

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G349	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2016
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1135 E TIPTON ST HUNTINGTON, IN 46750
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey dates: 2/29, 3/1, 3/2, 3/3, 3/4, 3/9, and 3/10/2016.</p> <p>Provider Number: 15G349 Facility Number: 000865 AIM Number: 100244090</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/18/16.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review, and interview, for 3 of 3 sample clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), the governing body failed to exercise operating direction over the facility to ensure maintenance and repairs were completed at the group home for clients #1, #2, #3, #4, and #5.</p>	W 0104	<p>Maintenance Requests have been submitted for all of the noted repairs. In an effort to ensure proper maintenance at other sites, property tours will begin on April 1, 2016. These tours will be completed by May 4th. Necessary repairs will be noted and Maintenance Requests will be submitted. Staff will complete the Residential Monthly Safety Checklist. If repairs are needed, Maintenance Requests will be submitted and the Residential</p>	04/08/2016

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>Findings include:</p> <p>Observations and interviews were conducted at the group home on 3/1/16 from 4:05pm until 6:00pm and on 3/2/16 from 6:00am until 8:10am. Clients #1, #2, #3, #4, and #5 were observed at the group home. On 3/1/16 from 4:35pm until 6:00pm, the following needed repairs were observed with the Residential Manager (RM):</p> <ul style="list-style-type: none"> -The RM stated the kitchen overhead light cover "did not fit the light" fixture and "was dirty." -The RM indicated the kitchen refrigerator had one of two (1 of 2) drawers inside the refrigerator held together with strips of gray duct tape. -The RM stated the kitchen cabinets had a worn finish "throughout" the kitchen, one cabinet was missing a door, and two other cabinet doors were damaged which prevented the doors from closing. The RM indicated the agency was planning to remodel the kitchen area in the next year. -The RM indicated the Women's side bathroom shower was missing the grab bar which exposed two holes in the shower wall. The RM indicated clients #1, #2, and #4 used the women's bathroom shower. -The RM stated the Men's side bathroom had a wall "beside the toilet with four (4) 		Coordinator will monitor the progress of the repairs.	

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	<p>metal screws exposed which stuck one fourth inch out from the wall." The RM indicated the location was where the prior toilet paper holder was attached and the screws were not removed when the holder was changed. The RM indicated the location of the four screws was at waist/knee height when sitting on the toilet.</p> <p>-The RM stated the Men's side bathroom had a four feet (4') area on the wall around the shower of "black mold." The RM indicated the maintenance man had treated the same area for mold in 11/2015.</p> <p>-The RM indicated the Men's side bathroom had damage to the dry wall finish on the corner of the wall near the entrance of the bathroom and the protective corner hard plastic covering was worn and "chipped" to expose a jagged edge at shoulder height. The RM indicated the the same chipped area had a nail exposed which was separated from the wall.</p> <p>-The RM indicated the living room blinds did not close completely. The living room blinds were missing sections and when the blinds were closed sections were missing.</p> <p>On 3/2/16 at 11:00am, an interview with Residential Coordinator (RC) #1 was conducted. RC #1 indicated clients #1,</p>			

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W 0368 Bldg. 00	<p>#2, #3, #4, and #5 lived at the group home. RC #1 indicated the group home was to undergo a remodel in the next year for the kitchen. RC #1 indicated no further information was available for review.</p> <p>On 3/4/16 at 9:10am, an interview with RC #1 was conducted. RC #1 indicated the group home kitchen was scheduled for a remodel in the next year. RC #1 provided maintenance and repair emails for review. RC #1 indicated the E-mails did not address the identified items.</p> <p>9-3-1(a)</p> <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. Based on record review and interview for 1 additional client (client #4), the facility failed to ensure client #4's medications were administered according to physician's orders.</p> <p>Findings include: The facility's reportable and investigative records were reviewed on 2/29/16 at 1:20pm.</p>	W 0368	The Residential Nurse was contacted immediately to ensure the health of the client. This staff went through a retraining with the Residential Nurse. All incidences of medication administration errors are monitored by the Residential Nurse. It is the policy of Pathfinder Services, Inc. to fully train staff in passing medication. If there is a problem in this area, the staff will be re-trained by the Residential Nurse and appropriate disciplinary action will be taken	04/08/2016

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	<p>-A 1/31/16 BDDS (Bureau of Developmental Disabilities Services) report for an incident on 1/30/16 at 5:45am indicated "While passing morning medication, staff got side tracked and had to take a resident to the restroom, after helping her to the restroom staff mistakenly gave [client #4] her roommate's medication...[Client #4] (was given) Synthroid 100mcg (micrograms). As soon as staff realized the error she contacted the residential nurse. The nurse instructed [the staff member] to hold [client #4's] morning dose of thyroid (medication). Staff were also instructed to watch for symptoms like nausea and vomiting for the rest of the day."</p> <p>On 3/4/16 at 9:10am, an interview was conducted with the Residential Coordinator (RC) #1. RC #1 indicated staff should ensure client #4's physician's orders were followed. RC #1 indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. RC #1 indicated staff did not follow physician's orders when client #4 was given her roommate's Synthroid medication.</p> <p>On 3/2/16 at 8:55am, a review was conducted of the facility's 11/13/13</p>				

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W 0369 Bldg. 00	<p>"Dispensing of Medications" and the 5/8/15 "Medication Administration Handbook" policy and procedures which indicated each client's physician orders should be followed.</p> <p>On 3/4/16 at 9:10am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>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 10 medications administered (for client #3) during the morning medication administration, the facility failed to administer medication without error for client #3.</p> <p>Findings include:</p> <p>On 3/2/16 at 6:30am, GHS (Group Home Staff) #1 selected client #3's "Nasonex</p>	W 0369	<p>We, at Pathfinder Services, Inc. require that each staff is trained on the proper procedure when passing medications. Medication Core A & B are requirements of all Direct Support Professionals. Refresher training is done on an annual basis. On February 10, 2016 a Medication Administration refresher with test was given to all Pathfinder Services staff to include those working at the Tipton St. site. A separate re-training regarding the implementation of client goals to</p>	04/08/2016

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	<p>50mcg (micrograms), 2 sprays into each nostril once daily" medication for allergies. GHS #1 uncapped the medication bottle, handed the bottle to client #3, and verbally asked client #3 to administer one (1) spray into each of client #3's nostrils. At 6:53am, GHS #1 indicated she instructed client #3 to administer one spray into each of client #3's nostrils. At 6:53am, client #3's 3/2016 MAR (Medication Administration Record) indicated "Nasonex 50mcg, 2 sprays into each nostril once daily."</p> <p>On 3/3/16 at 10:30am, client #3's record was reviewed. Client #3's 12/21/15 "Physician's Order" indicated "Nasonex 50mcg, 2 sprays into each nostril once daily" medication.</p> <p>On 3/4/16 at 9:10am, an interview was conducted with the Residential Coordinator (RC) #1. RC #1 indicated staff should ensure client #3's physician's orders were followed for client #3's nose spray medication. RC #1 indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. RC #1 indicated staff did not follow physician's orders when two sprays were ordered for each nostril and one spray was administered.</p>		self-administer their medications was completed as well. The Residential Nurse will monitor actual and potential errors that occur within the organization to determine the cause of the errors so that this information is used to prevent future errors.		

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W 0426 Bldg. 00	<p>On 3/2/16 at 8:55am, a review was conducted of the facility's 11/13/13 "Dispensing of Medications" policy and procedures which indicated each client's physician orders should be followed.</p> <p>On 3/4/16 at 9:10am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be administered according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.470(d)(3) CLIENT BATHROOMS</p> <p>The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.</p> <p>Based on observation, record review, and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2, and #3) and 2 additional clients (clients #4 and #5), to ensure the temperature of the water did not exceed 110 degrees Fahrenheit.</p> <p>Findings include:</p>	W 0426	Due to the temperature of the water in the group home being found to be over the acceptable limit, Maintenance Request was submitted and new mixing valves were installed. Each of our group homes have a Monthly Residential Safety Checklist to complete. The temperature is to be checked and documented on this form. Staff are directed to submit a Maintenance	04/08/2016

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	<p>Observations and interviews were conducted at the group home on 3/1/16 from 4:05pm until 6:00pm and on 3/2/16 from 6:00am until 8:10am. Clients #1, #2, #3, #4, and #5 were observed at the group home and clients used the water in the kitchen, women's bathroom, and men's bathroom to wash their hands and rinse dishes. During the observation periods the temperature of the water was observed with the Residential Manager (RM). On 3/1/16 at 5:20pm, client #3 took his dishes to the kitchen sink, turned on the hot water only, steam rose from the sink, and client #3 indicated the water was hot. At 5:20pm, the RM took the water temperature of the kitchen sink which was 119 degrees Fahrenheit. At 5:30pm, the RM took the women's bathroom sink temperature which was 119.8 degrees Fahrenheit. At 5:30pm, the RM took the men's bathroom sink temperature which was 122.8 degrees Fahrenheit. The RM indicated she would call the maintenance department because the water temperature should have been below 110 degrees Fahrenheit. At 6:00pm, the maintenance man arrived at the group home. At 6:00pm, the RM indicated the group home had two hot water heaters; one operated the kitchen and the women's side bathroom and the second hot water heater operated the</p>		<p>Request if the temperature is not acceptable. The Coordinator will monitor both the Monthly Residential Checklist for accuracy as well as the Maintenance Requests to ensure they are completed in a timely fashion.</p>	

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	<p>men's side bathroom.</p> <p>On 3/2/16 at 6:20am, the RM indicated the women's side bathroom was 108.3 degrees Fahrenheit. At 7:00am, the RM indicated the men's side bathroom was 114.5 degrees Fahrenheit. At 7:00am, the RM indicated the kitchen sink was 111.3 degrees Fahrenheit. At 7:00am, the RM indicated the hot water temperature was dropping and hot water should remain below 110 degrees Fahrenheit for clients #1, #2, #3, #4, and #5. The RM indicated clients #1, #3, and #5 could mix 110 degree hot water for safety. The RM indicated she did not believe clients #2 and #4 were able to mix hot water. The RM indicated clients #1, #3, #4, and #5 took their own showers.</p> <p>On 3/2/16 at 11:00am, an interview with the Residential Coordinator (RC) #1 was conducted. RC #1 indicated clients #1, #3, and #5 could mix their own hot water. RC #1 indicated clients #2 and #4 were not able to mix their own hot water. Hot Water Mixing assessments were requested for clients #1, #2, #3, #4, and #5. RC #1 indicated clients #1, #2, #3, #4, and #5 needed an antiscald device to control the temperature below 110 degrees Fahrenheit.</p>			
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	<p>Client #1's record was reviewed on 3/3/16 at 12:05pm and on 3/4/16 at 9:15am. Client #1's 12/10/15 FAT (Functional Assessment Tool) indicated client #1 was able to blend her own water independently. Client #1's 12/10/15 ISP (Individual Support Plan) indicated she needed an antiscald device to control the temperature below 110 degrees Fahrenheit.</p> <p>Client #2's record was reviewed on 3/3/16 at 11:28am. Client #2's 3/3/15 FAT (Functional Assessment Tool) did not indicate client #2's skill regarding her ability to blend her own hot water and indicated she did not recognize danger. Client #2's 3/3/15 ISP (Individual Support Plan) indicated she needed an antiscald device to control the temperature below 110 degrees Fahrenheit.</p> <p>Client #3's record was reviewed on 3/3/16 at 10:30am. Client #3's 3/10/15 FAT (Functional Assessment Tool) indicated client #3 was able to blend his own water independently. Client #3's 3/3/15 ISP (Individual Support Plan) indicated he needed an antiscald device to control the temperature below 110 degrees Fahrenheit.</p> <p>On 3/4/16 at 9:10am, an interview with</p>			

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W 0436 Bldg. 00	<p>the QIDP (Qualified Intellectual Disabilities Professional) and RC #1 was conducted. The QIDP indicated she thought clients #1, #3, and #5 were able to independently mix their own hot water. The QIDP indicated clients #2 and #4's records indicated the client were unable to safely mix their own hot water. The QIDP indicated client #2's record did not include an assessment for client #2's functional ability to mix her own hot water. The QIDP indicated the clients needed an antiscald device to control the hot water temperature below 110 degrees Fahrenheit.</p> <p>9-3-7(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #2), the facility failed to teach and encourage client #2 to wear her prescribed eye glasses.</p> <p>Findings include:</p>	W 0436	On 3/31/16 a retraining was conducted with all Pathfinder Services, Inc. staff regarding the use of adaptive equipment. A list of each group home client's adaptive equipment is maintained electronically. This list is then reviewed by the QDDP and IDT at each quarterly and annual meeting in an effort to determine the necessity	04/08/2016

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	<p>Observations and interviews were conducted at the group home on 3/1/16 from 4:05pm until 6:00pm and on 3/2/16 from 6:00am until 7:10am. Client #2 was observed at the group home and did not wear her prescribed eye glasses. During the observation periods client #2 watched television, looked at a book and magazine, chose an activity of coloring on paper, wrote on paper, dressed, took her medication, pureed food, and thickened her own food with the facility staff. No eye glasses were encouraged. On 3/2/16 at 7:10am, GHS (Group Home Staff) #7 retrieved client #2's prescribed eye glasses from the medication/staff office and prompted client #2 to wear her eye glasses. At 7:10am, GHS #7 indicated client #2's prescribed eye glasses were kept inside the staff/medication office area by the facility staff.</p> <p>On 3/3/16 from 12:30pm until 1:30pm, and on 3/4/16 from 10:50am until 11:25am, client #2 was observed at the facility owned day services and client #2 did not wear her prescribed eye glasses. During both observation periods client #2 sat at a table, leaned forward over the top of her puzzles, kept her face within inches of the puzzle she was completing, and did not wear her prescribed eye glasses.</p>		of a goal for the client regarding the use of the equipment.	

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W 0440 Bldg. 00	<p>Client #2's record was reviewed on 3/3/16 at 11:28am. Client #2's 2/11/16 Visual Assessment indicated client #2 wore prescribed eye glasses to see. Client #2's 3/3/15 FAT (Functional Assessment Tool) and 3/3/15 ISP (Individual Support Plan) indicated client #2 wore prescribed eye glasses to see. Client #2's ISP indicated client #2 did not like to wear her eye glasses and did not include an objective/goal to teach client #2 to wear her prescribed eye glasses.</p> <p>On 3/4/16 at 9:10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and RC #1 was conducted. The QIDP and RC #1 both indicated client #2 wore prescribed eye glasses to see and should have been taught and encouraged to wear her prescribed eye glasses.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 3 of 3 sampled clients (#1, #2, and #3) and 2 additional clients (#4 and #5), to ensure a completed evacuation drill was conducted at least</p>	W 0440	A retraining was conducted with Pathfinder Services, Inc. staff, on the proper procedures and guidelines for evacuation drills. This included the timing of the drills. All Pathfinder Services, Inc. drill forms are	04/08/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G349	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/10/2016
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	<p>every 90 days for the day shift (6:00 AM - 3:00 PM) of personnel.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 2/29/16 at 1:40pm. The review indicated the facility had failed to conduct a complete evacuation drill for clients #1, #2, #3, #4, and #5 for the period before 6/28/15 and after 2/2015 calendar year for the day shift of personnel.</p> <p>An interview with Residential Coordinator (RC) #1 was conducted on 2/29/16 at 1:55pm. RC #1 indicated the day shift of personnel was 6:00am until 3:00pm daily. RC #1 indicated the evacuation drills before 6/28/15 for the day shift were not completed. RC #1 indicated she was unable to locate any further evacuation drills for clients #1, #2, #3, #4, and #5.</p> <p>An interview with RC #1 was conducted on 3/4/16 at 9:10am. RC #1 indicated she was unable to locate any further evacuation drills for clients #1, #2, #3, #4, and #5.</p> <p>9-3-7(a)</p>		<p>maintained electronically. The form contains a schedule of the timeframes in which each drill is to be run. These drills are monitored by the Coordinator on a monthly basis.</p>	