated "Many of our customers require assistance in handling their money. In providing this service, it is our responsibility to provide controls to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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	
W000149	<p>safeguard their monies... You are expected to obtain an original store receipt for every purchase...For personal accounts, when receipts are unavailable for things such as for church offerings, purchases at a concession stand, etc. a hand written receipt must be created and initialed by both staff and client. All transactions should be recorded on the personal account sheet including money taken out for clients' personal use...."</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 1 of 1 allegation of neglect (for client #1), the facility neglected to implement their Abuse/Neglect/Mistreatment policy to ensure staff provided supervision at the group home for client #1 when he was left home alone.</p> <p>Findings include:</p> <p>On 8/19/14 at 10:10am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 08/01/2013 through 08/19/2014 and</p>	W000149	<p>This situation occurred on 1-28-14. It was reported per regulations. An investigation was completed. Staff involved was provided retraining regarding the Prevention of Abuse and Neglect. A system was developed and put into place to account for all clients during transportation away from the site.</p> <p>An informal checklist will be used by all staff doing transportation to insure that all clients are present and accounted for.</p> <p>The Community Supports Coordinator will do at least monthly spot checks to insure that the informal checklists are being utilized. Annual and as</p>	09/24/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>indicated the following:</p> <p>-A 1/28/14 BDDS report for an incident on 1/28/14 at 2:45pm, indicated client #1 "went to a doctor's appointment...and was dropped off at the group home where the (Group Home) Manager was at (sic). When [the Group Home Manager] left the home to pick up the [clients #2, #3, and #4] at day services, she forgot that [client #1] was at the home and left him there alone." The report indicated the Group Home Manager (GHM) returned home with clients #2, #3, and #4. Client #1 was "lying in bed, napping, upon [the GHM's] return. [Client #1] was not upset and he was not injured." The report indicated the GHM was suspended immediately pending an investigation.</p> <p>-The 2/3/14 Follow Up BDDS report indicated the investigative results that "Neglect" was substantiated by the GHM when she "left [client #1] home alone while doing transport for the other men who live in the home. [Client #1's] level of supervision is 24 hour (supervision by group home staff)." The investigation results indicated the GHM received retraining, corrective action, and was assisted to develop a system for the group home to account for each client's whereabouts during each day.</p>		needed training will be provided to all Community Supports staff regarding the Prevention of Abuse and Neglect.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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
	<p>Client #1's record was reviewed on 8/20/14 at 10:40am. Client #1's 10/29/13 ISP (Individual Support Plan) and 5/2/14 BSP (Behavior Support Plan) both indicated client #1 "required" twenty-four hour staff supervision in the group home. Client #1's plans indicated he had limited verbal skills, did not recognize personal dangers, was not aware of the dangerous situations around him, did not possess community safety skills, and did not possess pedestrian safety skills.</p> <p>On 8/21/14 at 8:50am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) and Qualified Intellectual Disabilities Professional (QIDP) was conducted. The CSA/RN indicated the GHM neglected to supervise client #1 according to his identified supervision needs. Both staff stated client #1 was left at home alone "about 10 minutes" on 1/28/14.</p> <p>On 8/19/14 at 2:45pm, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 8/19/14 at 2:45pm, a review of the facility's records indicated the facility's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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
W000192	<p>undated "Handling client Abuse, Neglect, and Injuries of Unknown Origin & BDDS Incident Reporting" policy which indicated "It is Pathfinder Services, Inc. policy to provide a service where clients are free from abuse, neglect, or exploitation. In the event that any of these conditions are suspected, an investigation will immediately be conducted...Any alleged, suspected, or actual abuse-physical, sexual, emotional, or domestic improper treatment, neglect-failure to provide appropriate care, environment, food, medical care, or supervision, exploitation or any other mistreatment must be immediately reported...." The policy and procedure indicated staff would be suspended pending an investigation.</p> <p>9-3-2(a)</p> <p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on observation, record review, and interview, for 1 of 2 sampled clients (client #1), the facility failed to ensure staff displayed competence related to client #1's medication labels during medication administration.</p>	W000192	A new staff training curriculum in medication administration will be developed and all staff of the group home will participate in this training to increase their medication administration skills so that they can demonstrate competency in meeting clients	09/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>Findings include:</p> <p>On 8/20/14 at 6:31am, GHS (Group Home Staff) #1 asked client #1 to come to the medication room for medication administration. GHS #1 compared client #1's labels on client #1's medications of "Escitalopram 5mg (milligrams) 1 tab (tablet) every morning w/10mg (with 10mg tablet) = (to equal) 15mg" medication and client #1's "Escitalopram 20mg 1 tab (tablet) one time daily" medication for behaviors. Client #1's 8/2014 MAR (Medication Administration Record) indicated "Escitalopram (Lexapro) 10mg daily for anxiety...dose change see new sheet...Escitalopram 5mg daily...Escitalopram 20mg take 1 tablet by mouth daily for anxiety (start date 8/5/14)...." At 6:40am, GHS #1 indicated client #1's medication labeling bottles for his Lexapro medications did not match client #1's MAR. GHS #1 indicated client #1's physician's orders were not available for her to review. GHS #1 administered the medications to client #1. At 6:40am, GHS #1 stated she could administer client #1's medications of Lexapro 5mg with the 20mg tablet because "everyone else has signed they did it this way too." GHS #1 indicated client #1's medication label did not match the MAR. GHS #1 indicated she had</p>		<p>health needs.</p> <p>All other group home staff of the agency will also receive training in this curriculum to increase their medication administration skills. Annual and ongoing trainings will occur to refresh and remind staff of proper medication administration procedures. The agency nurses/QDDP's will observe a med pass on at least a monthly basis to insure that procedures are being followed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>been trained for Core A/Core B medication administration training.</p> <p>On 8/19/14 at 9:55am, a record review was completed of the facility's policy and procedures, 1/3/2014 "Medication Administration" policy, which indicated the staff will complete the Core A and Core B Medication Administration Curriculum. The Core A/Core B Curriculum included but was not limited to, the following information: "All staff follow the six rights of medication administration...." The policy and procedure indicated the nurse should be notified by the staff if the "information on the MAR corresponds Exactly (sic) to the label on the medication. If it does not, call the nurse for further instructions."</p> <p>On 8/21/14 at 8:50am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN stated she was not called by the facility staff when client #1's medication label on client #1's Lexapro 5mg did not match the 8/2014 MAR "Exactly." The CSA/RN indicated she should have been called and was not. The CSA/RN indicated the facility staff were trained to follow the Core A/Core B medication administration training. The CSA/RN</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/25/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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
W000369	<p>stated the facility followed "Living in the Community" for medication administration.</p> <p>On 8/21/14 at 8:50am, a record review of the facility's 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated the staff should contact the nurse for guidance if the medication labels did not match the medication record.</p> <p>9-3-3(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 1 of 24 medications administered during the morning medication administration (client #1), the facility failed to ensure client #1's medication was given without error.</p> <p>Findings include:</p> <p>On 8/20/14 at 6:31am, GHS (Group Home Staff) #1 asked client #1 to come to the medication room for medication</p>	W000369	<p>A new staff training curriculum in medication administration will be developed and all staff of the group home will participate in this training to increase their medication administration skills so that they can demonstrate competency in administering medications without error. All other group home staff of the agency will also receive training in this curriculum to increase their medication administration skills. Annual and ongoing trainings will occur to refresh and remind staff or proper medication</p>	09/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>administration. GHS #1 compared client #1's "Nasonex (nose spray for allergies) 2 sprays daily into each nostril." GHS #1 handed client #1 the Nasonex medication spray bottle. Client #1 inserted the applicator into his left nostril, pumped the applicator seven (7) times, and each time client #1 failed to press the applicator completely to the bottle to equal one complete spray dose. GHS #1 did not redirect or teach client #1 regarding the application of the medication. Client #1 inserted the applicator into his right nostril, pumped the applicator eight (8) times, and each time client #1 failed to press the applicator completely to the bottle to equal one complete spray dose. GHS #1 did not redirect or teach client #1 regarding the application of the medication. At 6:40am, GHS #1 stated client #1 did not pump the applicator for his Nasonex medication "completely" to equal one spray dose. GHS #1 stated "it's okay, he does that."</p> <p>On 8/20/14 at 10:40am, client #1's Physician's Order and 8/2014 MAR (Medication Administration Record) both indicated "Nasonex (nose spray for allergies) 2 sprays daily into each nostril."</p> <p>On 8/19/14 at 9:55am, a record review</p>		<p>administration procedures. Co-workers/Supervisor or/QDDP/Nurse will make sure that every med pass is observed and documented to insure that the competency of medication administration is demonstrated by all staff of the group home. Once that competency has been assured, then the agency nurses/supervisor/QDDP's will observe a med pass on at least a monthly basis to insure that procedures are being followed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>was conducted of the facility's policy and procedures, 1/3/2014 "Medication Administration by Staff," which indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site (for application), and the time...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 8/21/14 at 8:50am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN indicated client #1 should have been redirected to administer 2 sprays into each nostril. The CSA/RN indicated the facility staff should administer medications according to Core A/Core B medication administration training. The CSA/RN indicated client #1 should not have been allowed to administer 7 partial sprays in the left nostril and 8 partial sprays in the right nostril of medication. The CSA/RN indicated this medication was given in error of his physician's order.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
W000382	<p>On 8/21/14 at 8:50am, a record review of the facility's 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, the facility failed to keep medications locked/secured when not administered for 2 of 2 sampled clients (#1 and #2) and 2 additional clients (clients #3 and #4) who resided in the home.</p> <p>Findings include:</p> <p>On 8/20/14 from 6:00am until 7:45am, clients #1, #2, #3, and #4 walked independently throughout the group home. From 6:00am until 7:45am, the medication cabinet with client #1, #2, #3, and #4's medications was observed inside the unsecured laundry room and the cabinet was not locked. At 6:40am, GHS (Group Home Staff) #1 indicated the</p>	W000382	<p>A new staff training curriculum in medication administration will be developed and all staff of the group home will participate in this training to increase their medication administration skills so that they can demonstrate competency in insuring that medications are stored in a locked location except for when being prepared for administration. All other group home staff of the agency will also receive training in this curriculum to increase their medication administration skills. Annual and ongoing trainings will occur to refresh and remind staff of proper medication administration procedures. Co-workers/Supervisor/QDDP/Nurse will make sure that every med pass is observed and documented to insure that the competency of medication</p>	09/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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			
	<p>medication cabinet was not locked. During the observation period client #1 entered and exited the room, walked by the unlocked cabinet to switch loads of laundry from the washer to the dryer and from the dryer into a basket. During the observation period clients #2 and #4 walked into and out of the laundry room with the unsecured medication cabinet.</p> <p>On 8/19/14 at 9:55am, a record review was completed of the facility's policy and procedures, 1/3/2014 "Medication Administration by Staff," which indicated "Make sure to always lock up medications."</p> <p>On 8/21/14 at 8:50am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN indicated medications should be kept locked/secured when medications were not administered. The CSA/RN indicated the facility followed "Living in the Community" for medication administration.</p> <p>On 8/21/14 at 8:50am, a record review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication</p>		<p>administration is demonstrated by all staff of the group home. Once that competency has been assured, then the agency nurses/supervisor/QDDP's will observe a med pass on at least a monthly basis to insure that procedures are being followed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/25/2014
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT 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	
	should be kept secure when not administered. 9-3-6(a)				