

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2011
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN46783		
(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 investigation of complaint #IN00097762.</p> <p>Complaint #IN00097762: Substantiated, Federal and State deficiencies related to the allegation(s) are cited at W149, W153, W155 and W156.</p> <p>Dates of Survey: October 20 and 21, 2011.</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>Provider Number: 15G543 AIM Number: 100245390 Facility Number: 001057</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 11/7/11 by Chris Greeney, Medical Surveyor Supervisor and 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.

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W0149	<p>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, the facility failed to ensure direct care staff (DCS) followed their Handling Abuse and Neglect policy for 1 of 3 sampled clients (client A) as indicated in 1 of 3 Bureau Of Developmental Disabilities Services (BDDS) reports reviewed.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/20/11 at 3:00 P.M. including the BDDS reports for the time period between 9/20/11 and 10/20/11. The reports indicated the following:</p> <p>A BDDS report dated 9/29/11 for an incident on 9/22/11 at 3:00 P.M. indicated "On Thursday 9/22/11, [Name of DCS #1] was witnessed to pick up [client A] on the group home transit while loading to return to the group home at the end of the day. [DCS #1] apparently wanted [client A] to sit in another seat so he picked her up under the armpits, carried her to the back seat and sat her in the seat. [Client A] was then sitting in the outer seat, and [DCS #1] was witnessed to shove her over to the side closer to the window. During that time the staff witnessing this</p>	W0149	<p>Our organization does have an Abuse and Neglect Policy, and as of recently, we have a new policy implemented entitled Reporting Reasonable Suspicion of a Crime. We did have an incident where one of our staff did handle a situation appropriately, to where it was reported he physically moved one of our clients during a time that any type of Crisis Intervention Techniques were not warranted. When it was brought to the Community Supports Coordinator's attention that this incident happened, this staff was suspended immediately for 5 days while we did our investigation into his actions and his interactions with our clients. This staff was suspended on 09/29/2011, and was brought back in to meet with us on 10/06/2011 to discuss the findings of our investigation. During our investigation, while we do feel that something occurred on the vehicle that was uncalled for, we didn't feel that was abusive in nature, and in our investigation with all of his co-workers, nobody else had ever seen him touch a client in any fashion that was not in a joking manner. In our meeting with the staff on 10/06/2011 he was released back to work, but he was counseled on assuring that</p>	10/21/2011	

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	<p>event heard a loud thump and is unsure if this could have been a body part of [client A's] hitting the side of the transit or not. [Client A] was crying during this event. When the coworker (DCS #2) asked DCS #1 about this, he (DCS #1) just stated [client A] was crying because he was talking with her. DCS #2 made a verbal report right after the incident to the assistant manager (AM)." The report indicated the AM did not report the incident to the administrator immediately, and DCS #1 was not suspended immediately.</p> <p>A Follow-up BDDS report dated 10/8/11 for the incident on 9/22/11 indicated "... [DCS #1] had been inappropriate, but not abusive." He had wanted (client A) to sit in a different location, because (client A) kicks the driver's seat and DCS #1 is very distracted by this while he is driving the transit. DCS #1 picked her up and moved her to another seat, when she refused to move on her own. DCS #1 was retrained, and put on probation for three months. The AM and and the group home manager (GM) were both given written corrective actions for not reporting immediately.</p> <p>The agency policy: Handling Client Abuse, Neglect, Injuries of Unknown Origin & BDDS incident Reporting dated 11/1/10 was reviewed on 10/21/11 at 9:00</p>		<p>at no time should he be physically restraining any of our clients in any fashion unless it is written in their behavior plan to do so and the situation warrants it. Specific examples were given and talked about when it could be used and when it could not. In the meeting the staff still noted that he never put his hands on her at all the day, but did demonstrate a clear understanding of what we discussed. Our organization did an annual Prevention of Abuse and Neglect training which was led by our Community Supports Director and our Community Supports Associate Director. At this training, both our Abuse and Neglect policy and our Reporting Reasonable Suspicion of a Crime policy was went over with all of our Community Supports Staff. These trainings were held on 10/12/2011, 10/13/2011, 10/17/2011, and 10/21/2011. All Community Support staff were required to attend one of the training sessions. The Group Home Managers and Coordinators will continue to watch for any inappropriate behavior or interactions from our staff, and will address these immediately to assure the safety of our clients.</p>		

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	A.M.. and indicated the following: "Suspected Abuse, Neglect, or Mistreatment: Any suspected abuse (improper treatment), neglect (failure to provide appropriate care, food, medical care, or supervision), or mistreatment must be immediately reported... In the event of suspected abuse, neglect or mistreatment of a client by staff of other individuals, the facility will assure that the staff or other individuals do not have contact with the client until the situation is resolved and there is no risk to the client...Reportable Incidents, as defined the Bureau of Developmental Disability Services (BDDS), are any event characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual, or death to an individual. If an employee or agent of Pathfinder Services, Inc. witnesses such an incident, they are required to inform their supervisor and / or the client's QMRP immediately. The supervisor and / or QMRP will then determine if the incident is reportable to BDDS based on the standards detailed in Indiana code 460 IAC 6-9-5. If the incident is determined to be reportable, then the supervisor or QMRP will complete a BDDS Incident Report through Indiana's online incident reporting system. If the person witnessing the incident serves the client as a case			

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	<p>manager, then they are to report the incident themselves. If the incident involves abuse, neglect or exploitation, the report must be copied to Adult Protective Services (APS) or Children Protective Services (CPS). All incident reports must be copied to the client's case manager if he/she has one. Additionally, all incident reports must be copied to the client's supervising program coordinator (Community Integration and Community Supports).</p> <p>The Community Supports Coordinator (CSC) was interviewed on 10/20/11 at 3:45 P.M.. When asked about the facility policy, the CSC stated, "Our policy is to not use any CPI (Physical Intervention) unless it is warranted. No, in this situation the staff did not follow policy."</p> <p>9-3-2(a)</p> <p>This federal tag relates to complaint #IN00097762.</p>				

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W0153	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to immediately report an allegation of staff mistreatment/abuse for 1 of 3 sampled clients (client A) to the administrator and to the Bureau Of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/20/11 at 3:00 P.M. including the BDDS reports for the time period between 9/20/11 and 10/20/11. The reports indicated the following:</p> <p>A BDDS report dated 9/29/11 for an incident on 9/22/11 at 3:00 P.M. indicated "On Thursday 9/22/11, [Name of DCS #1] was witnessed to pick up [client A] on the group home transit while loading to return to the group home at the end of the day. [DCS #1] apparently wanted [client A] to sit in another seat so he picked her up under the armpits, carried her to the back seat and sat her in the seat. [Client A] was then sitting in the outer seat , and</p>	W0153	<p>One of our staff witnessed an incident that she was not comfortable with and reported this to the assistant manager on duty on 09/22/2011. The assistant manager didn't seem to comprehend from what the staff said that it was a big issue, so she merely sent an email to the group home manager, who did not receive her email until the next day. In what the assistant manager had written, the group home manager was unclear on what occurred so she emailed the staff who made the initial report to get clarification. By the time group home manager got the response and emailed the incident to the Coordinator it was a week after the actual incident occurred. As soon as the Coordinator became aware of the incident on 09/29/2011, the staff in question was suspended for 5 days, an investigation was started, and a BDDS report was submitted. The staff who witnessed the incident did what she needed to do, and reported it to her supervisor immediately upon returning on the house. The process seemed to stray from our written policy when the Assistant Manager</p>	10/21/2011	

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	<p>[DCS #1] was witnessed to shove her over to the side closer to the window. During that time the staff witnessing this event heard a loud thump and is unsure if this could have been a body part of [client A's] hitting the side of the transit or not. [Client A] was crying during this event. When the coworker (DCS #2) asked [DCS #1] about this, he (DCS #1) just stated [client A] was crying because he was talking with her. [DCS #2] made a verbal report right after the incident to the assistant manager (AM)." The report indicated the AM did not report the incident to the administrator immediately.</p> <p>A Follow-up BDDS report dated 10/8/11 for the incident on 9/22/11 indicated "... [DCS #1] had been inappropriate, but not abusive." He had wanted (client A) to sit in a different location, because (client A) kicks the driver's seat and DCS #1 is very distracted by this while he is driving the transit. DCS #1 picked her up and moved her to another seat, when she refused to move on her own. DCS #1 was retrained, and put on probation for three months. The AM and and the group home manager (GM) were both given written corrective actions for not reporting immediately.</p> <p>The Community Supports Coordinator (CSC) was interviewed on 10/20/11 at 3:45 P.M.. When asked about the incident</p>		<p>failed to call the Group Home Manager and the Coordinator with the concern. The Coordinator spoke with both the manager and that assistant manager on 09/29/2011 and they were counseled on the importance of reporting any incidents of suspected abuse, neglect, or mistreatment immediately. We also spoke about the importance of doing this reporting through phone rather than through email so that they could assure that the other person gets the information immediately. Our organization did an annual Prevention of Abuse and Neglect training which was led by our Community Supports Director and our Community Supports Associate Director. At this training, both our Abuse and Neglect policy and our Reporting Reasonable Suspicion of a Crime policy was went over with all of our Community Supports Staff. These trainings were held on 10/12/2011, 10/13/2011, 10/17/201, and 10/21/2011. All Community Support staff were required to attend one of the training sessions. It was specified numerous times while going over our policies that when you see something that you feel is possible abuse, neglect, or mistreatment of our clients that this must be reported immediately to your supervisor and then to the Coordinator of the site so action can be taken immediately and the proper reports filled out. The</p>		

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	<p>being reported to the administrator and BDDS timely, the CSC stated, "We reported it as soon as we were aware of the incident." The CSC indicated the AM had not fully comprehended the situation at the time DCS #2 had reported it to her, and that had caused some of the delay in reporting.</p> <p>9-3-2(a)</p> <p>This federal tag relates to complaint #IN00097762.</p>		<p>Group Home Managers and Coordinators will continue to watch for any inappropriate behavior or interactions from our staff, and will report these immediately to assure the safety of our clients.</p>		
W0155	<p>The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview, the facility failed to take action to prevent the potential for further mistreatment/abuse for 1 of 3 sampled clients (client A) after an allegation of staff mistreatment/abuse was reported, by failing to take immediate measures to protect individuals during the investigation.</p>	W0155	<p>One of our staff witnessed an incident that she was not comfortable with and reported this to the assistant manager on duty on 09/22/2011. The assistant manager didn't seem to comprehend from what the staff said that it was a big issue, so she merely sent an email to the group home manager, who did not receive her email until the</p>	11/18/2011	

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	<p>Findings include:</p> <p>Facility records were reviewed on 10/20/11 at 3:00 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time period between 9/20/11 and 10/20/11. The reports indicated the following:</p> <p>A BDDS report dated 9/29/11 for an incident on 9/22/11 at 3:00 P.M. indicated "On Thursday 9/22/11, [Name of DCS #1] was witnessed to pick up [client A] on the group home transit while loading to return to the group home at the end of the day. [DCS #1] apparently wanted [client A] to sit in another seat so he picked her up under the armpits, carried her to the back seat and sat her in the seat. [Client A] was then sitting in the outer seat, and [DCS #1] was witnessed to shove her over to the side closer to the window. During that time the staff witnessing this event heard a loud thump and is unsure if this could have been a body part of [client A's] hitting the side of the transit or not. [Client A] was crying during this event. When the coworker (DCS #2) asked DCS #1 about this, he (DCS #1) just stated [client A] was crying because he was talking with her. DCS #2 made a verbal report right after the incident to the assistant manager (AM)." The report indicated the AM did not report the</p>		<p>next day. In what the assistant manager had written, the group home manager was unclear on what occurred so she emailed the staff who made the initial report to get clarification. By the time group home manager got the response and emailed the incident to the Coordinator it was a week after the actual incident occurred. As soon as the Coordinator became aware of the incident on 09/29/2011, the staff in question was suspended for 5 days and an investigation was started. Due to the delay in the information getting to the Coordinator, the suspension was not immediate, and the staff in question did work five more days at the home after the incident in question. Our policy is to suspend immediately while an investigation takes place. Due to the delay in the information getting to the Coordinator about the incident this did not happen. The Coordinator spoke with both the manager and that assistant manager on 09/29/2011 and they were counseled on the importance of reporting any incidents of suspected abuse, neglect, or mistreatment immediately. We also spoke about the importance of doing this reporting through phone rather than through email so that they could assure that the other person gets the information immediately. Our organization did an annual Prevention of Abuse</p>		

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	<p>incident to the administrator immediately. The report indicated the investigation of the incident was not started immediately, and DCS #1 was not suspended immediately.</p> <p>The facility internal investigation documentation dated 9/28/11 was reviewed on 10/20/11 at 3:18 P.M.. The investigation documentation indicated the facility had completed a full and thorough investigation. The staff were interviewed by the facility investigator and by the a local police officer. DCS #1 was suspended on 9/28/11, but he had worked three more shifts in the home between the time of the allegation and the investigation.</p> <p>The Community Supports Coordinator (CSC) was interviewed on 10/20/11 at 3:45 P.M.. When asked about DCS #2 continuing to work until the investigation was started, the CSC stated, "He worked three more shifts, before he was suspended."</p> <p>9-3-2(a)</p> <p>This federal tag relates to complaint #IN00097762.</p>		<p>and Neglect training which was led by our Community Supports Director and our Community Supports Associate Director. At this training, both our Abuse and Neglect policy and our Reporting Reasonable Suspicion of a Crime policy was went over with all of our Community Supports Staff. These trainings were held on 10/12/2011, 10/13/2011, 10/17/201, and 10/21/2011. All Community Support staff were required to attend one of the training sessions. It was specified numerous times while going over our policies that when you see something that you feel is possible abuse, neglect, or mistreatment of our clients that this must be reported immediately to your supervisor and then to the Coordinator of the site so action can be taken immediately and the proper reports filled out. The Group Home Managers and Coordinators will continue to watch for any inappropriate behavior or interactions from our staff, and will report these immediately to assure the safety of our clients. The Coordinators will assure that when an incident of possible abuse, neglect, or mistreatment of our clients is reported that a suspension takes place immediately while an investigation takes place so that the staff has no contact with the clients we serve while the investigation is taking place. An email will be sent to all</p>		

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W0156	<p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed to report the results of an investigation of possible staff abuse involving 1 of 3 sampled clients (client A) to the Bureau of Developmental Disabilities Services (BDDS) and other officials within five working days in accordance with State law.</p> <p>Findings include:</p> <p>Facility records were reviewed on 10/20/11 at 3:00 P.M. including the BDDS reports for the time period between 9/20/11 and 10/20/11. The reports indicated the following:</p> <p>A BDDS report dated 9/29/11 for an incident on 9/22/11 at 3:00 P.M. indicated "On Thursday 9/22/11, [Name of DCS</p>	W0156	<p>Coordinators on 11/18/2011 reminding them of this requirement.</p> <p>There was an incident of possible abuse that was reported on Thursday 09/29/2011 through a BDDS Report. Following we conducted our investigation and met again with the staff on Thursday 10/06/2011. Our follow up incident report for this investigation should have been submitted that same day, on Thursday 10/06/2011, but the follow up was on reported until Saturday 10/08/2011 which was outside of the timeline given in the regulations. An email will be sent to all QDDPs and Coordinators reminding them of the standard that follow up reports must be submitted within 7 days of receiving the correspondence that a follow up report is needed, and that in instances of possible abuse and neglect, that the follow up must be completed and sent in within 5</p>	11/18/2011	

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	<p>#1] was witnessed to pick up [client A] on the group home transit while loading to return to the group home at the end of the day. [DCS #1] apparently wanted [client A] to sit in another seat so he picked her up under the armpits, carried her to the back seat and sat her in the seat. [Client A] was then sitting in the outer seat , and [DCS #1] was witnessed to shove her over to the side closer to the window. During that time the staff witnessing this event heard a loud thump and is unsure if this could have been a body part of [client A's] hitting the side of the transit or not. [Client A] was crying during this event. When the coworker (DCS #2) asked [DCS #1] about this, he (DCS #1) just stated [client A] was crying because he was talking with her. DCS #2 made a verbal report right after the incident to the assistant manager (AM)." The report indicated the AM did not report the incident to the administrator immediately. The report indicated the investigation of the incident was not started immediately, and the DCS #1 was not suspended immediately.</p> <p>A Follow-up BDDS report dated 10/8/11 for the incident on 9/22/11 indicated "...DCS #1 had been inappropriate, but not abusive." He had wanted (client A) to sit in a different location, because (client A) kicks the driver's seat and DCS #1 is</p>		<p>working days from the initial submitted report. This email will be sent by Friday 11/18/2011. To monitor this, when an initial incident report is submitted the coordinator of the site will mark their calendar to note the date that the follow up report is due. If the coordinator has not seen the follow up report by that date, they will check with the QDDP on the due date to assure that it gets completed on time to be in compliance with the reporting standard.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/21/2011
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	<p>very distracted by this while he is driving the transit. DCS #1 picked her up and moved her to another seat, when she refused to move on her own. DCS #1 was retrained, and put on probation for three months. The AM and and the group home manager (GM) were both given written corrective actions for not reporting immediately.</p> <p>An interview with the Community Supports Coordinator (CSC) was conducted on 10/20/11 at 3:45 P.M.. When asked about the outcome of the facility investigation being reported to BDDS within five working days, the CSC indicated the results had not been reported timely.</p> <p>9-3-2(a)</p>				