

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G491	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/13/2014
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534
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(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	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 7, 10, 12, and 13, 2014.</p> <p>Facility number: 001005 Provider number: 15G491 AIM number: 100245050</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 12/1/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000454	<p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were administered to 1 of 4 sampled clients (#3) with proper infection control methods to avoid spreading sources and transmission of</p>	W000454	<p>Staff have been retrained in proper infection control while passing medications. Staff will follow the proper infection control procedure when passing medications for all clients. Initially the manager will make observations of staff during medications administration</p>	12/13/2014

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>infections.</p> <p>Findings include:</p> <p>On 11/10/14 between 5:45 AM and 7:20 AM, group home observation was conducted. Between 6:28 AM and 6:54 AM, medication administration was observed. At 6:28 AM, DSP (Direct Support Professional) #2 assisted Client #3 with medication administration. DSP #2 used alcohol gel to disinfect her hands and then put latex gloves on. DSP #2 popped all of Client #3's medications into a medication cup when Client #3 was not present. DSP #2 opened the door with her gloves on to let Client #3 into the room. When Client #3 came into the medication room, DSP #2 handed Client #3 each medication from her right gloved hand to Client #3's right hand. DSP #2 asked Client #3 to identify each of her two pills. Client #3 took her medication.</p> <p>On 11/13/14 at 1:12 PM, the facility Administrator indicated DSP #2 did not follow proper infection control methods while assisting Client #3 with her medication administration.</p> <p>9-3-7(a)</p>		<p>several times weekly to assure the procedures are being followed properly. Once it is assured that the procedure is understood and being followed, the manager will make observations several times monthly. Observations will be documented on a monitoring form which will be submitted to the Coordinator for review. Additional observations will be made by professional staff when visiting the location.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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