

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G731	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 495 THOMAS RD HUNTINGTON, IN 46750
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 7/13, 7/14, 7/15, 7/16, 7/17, 7/20 and 7/21/2015.</p> <p>Provider Number: 15G731 Facility Number: 011263 AIM Number: 200838690</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and #8), the facility failed to ensure the clients' personal home was not used by others as a formal day program.</p> <p>Findings include:</p>	W 0125	<p>Since the exit of the Thomas Road Survey, all of our counties that have day services being operated out of a group home have been notified. We are currently in search of new properties to purchase or rent that are accessible and we would be able to provide day services from. Properties have been</p>	11/15/2015

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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	<p>On 7/15/15 from 1:00pm until 1:20pm, clients #1, #2, #3, #4, #5, #6, #7, and #8's group home was visited. During the observation period clients #5 and #7 were present with four (4) non group home staff with six (6) additional clients who did not live at the group home. From 1:00pm until 1:20pm, the eight clients present during the Day Services observation walked throughout the group home living room, bathrooms, kitchen, dining room, activity room, the two upstairs living rooms, and lower living room areas. At 1:10pm, Day Services Staff (DSS) #1 stated "all" the clients who attend day services at the group home had access to clients #1, #2, #3, #4, #5, #6, #7, and #8's group home, watched television, ate meals, used the bathrooms, and used the group home equipment during day service times.</p> <p>On 7/16/15 at 9:45am, an interview was conducted with the Agency Community Supports Associate Director/Registered Nurse (CSA/RN) and the CSC (Community Supports Coordinator) was conducted. The CSA/RN and the CSC both indicated the agency had not notified clients #1, #2, #3, #4, #5, #6, #7, and #8 and/or their legally sanctioned representatives that Day Services were housed within the group home. Both</p>		<p>looked at for both Huntington and Marshal/Starke counties. We are hoping that by September 15th we will have located a property in which we can move our Thomas Road and Tipton Street Day Services locations in to. If we are purchasing, then we would need to allow until around October 15th for closing, and then would like until November 15th to be able to make any needed modifications of the location to make it as accessible as would be needed for our clients. Our CEO, John Niederman, and our Director of Community Supports, Sandy Wing, are working together to find an appropriate locations for our day services to be run from. We will work quickly through the process and try to be moved in to a new day services location as soon as we can. For now, to assure that all clients and guardians are aware that day services are being conducted from the home and to make sure that they are okay with this practice until a new location and be found, a letter and consent form will be distributed to all clients residing in the group home and/or their guardains by 08/14/2015 requesting that they be returned by 08/20/2015.</p>				

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W 0149 Bldg. 00	<p>professional staff indicated the agency allowed other agency clients, other agency staff, and visitors not associated directly with client #1, #2, #3, #4, #5, #6, #7, and #8's group home to have access to their group home, the living space, and equipment.</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 abuse, neglect, and/or mistreatment (for client #5), the facility neglected implement the agency's policy and procedure to prohibit abuse, neglect, and/or mistreatment and neglected to ensure staff supervised client #5 according to her identified needs, ISP (Individual Support Plan), and BSP (Behavior Support Plan).</p> <p>Findings include:</p> <p>On 7/13/15 at 2:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 01/2015 through 7/13/2015 and indicated</p>	W 0149	<p>When the incident happend on 01/11/2015 with client 5 we immediately made a chage to our process when giving her medications. We made a change to her BSP, which was approved by the Human Rights Committee, noting that two staff needed to be present for her med passes. With this, one staff could be focused on the med pass itself and following our medication administration procedures and the other staff would remain focused on client 5, assuring she did not try to take any additional medications. This system seems to be working well for her. In January, staff were directed to make sure they are following all ISPs and BSPs as written. Another email will be sent to</p>	08/20/2015

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	<p>the following for client #5:</p> <p>-A 1/12/15 BDDS report for an incident on 1/11/15 at 8:30pm, indicated client #5 "was taken to the [name of Hospital] Emergency Room (ER) on Sunday evening. She had loose stool and some vomiting. Due to her Prader Willi diagnosis (compulsive eating), she does not vomit typically unless there is a problem so [the agency] felt she should get checked out. [Client #5] eventually admitted to the (facility) staff with her at the hospital that while staff were signing the med (medication) book on Sunday morning, [client #5] took a bottle of Vitamin D capsules (for Vitamin Replacement) from the medication cabinet and left the med room. Staff did find the empty bottle of vitamin D to confirm [client #5's] admission. The hospital staff called poison control to seek any guidance they had in regards to an overdose on Vitamin D, ordered lab work, and an X-ray of [client #5's] abdomen." The report indicated "all testing came back within normal limits." The report indicated client #5 was admitted to the hospital overnight for observation and client #5 was released back to the group home the following day. The report indicated client #5's one on one supervising staff was "waiting for [client #5] outside the med room" and</p>		<p>Thomas Road staff, as well as all other group home employees, reminding them the importance of following all ISP, BSP, high risk plans, etc for the health and safety of our clients. They will be asked that if they find that a co-worker is not following procedures as written for the clients to please report this to their supervisor immediately. This email will be sent by the community supports coordinator on 08/14/2015. Group Home Manger will receive an additional email on 08/14/2015 by the community supports coordinator letting them know that if they have any staff that are not following plans as wirtten for their clients they need to get with the coordinators to discuss the issues so that proper action can be taken to assure the health and safety of our clients.For client 5 we do have a competncy quiz that goes along with her BSP. This will be redistributed to all Thomas Road employees on 08/17/2015 and they will be required to turn this in to the Community Supports Coordinator by 08/20/2015. If based off of the quiz it is determined that anyone does not have a clear understand of client 5's plan, they will receive retraining by the QDDP. The Thomas Road does have thier regulary scheduled house meeting on 08/25/2015. At this meeting all of these points will be reiterated again.</p>				

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	<p>indicated client #5's plans were amended to include that client #5's one on one staff was to be with client #5 and the staff who administered medications during each medication administration period.</p> <p>-A 1/13/15 BDDS report for a hospital stay on 1/12/15 and a 1/16/15 Follow Up BDDS report to the incident on 1/11/15 indicated client #5 "does take Vitamin D 3 on a regular basis. Her prescription states that [client #5] will take 5000 IU of Vitamin D 3 daily The bottle that [client #5] took was a new bottle in which only a few pills were missing, so [client #5] took approximately 255 tablets of 2000 IU of Vitamin D 3." The report indicated client #5 was released from the hospital on 1/12/15, "seemed fine at first, but as the day went on, her stomach began to get more distended and she was not feeling well. [Client #5] could not finish dinner, which with her syndrome never happens so she was taken back to the ER and admitted." The report indicated client #5 was released to the group home on 1/15/15 and "doing well." Client #5's 1/13/15 BDDS report indicated "staff will have their eyes on [client #5] during medication" administration times and two staff will remain in the medication room with client #5 to ensure client #5's plans were implemented.</p>			

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	<p>Client #5's record was reviewed on 7/13/15 at 6:30pm. Client #5's 7/1/15 BSP and 7/2015 ISP both indicated client #5 had the "maladaptive behavior" of obsessive compulsive disorder, and behavioral issues. "Due to [client #5's] diagnosis of Prader Willi, [client #5] has been known to break into the locked refrigerator and cabinets at her family home along with the group home and consume uncooked food. By her consuming these uncooked foods, [client #5] ended up in the hospital with food poisoning a couple of times while residing in the family home. The cabinets and refrigerator/freezer at [client #5's] family home have always had locks and at times, security alarms in place to try and help deter [client #5] from getting foods that could be detrimental to her health...." Client #5's BSP indicated she had taken food to consume from the trash, garbage, taken money from others, and/or items found inside, outside, and on the ground. Client #5's BSP and ISP both indicated she was to have direct eye sight supervision by facility staff while outside her bedroom at the group home. Client #5's 3/4/15 and 6/2015 "Physician's Order" indicated "Vitamin D3 5000 IU, take 1 tab (tablet) by mouth daily for Vitamin replacement."</p> <p>On 7/13/15 at 3:00pm, an interview with</p>			

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	<p>the CSC (Community Supports Coordinator) was conducted. The CSC indicated client #5 had taken the bottle of pills without staff knowledge. The CSC indicated the facility followed the BDDS policy for abuse/neglect/mistreatment and indicated client #5 was not being supervised by facility staff correctly according to client #5's ISP, BSP, and identified needs when client #5 was able to successfully remove a bottle of prescription medication from the medication cabinet inside the medication room with a staff member present. The CSC stated "It was neglect" when client #5 was not provided with the identified supervision level required to keep her safe on 1/11/15.</p> <p>On 7/13/15 at 2:00pm, 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 7/13/15 at 2:00pm, a review of the facility's records indicated the facility's 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</p>			

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W 0249 Bldg. 00	<p>exploitation."</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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 record review and interview, for 1 of 8 clients (client #5), the facility failed to implement client #5's ISP (Individual Support Plan) and BSP (Behavior Support Plan) to ensure staff provided client #5 with staff supervision at the group home based on her identified needs.</p> <p>Findings include:</p> <p>On 7/13/15 at 2:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 01/2015 through 7/13/2015 and indicated the following for client #5:</p> <p>-A 1/12/15 BDDS report for an incident on 1/11/15 at 8:30pm, indicated client #5</p>	W 0249	<p>When the incident happend on 01/11/2015 with client 5 we immediately made a chage to our process when giving her medications. We made a change to her BSP, which was approved by the Human Rights Committee, noting that two staff needed to be present for her med passes. With this, one staff could be focused on the med pass itself and following our medication administration procedures and the other staff would remain focused on client 5, assuring she did not try to take any additional medications. This system seems to be working well for her. An email was sent to all of the Thomas Road staff on 07/24/2015 by the community supports coordinator reminding them the importance of active treatment when working with our clients. This email will be sent to</p>	08/14/2015	

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	"was taken to the [name of Hospital] Emergency Room (ER) on Sunday evening. She had loose stool and some vomiting. Due to her Prader Willi diagnosis (compulsive eating), she does not vomit typically unless there is a problem so [the agency] felt she should get checked out. [Client #5] eventually admitted to the (facility) staff with her at the hospital that while staff were signing the med (medication) book on Sunday morning, [client #5] took a bottle of Vitamin D capsules (for Vitamin Replacement) from the medication cabinet and left the med room. Staff did find the empty bottle of vitamin D to confirm [client #5's] admission. The hospital staff called poison control to seek any guidance they had in regards to an overdose on Vitamin D, ordered lab work, and an X-ray of [client #5's] abdomen." The report indicated "all testing came back within normal limits." The report indicated client #5 was admitted to the hospital overnight for observation and client #5 was released back to the group home the following day. The report indicated client #5's one on one supervising staff was "waiting for [client #5] outside the med room" and indicated client #5's plans were amended to include that client #5's one on one staff was to be with client #5 and the staff who administered medications during each		all group home employees agency wide by the community supports coordinator on 08/14/2015. Group Home Mangers will receive an additional email on 08/14/2015 by the community supports coordinator letting them know that if they have any staff that are not following active treatment practices they need to get with the coordinators to discuss the issues so that proper action can be taken to assure we are providing quality care for our clients. The Thomas Road staff do have thier regulary scheduled house meeting on 08/25/2015. At this meeting the importance of active treatment will be reiterated.	

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	<p>medication administration period.</p> <p>-A 1/13/15 BDDS report for a hospital stay on 1/12/15 and a 1/16/15 Follow Up BDDS report to the incident on 1/11/15 indicated client #5 "does take Vitamin D 3 on a regular basis. Her prescription states that [client #5] will take 5000 IU of Vitamin D 3 daily The bottle that [client #5] took was a new bottle in which only a few pills were missing, so [client #5] took approximately 255 tablets of 2000 IU of Vitamin D 3." The report indicated client #5 was released from the hospital on 1/12/15, "seemed fine at first, but as the day went on, her stomach began to get more distended and she was not feeling well. [Client #5] could not finish dinner, which with her syndrome never happens so she was taken back to the ER and admitted." The report indicated client #5 was released to the group home on 1/15/15 and "doing well." Client #5's 1/13/15 BDDS report indicated "staff will have their eyes on [client #5] during medication" administration times and two staff will remain in the medication room with client #5 to ensure client #5's plans were implemented.</p> <p>Client #5's record was reviewed on 7/13/15 at 6:30pm. Client #5's 7/1/15 BSP and 7/2015 ISP both indicated client #5 had the "maladaptive behavior" of</p>			

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	<p>obsessive compulsive disorder, and behavioral issues. "Due to [client #5's] diagnosis of Prader Willi, [client #5] has been known to break into the locked refrigerator and cabinets at her family home along with the group home and consume uncooked food. By her consuming these uncooked foods, [client #5] ended up in the hospital with food poisoning a couple of times while residing in the family home. The cabinets and refrigerator/freezer at [client #5's] family home have always had locks and at times, security alarms in place to try and help deter [client #5] from getting foods that could be detrimental to her health...." Client #5's BSP indicated she had taken food to consume from the trash, garbage, taken money from others, and/or items found inside, outside, and on the ground. Client #5's BSP and ISP both indicated she was to have direct eye sight supervision by facility staff while outside her bedroom at the group home. Client #5's 3/4/15 and 6/2015 "Physician's Order" indicated "Vitamin D3 5000 IU, take 1 tab (tablet) by mouth daily for Vitamin replacement."</p> <p>On 7/13/15 at 3:00pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated client #5 had taken the bottle of pills without staff knowledge. The CSC</p>			

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W 0368 Bldg. 00	<p>indicated client #5 was not supervised according to client #5's identified needs when client #5 was able to successfully remove a bottle of prescription medication from the medication cabinet inside the medication room with a staff member present. The CSC indicated client #5 was not provided with her identified supervision level required to keep client #5 safe on 1/11/15. The CSC indicated client #5's one on one staff were waiting for her outside the medication room and now client #5 will have two staff in the medication room with her during medication administration to ensure staff had eyes on client #5 when outside client #5's bedroom.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview, for 1 of 1 client (client #8), the facility failed to ensure medications were administered according to physician's order for client #8.</p> <p>Findings include:</p>	W 0368	Our Medication Administration Handbook was updated and redistributed to all group home employees on May 8, 2015. They took a competency test on proper procedures and this was turned in to our agency nurse on May 22, 2015. All Thomas Road employees were included in this.	08/20/2015

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	<p>On 7/13/15 at 2:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 01/2015 through 7/13/2015 and indicated the following for client #8:</p> <p>-A 6/22/15 BDDS report for an incident on 6/21/15 at 7:00am indicated "Staff called [the administrator] on Sunday morning to let me know that they had passed another peer's Klonopin (for behaviors) to [client #8]."</p> <p>Client #8's record was reviewed on 7/15/15 at 10:00am. Client #8's 6/9/15 "Physician's Order" did not indicate the prescribed medication of Klonopin.</p> <p>On 7/13/15 at 3:00pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated client #8's Physician's Orders was not followed when medication were given in error.</p> <p>On 7/15/15 at 9:40am, a record review was conducted of the facility's policy and procedures, 5/8/2015 "Medication Administration by Staff," which indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the</p>		<p>Since this time, we did have another medication error in which a client received a medication that they should not have. An email was sent to all Thomas Road employees on 07/24/2015 by the community supports coordinator reminding them of the importance of staying focused and following all of our medication administration procedures during each and every medication pass. An email will be sent to all group home employees agency wide on 08/14/2015 reminding them as well that they are in need of making sure that with each medication pass they are following the proper procedures they were trained to do in order to assure the health and safety of our clients. Our medication administration policy and the competency test will be redistributed to all Thomas Road employees on 08/14/2015 and they will be asked to read the policy, complete the test, and have this turned in to the Community Supports Coordinator by 08/20/2015. These tests will be reviewed and if anyone appears to be struggling with the concepts discussed in the policy, they will meet one on one with one of our agency nurses to get further re-training. Thomas Road employees do have a regularly scheduled staff meeting on 08/25/2015 where the importance of proper medication administration will be reviewed</p>				

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	<p>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 7/15/15 at 9:40am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN indicated client #8 should not have been given another client's prescribed medication. The CSA/RN indicated the facility staff should administer medications according to Core A/Core B medication administration training. The CSA/RN indicated this medication was given in error of her physician's order.</p> <p>On 7/15/15 at 9:40am, 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>		again.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2015

FORM APPROVED

OMB NO. 0938-0391

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