

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G033	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 456 W MARKET ST WABASH, IN 46992
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: 4/29, 4/30, 5/1, and 5/4/2015.</p> <p>Provider Number: 15G033 Facility Number: 000593 AIM Number: 100233370</p> <p>This federal deficiency also reflects state findings in accordance with 460 IAC 9.</p>	W 000		
W 454 Bldg. 00	<p>483.470(l)(1) INFECTION CONTROL</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility failed to implement and teach sanitary methods during client #1's medication administration and clients #1, #2, #3, #4, #5, #6, and #7's dining opportunities.</p> <p>Findings include:</p> <p>1. On 4/29/15 at 3:55pm, Group Home</p>	W 454	<p>W454- Infection Control What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice: 1. A goal will be created and added to #1 Individual Support Plan for education on the proper/sanitary disposal of a medication that is dropped on the floor.2. A goal will be created and added to #1, #2, & #7's Individual Support Plans for sanitary/proper ways of handling food. 3. All staff in home will be trained on Universal</p>	05/24/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G033	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 456 W MARKET ST WABASH, IN 46992
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Staff (GHS) #1 asked client #1 to come to the medication room. GHS #1 selected client #1's "Calcium Antacid" (for nutritional supplement), poured one tablet into the medication cup, and handed the medication to client #1. Client #1 picked up the tablet with her fingers, placed it on her tongue, and the tablet fell from client #1's mouth onto the carpeted floor. Client #1 and GHS #1 looked at each other and GHS #1 prompted client #1 "What are you going to do?" Then client #1 bent over from her chair, picked up the tablet from the floor, and consumed the tablet. GHS #1 stated "Probably should have gotten another pill."</p> <p>Client #1's record was reviewed on 4/30/15 at 8:25am. Client #1's 3/20/15 "Physician's Orders" and 4/2015 MAR (Medication Administration Record) both indicated "Calcium Antacid 1 tablet 3 x (three times) daily" for nutritional supplement.</p> <p>2. On 4/30/15 from 5:30am until 7:20am, clients #1, #2, #3, #4, #5, #6, and #7 were observed at the group home. At 6:10am, client #7 carried a plate of seven (7) waffles from the kitchen counter to the dining room table. GHS #2 and GHS #4 stood in the kitchen and dining rooms. Client #7 touched each</p>		<p>Precautions for sanitary practices/handling of food; disposal of blood; and dropped medication disposal. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: 1. Staff will take the opportunity to educate clients #1, #2, #3, #4, #5, #6, & #7 anytime a medication is dropped on the floor of proper sanitary practices. 2. Staff will inform Res. Mgr. and Nurse, anytime they see a pattern and possible need for a goal from improper Universal Precautions/infection control. 3. Staff will document educating client's #1, #2, #3, #4, #5, #6, & #7 on proper sanitary practices with medications using an informal tracking sheet once a day at med pass. What measures will be put into place or what systematic changes you will make to ensure that the deficient practices does not recur: 1. QIDP will review Clients #1 thru #7 Individual support plans. 2. All staff will be in-serviced on proper disposal of food that has been fingered by client(s) per Universal Precautions/Infection Control Procedure. 3. QIDP will create a goal for Client #1- medication goal to address sanity practice of proper disposal of dropped medications and add to her individual support plan. 4. QIDP</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G033	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 456 W MARKET ST WABASH, IN 46992
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>waffle on the plate with her fingers, licked her fingers between touching each waffle, and selected a waffle from the bottom of the stack on the plate. No staff redirection was observed. At 6:10am, client #7 set the remaining waffles on the plate on the dining room table. At 6:10am, client #2 sat down at the dining room table, put her finger into each waffle on the plate of six (6) waffles, and selected a waffle from the plate. At 6:15am, client #1 touched each of the five (5) remaining waffles on the plate with her finger and selected a waffle to put on her plate. No staff redirection was observed. From 6:15am until 6:55am, clients #3, #4, #5, and #6 sat down at the dining room table, selected their waffles from the plate on the table, and consumed the waffles. No staff redirection was observed.</p> <p>On 5/1/15 at 8:35am, an interview with the Agency Licensed Practical Nurse (LPN) and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The LPN indicated staff should have redirected client #1 and provided a different medication tablet. The LPN and QIDP both indicated client #1 should not have consumed medication which had been dropped on the floor. The LPN indicated clients #1, #2, #3, #4, #5, #6, and #7 should not have eaten</p>		<p>will create goal for Client #1, #2, & #7 -sanitary/dining goal for proper ways to handling and passing foods and add to their Individual support plans.How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place:</p> <p>1. Medication Goal for client #1 will be worked on daily during active treatment and house staff will document on her goal sheet daily.2. Sanitary/Dining Goals for clients #1, #2, #7 will be worked on daily during active treatment and house staff will document on their goal sheets daily.3. Informal tracking sheets will be documented on daily for client's #1-#7 during med pass in the evening. 4. QIDP will review goals and informal tracking sheets monthly. And share any issues or concerns with Res. Nurse. What date will the systematic changes be complete: 1. 05/24/2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G033	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 456 W MARKET ST WABASH, IN 46992
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>waffles handled by other clients with their fingers. The LPN indicated the agency followed Core A/Core B Living in the Community Medication Administration training. The LPN indicated the agency trained the staff to follow "Universal Precautions" for sanitation in Core A/Core B medication administration training.</p> <p>On 5/1/15 at 8:35am, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>On 5/1/15 at 8:35am, the facility's 5/14/12 "Medication Administration Handbook" indicated the facility staff were to follow "Universal precautions" when administering medications.</p> <p>9-3-7(a)</p>			