STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G765	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 08/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	2033 DUNCAN DR 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	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 8/19, 8/20, 8/21, 8/22, and 8/25/2014. Facility Number: 012373 Provider Number: 15G765 AIMS Number: 200993530 Surveyor: Susan Eakright, QIDP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/8/14 by Ruth Shackelford, QIDP.	W000000		
W000130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3), the facility failed to encourage and teach personal privacy when opportunities existed for clients #1, #2, and #3.	W000130	Staff of this group home will be retrained in the procedure of medication administration to insure that privacy is given to residents while receiving their medication. All group home staff of Pathfinder Services will also receive retraining on the medication administration	09/24/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Findings include: On 8/19/14 from 7:27am until 7:50am, client #3 had his morning medication administered by GHS (Group Home Staff) #2 inside the medication administration room. GHS #2 selected, named, and encouraged client #3 to verbalize the reasons for his medications. During client #3's medication administration, clients #1 and #2 walked into and out of the medication administration room. Clients #1 and #2 stood next to the GHS #2 and stood next to the desk watching the medication administration. Client #2 was redirected by GHS #2 one time to leave for client #3's privacy and client #2 left the room. Client #2 returned to the medication room and stood watching without redirection to ensure client #3's privacy. At 7:50am, client #3 took his medications and then GHS #2 and clients #1, #2, and #3 left the medication room. On 8/19/14 from 6:05am until 7:55am, clients #1 and #3 walked into and out of the facility bathroom three times, used the toilet, and did not close the bathroom door. On 8/19/14 from 3:45pm until 6:10pm, client #3 was observed at the group		procedures to insure all group home clients receive privacy during their med pass. Annual and ongoing trainings will occur for all group home staff as reminders of proper medication administration procedure. A co-worker/supervisor will observe a med pass daily to insure that privacy is given during the med pass. Once staff have demonstrated competency, this will extend to observations being done 1 time per week, then every other week. The agency nurses/QDDP's will observe a med pass on at least a monthly basis to insure that procedures are being followed. Formal goals will be written for Clients #1 & #3 for them to work on independently closing the bathroom door giving them privacy. Staff will continue to give verbal reminders until this skill is acquired. If there are other group home residents noted to not close the door when using the bathroom, formal goals will be implemented so that they acquire that skill. Observations will continually be made by all staff at all locations to provide verbal reminders or physical assistance to close the door. This information will be provided to the QDDP so that a formal goal can be written and implemented as needed.	

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	home. At 4:25pm, client #3 used the bathroom with staff assistance and GHS #1 did not close the door. On 8/20/14 at 9:50am, client #1's record was reviewed. Client #1's 12/4/13 ISP (Individual Support Plan) indicated she was not independent with the skill of privacy and using the bathroom. Client #1's ISP indicated a goal/objective to wipe after using the restroom. On 8/20/14 at 9:30am, client #2's record was reviewed. Client #2's 7/16/14 ISP indicated she was not independent with the skill of privacy or bathroom skills. Client #2's ISP indicated a goal/objective to wash her hands after using the restroom. 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 the staff should have taught and encouraged clients #1, #2, and #3 personal privacy when clients used the bathroom and when medications were administered. The CSA/RN indicated staff should use formal and informal opportunities to teach clients personal privacy. 9-3-2(a)			

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W000454	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #1 and #2) and 1 additional client (client #3), the facility failed to ensure clients #1, #2, and #3 used sanitary methods when eating, after toileting, and during medication administration when opportunities existed. Findings include: 1. On 8/19/14 from 3:45pm until 4:25pm, client #2 did not wash her hands. At 4:25pm, client #2 was prompted by GHS (Group Home Staff) #1 to sit at the dining room table, eat an apple with her fingers, and client #2 was not prompted or encouraged to wash her hands before eating. 2. On 8/19/14 from 6:35am until 6:55am, clients #2 and #3 did not wash their hands. From 6:35am until 6:55am, clients #2 and #3 consumed their breakfast of cheerios with milk, toast, and a fried egg. From 6:35am until 6:55am, clients #2 and #3 used their fingers to eat	W000454	All 4 residents of the home will complete the hand washing curriculum to remind them of proper hand washing. Staff of this group home will also be retrained in proper hand washing techniques so that all residents are protected from possible infections. Ongoing training and refreshers will be provided to all group home staff and residents in hand washing. Hand washing posters and verbal prompts will be provided as needed. Co-workers/Supervisors will monitor on a daily basis that handwashing is being completed by residents and staff. Once competency is demonstrated, this observation will be done weekly and then periodically as needed. Community Supports Coordinator will monitor trainings to insure that this is provided on a quarterly basis.	09/24/2014

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	toast, pushed their wet cheerio cereal onto their spoon, and were not prompted or encouraged to wash their hands. 3. On 8/19/14 from 6:05am until 7:55am, client #1 entered and exited the facility's bathroom located off the living room four times and did not wash her hands when she exited the bathroom. 4. On 8/19/14 at 7:27am, client #3 had his morning medication administered by GHS #2 and client #3 was not prompted or encouraged to wash his hands. During client #3's medication administration period, client #3 sorted trash in the uncovered trash can, picked up lint from the floor, handled a dropped pill from the floor, and handled each medication with his fingers before swallowing the medication. On 8/20/14 at 8:20am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN indicated the staff should have taught and encouraged clients #1, #2, and #3 to wash their hands before eating, after using the bathroom, and before medications were administered. The CSA/RN indicated staff were trained during Core A/Core B medication training to follow Universal Precautions.			

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	On 8/20/14 at 8:20am, 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. 9-3-7(a)			