

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: April 23, 24, 25, 26, 27, 30, May 1, and 2, 2012</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP.</p> <p>Facility Number: 001202 Provider Number: 15G617 AIMS Number: 100245670</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on May 7, 2012 by Dotty Walton, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962			
(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			
W0124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on record review and interview for 1 of 2 sample clients (client #1) who received psychotropic medication used for behaviors, the facility failed to ensure client #1's family member/advocate/guardian was informed of risks of the psychotropic medications and the right to refuse the treatment.</p> <p>Findings include:</p> <p>A review of client #1's record was completed on 4/26/12 at 12:40pm. Client #1's 4/11/11 Individual Support Plan (ISP) indicated client #1 had a family member who was his advocate. Client #1's 2/23/12 ISP indicated client #1's family member/advocate was currently his guardian. Client #1's 5/1/11 BSP (Behavior Support Plan) indicated he had targeted behaviors of verbal aggression, physical aggression, invading other people's personal space, disliked waiting for food, and "quite violent." Client #1's 3/19/12 Psychiatric medication review</p>	W0124	<p>What corrective actions(s) will be accomplished for these residents found to have been affected by the deficient practice?A revised behavior plan was completed and signed by the guardian How will you identify other residents have the potential to be affected by the same deficient practice and what corrective action will be take?A new statement is going to placed in all behavior (in the medical section) that states: The team has discussed the use of psychotropic medications for this client and the benefits far outweigh the risks involved. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?The client's behavior plans are reviewed quarterly and annually. The team will be able to discuss the client's psychotropic medication at that time. How the corrective action(s) will be monitored to</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962			
(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>indicated the use of Trazodone (a psychotropic medication used for Episodic Mood Disorder behaviors) 150mg (milligrams) at bedtime, Exelon (a psychotropic medication used for Dementia behaviors) 9.5mg patch once a day, Risperidone (a psychotropic medication used for Episodic Mood Disorder behaviors) 1mg three times a day, and Luvox (a psychotropic medication used for Obsessive Compulsive Disorder behaviors) 200mg once a day. Client #1's record did not indicate if client #1 and his advocate had been notified of the risks, benefits, and the right to refuse treatment prior to the use of the behavioral medications. No documentation of the risks, benefits, or the right to refuse treatment was available for review.</p> <p>An interview with the Program Director/Qualified Mental Retardation Professional (PD/QMRP) and Site Director (SD) was conducted on 5/2/12 at 9:10am. The SD indicated client #1 had a family member who was his advocate when he was admitted 4/2011 and became client #1's guardian. The PD/QMRP indicated client #1 was assessed on admission that he could not give informed consent and did not understand risk versus benefits of his psychotropic medications. The PD/QMRP indicated</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The client will have quarterly and annual meetings where the behavior goals and plans will be reviewed by the entire team. Each team member will sign the plans that they understand the risk versus benefits of psychotropic medications. What is the date by which systemic changes will be completed? 06/01/2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(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>client #1 had signed his ISP 4/11/11 and 5/1/11 BSP on 11/10/11. The PD/QMRP indicated she had not explained the risk and benefits to client #1's family member who was client #1's advocate in 2011 and later his guardian. The PD/QMRP indicated no documentation of the risks, benefits, or the right to refuse treatment was available for review.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962			
(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			
W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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 observation, record review, and interview, for 1 of 3 sample clients (client #1) with a BSP (Behavior Support Plan), the facility failed to implement client #1's BSP when opportunities existed.</p> <p>Findings include:</p> <p>On 4/23/12 from 3:50pm, until 7:05pm, client #1 walked independently throughout the group home with Group Home Staff (GHS) #1, GHS #2, GHS #3, and GHS #4. At 4pm, client #1 walked up to the surveyor and stated "How are ya doing." Client #1 touched the surveyor's hair, arm, and neck without redirection by the facility staff. At 4:27pm, client #1 walked up to the surveyor, stood with his face inches from the surveyor's face, and stated "How are ya doing" without redirection by the facility staff. At 4:30pm, GHS #1 stood across the room from client #1. Client #1 walked up to the surveyor, stood next to the surveyor against her body, wrapped his arm around</p>	W0249	<p>What corrective actions(s) will be accomplished for these residents found to have been affected by the deficient practice?The staff has been retrained on the behavior plan, regarding the client's personal space issues. How will you identify other residents have the potential to be affected by the same deficient practice and what corrective action will be take?If it is found that other residents have personal space needs identified, then the QDDP and IDT will formulate a behavior plan. The behavior plan will be approved by the Human Rights Committee and any guardians. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?The QDDP will complete needed behavior plans and the staff will be trained on them and sign off on a training sheet. How the corrective action(s) will be monitored to ensure the deficient practice</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(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>the surveyor, and began to rub the surveyor's back without redirection by the facility staff. At 4:52pm, GHS #3 was exiting the group home with other clients when client #1 walked up to the surveyor, touched the surveyor's buttocks, and attempted to touch the surveyor's chest area of the body. GHS #3 did not redirect client #1's behavior.</p> <p>A review of client #1's record was completed on 4/26/12 at 12:40pm. Client #1's 4/11/11 and 2/23/12 Individual Support Plan (ISP) indicated a goal/objective to stay one foot (1') away when speaking to others and a 5/1/11 BSP. Client #1's 5/1/11 BSP indicated client #1 had targeted behaviors of invading other people's personal space, and could be "quite violent." Client #1's BSP indicated "To address [client #1's] personal space issues: 1. When [client #1] comes up to and starts to touch you or is way too close simple (sic) say something like: whoa [client #1] you are a little too close and put your hand up. 2. This is generally enough to remind [client #1] not to get too close. When he continues to invade personal space then people are not going to be able to talk to him." Client #1's BSP indicated when he "refuses" redirection, staff should offer a change of activity and prompt client #1 to become involved in an activity.</p>		<p>will not recur, i.e., what quality assurance program will be put into place?The behavior plans will be monitored quaterly and annually for any needed changes.What is the date by which the systemic changes will be completed?June 1, 2012</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(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>An interview with the Program Director/Qualified Mental Retardation Professional (PD/QMRP) and Site Director (SD) was conducted on 5/2/12 at 9:10am. The SD and PD/QMRP both indicated client #1 should have been redirected each time he invaded other people's personal space. The PD/QMRP indicated client #1 does not recognize danger and does not recognize visitors or unknown people. The PD/QMRP indicated client #1's objective/goal and his BSP were not implemented by facility staff when opportunities existed.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962		
(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	
W0262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on observation, record review, and interview, for 1 of 1 sample client (client #1) in the group home with restrictive dining practices employed, the facility's specially constituted committee (HRC) failed to approve client #1's restrictive dining plan prior to implementation.</p> <p>Findings include:</p> <p>On 4/23/12 from 3:50pm until 7:05pm, and on 4/24/12 from 5:25am until 7:40am, client #1 sat at the dining room table during supper on 4/23/12 and breakfast on 4/24/12 with a facility staff next to him. During both observation periods client #1 was provided an empty plate with no food. During both observation periods the facility staff next to client #1 filled the plate in front of the staff person with pureed food for client #1. During both meal observations client #1 was given a single bite (teaspoonful) of food to consume before staff provided client #1 another bite to eat onto client #1's plate. Client #1 was prompted by the</p>	W0262	<p>What corrective actions(s) will be accomplished for these residents found to have been affected by the deficient practice?The dining protocol has been added to the client's behavior plan. The plan has been approved by the IDT, guardian and the Human Rights Committee. How will you identify other residents have the potential to be affected by the same deficient practice and what corrective action will be take?When a client is identified to have dining needs that are restrictive in nature, then a dining protocol will be added to the client's behavior plan. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?The QDDPs will review all behavior plans that have restrictive measures, in place, with the Human Rights Committee and guardians. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality</p>	06/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>facility staff to set his spoon down on the table between each bite, clap his hands twice, and prompted to drink fluid between bites.</p> <p>A review of client #1's record was completed on 4/26/12 at 12:40pm. Client #1's 4/11/11 Individual Support Plan (ISP) indicated a 5/11/11 dining skill goal to slow down while eating with three verbal prompts and physical assistance. Client #1's dining goal "Rationale: [client #1] will eat his meal extremely fast and then want more immediately, could be a choking risk...Task analysis: 1. Consistency of diet: Pureed. 2. Consistency of liquid: Regular. 3. 1:1 (one on one) supervision/assistance, upright for all oral intake and stay upright for twenty minutes for all oral intake. 4. Provided plate to plate with pureed material by presenting approximately 2 (two) ounces of pureed material on the plate at a time. 5. To encourage a slower rate of feeding provide verbal cues for client to put utensil on the table and complete a strategy such as clapping his hands twice before picking up utensil for additional presentation of pureed. 6. Encourage liquid intake following 2 to 3 presentations of pureed food...8. Encourage client to sip versus gulp by providing verbal cues at meal. Do not allow client to have additional</p>		<p>assurance program will be put into place?The Human Rights Committee will meet quarterly to ensure all behavior plans are reviewed and approved.What is the date by which the systemic changes will be completed.June 1, 2012</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962			
(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>presentation until he has taken a drink...Barriers: A history of bad eating habits and severe mental retardation." Client #1's 8/22/11 "Dysphagia/Dining Protocol" indicated client #1 was at risk because he "eats rapidly and does not chew properly" and indicated the same protocol stated in client #1's 5/11/11 dining skill goal. Client #1's 9/5/11 "Choking Risk Assessment" signed by the Registered Dietician indicated client #1 was at a "High Risk" for choking and recommended the 5/11/11 dining goal rationale.</p> <p>Client #1's 5/1/11 BSP included the targeted behavior of verbal aggression, physical aggression, disliked waiting for food, and could be "quite violent." Client #1's BSP did not include client #1's restrictive dining plan for plate to plate presentation of food. No HRC consent for client #1's plate to plate presentation of food was available for review.</p> <p>An interview with the Program Director/Qualified Mental Retardation Professional (PD/QMRP) and Site Director (SD) was conducted on 5/2/12 at 9:10am. The PD/QMRP and the SD both indicated client #1's plate to plate presentation of food was not reviewed by the HRC. The PD/QMRP indicated she had not identified client #1's plate to plate</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(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>presentation of food as a restrictive practice. The PD/QMRP indicated client #1 did not have access to his food.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962		
(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	
W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on record review and interview for 1 of 2 sample clients (client #1) living in the group home with psychotropic medication in his Behavior Support Plan (BSP), the facility's specially constituted committee (HRC) failed to ensure the BSP was consented to by client #1's family advocate/guardian prior to implementation.</p> <p>Findings include:</p> <p>A review of client #1's record was completed on 4/26/12 at 12:40pm. Client #1's 4/11/11 Individual Support Plan (ISP) indicated client #1 had a family member who was his advocate. Client #1's 2/23/12 ISP indicated client #1's family member/advocate was currently his guardian. Client #1's 5/1/11 BSP indicated he had targeted behaviors of verbal aggression, physical aggression, invading other people's personal space, disliked waiting for food, and could be "quite violent." Client #1's 3/19/12 Psychiatric medication review indicated the use of Trazodone (a psychotropic medication used for Episodic Mood</p>	W0263	<p>What corrective actions(s) will be accomplished for these residents found to have been affected by the deficient practice?A revised behavior plan was completed. It was approved and signed by the guardian and the Human Rights Committee. How will you identify other residents have the potential to be affected by the same deficient practice and what corrective action will be take?The QDDPs will ensure all advocate, health care representative and/or guardian information is up to date. This will ensure that all necessary paperwork will be approved by the correct person. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?The client's general information will be updated annually or as needed to ensure the most current data is available. A functional assessment will also be completed to determine whether or not a client needs someone to advocate for them. How the corrective action(s) will be monitored to</p>	06/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962			
(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>Disorder behaviors) 150mg (milligrams) at bedtime, Exelon (a psychotropic medication used for Dementia behaviors) 9.5mg patch once a day, Risperidone (a psychotropic medication used for Episodic Mood Disorder behaviors) 1mg three times a day, and Luvox (a psychotropic medication used for Obsessive Compulsive Disorder behaviors) 200mg once a day. Client #1's BSP did not include a consent from client #1's family member/advocate who became his guardian for the use of client #1's psychotropic medications. The HRC consented to the plan on 11/10/11 without consent from the family member/advocate who became client #1's guardian.</p> <p>An interview with the Program Director/Qualified Mental Retardation Professional (PD/QMRP) and Site Director (SD) was conducted on 5/2/12 at 9:10am. The SD indicated client #1 had a family member who was his advocate when he was admitted 4/2011 and became client #1's guardian. The PD/QMRP indicated client #1 was assessed on admission that he could not give informed consent. The PD/QMRP indicated client #1 had signed his ISP 4/11/11 and 5/1/11 BSP on 11/10/11. The PD/QMRP indicated she had not sent client #1's BSP to his family member who was client #1's advocate in 2011. The PD/QMRP</p>		<p>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The client's information will be updated during their quarterly and annual meetings to ensure all advocate data is current.What is the date by which the systemic changes will be completed?June 1, 2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(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>indicated she had not sent client #1's BSP to that person since becoming client #1's guardian to sign. The PD/QMRP indicated she should have ensured written consent was obtained from the guardian.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962			
(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			
W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review, for 1 of 1 client (client #1) with an identified medical need, the facility's nursing services failed to ensure client #1's sunburn was identified, assessed, and treated.</p> <p>Findings include:</p> <p>On 4/23/12 from 3:50pm until 7:05pm, client #1 was observed with a bright red sunburn covering the top of his bald head. At 4:15pm, client #1 stated "Yeah it hurts, I can't wear my hat." Client #1 stated "It's sore too." At 6:30pm, client #1 and Group Home Staff (GHS) #1 both indicated client #1 had went to the Special Olympics on Saturday (4/21/12) outside and had gotten sunburned on top of his bald head. GHS #1 stated "It was a cold cloudy day and he still got burned." GHS #1 stated "No sunscreen" had been applied on client #1 on 4/21/12. At 6:45pm, GHS #1 provided a review of client #1's 4/2012 MAR (Medication Administration Record) and stated "We did not apply sunscreen and should have." Client #1's 4/2012 MAR did not indicate the use of sunscreen, did not identify</p>	W0331	<p>What corrective actions(s) will be accomplished for these residents found to have been affected by the deficient practice?The nurse completed a sunburn protocol for the client. The staff have been trained on the new sun burn protocol. The protocol teaches staff how to deal with the client's skin sensitivity to sun. How will you identify other residents have the potential to be affected by the same deficient practice and what corrective action will be take? The nurse provided training information to all staff regarding the importance of applying sunscreen to clients even when the sun is not visibly present. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur?High risk plans will be put in place for client's who have skin sensitivity to the sun How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?The high risk plans are reviewed and updated as</p>	06/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(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>client #1 had a sunburn, and did not indicate a treatment for client #1's sunburn.</p> <p>On 4/26/12 at 12:40pm, client #1's record was reviewed. Client #1's 4/11/11 and 2/12/12 ISP (Individual Support Plan) indicated client #1 had diagnoses which included, but were not limited to, Diabetes Mellitus, Dementia, Hypertension, Aspirin Therapy (for Atrial Fibrillation), and picking his skin. Client #1's 1/26/12 "Physician Orders" indicated medications of Metformin (for Diabetes) and the use of psychotropic medications for behaviors. Client #1's record did not indicate he had a sunburn on the top of his head.</p> <p>On 4/26/12 at 12:40pm, the Agency Nurse provided client #1's 4/21/12 at 3pm incident which indicated "Mild Sunburn. Client was at a Special O (Olympics) event and got a sunburn. Suggestions to avoid reoccurrence: Apply Sunscreen. Comments: House Manager re educated staff about using sunscreen even when the sun is not out."</p> <p>On 5/2/12 at 9:10am, an interview was conducted with the Agency Nurse and the Site Director (SD). The Agency Nurse and SD both indicated staff should have applied sunscreen to client #1 before</p>		<p>needed and during annual meetings. The staff are trained on basic first aid through agency provided trainings. What is the date by which the systemic changes will be completed? June 1, 2012</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G617	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/02/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
---	--

(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>going outside for the day at the Special Olympics and did not. The Agency Nurse stated "It's taught in basic first aid class to use sunscreen on a regular basis. [Client #1] is fair skinned, on psychotropic medications, Aspirin Therapy, a diabetic, and bald. [Client #1] should have had sunscreen on" and did not. The Agency Nurse stated "The incident report recorded [client #1's] sunburn," and she was not aware if relief creams were applied to soothe client #1's sunburn.</p> <p>9-3-6(a)</p>			