

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00185515.</p> <p>Complaint #IN00185515-Substantiated, Federal/State deficiency related to the allegation is cited at W154.</p> <p>Survey Dates: 2/16, 2/17, 2/18 and 2/26/16.</p> <p>Facility Number: 001048 Provider Number: 15G534 AIM Number: 100245410</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/3/16.</p>	W 0000		
W 0153 Bldg. 00	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for</p>	W 0153	Reports of injury of unknown	03/30/2016

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>1 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to report an injury of unknown source to state officials (Bureau of Developmental Disabilities Services-BDDS and/or to Adult Protective Services-APS) involving client G in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's 7/13/15 Client Accident/Incident Report indicated on 7/13/15 at 6:00 AM, client G was found to have a bruise and a rug burn on his right hip and knee. The facility's incident report indicated the bruise measured .5 by .5 (inch) and the rug burn measured "2 x (by) 1.5" (inches). The facility's reportable incident reports and/or investigations reviewed from July 2015 to February 2016 indicated the facility did not report the suspicious injury/bruise of unknown source to state officials.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 2/17/16 at 11:00 AM indicated she did not locate a reportable incident report for client G's suspicious injury of unknown source.</p>		<p>source will be reported within 24 hours of incident occurring. All staff will be retrained on how to properly complete an incident report and how to specifically report and investigate an injury of unknown source. Compliance will be monitored continually for each incident as part of normal routine monitoring. The QDDP will monitor each unknown source reported, and will check to see if the followin questions were asked. All reportable incidents of unknown source will include the following information: 1. Who was involved 2. Who were the witnesses interviewed and what were the findings of the interviews. 3. Where did the incident happen 4. Where was each staff when it happened 5. What was the client doing when it happened 6. What were each of the staff doing when it happened 7. How did the incident happen 8. What is the plan to prevent a repeat of the incident The QDDP will review EACH incident report for compliance that the above questions are asked and answered.</p>		

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W 0154 Bldg. 00	<p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 4 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct an investigation and/or a thorough investigation for allegations of abuse, neglect and/or injuries of unknown source involving clients A, C and G.</p> <p>Findings include:</p> <p>1. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's 2/8/16 reportable incident report indicated "Bruise of unknown origin was found on Left inner elbow area that was 3/4 inches by 1/2 inch. The Upper bicep area consisted of a bruise of 1/2 inch on left arm. The right fore arm area had a bruise the size of 1/4 (quarter). These are being investigated as they are of unknown origin. To note, [client C] does bruise easily due to being on aspirin for circulation."</p>	W 0154	<p>Reports of injury of unknown source will be reported within 24 hours of incident occurring. All staff will be retrained on how to properly complete an incident report and how to specifically report and investigate an injury of unknown source. Compliance will be monitored continually for each incident as part of normal routine monitoring. The QDDP will monitor each unknown source reported, and will check to see if the following questions were asked. 1. Who was involved 2. Who were the witnesses interviewed and what 3. Where did the incident happen 4. Where was each staff when it happened 5. What was the client doing when it happened 6. What were each of the staff doing when it happened 7. How did the incident happen 8. What is the plan to prevent a repeat of the incident</p>	03/24/2016	

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	<p>The facility's 2/9/16 Client Accident/Incident Report indicated facility staff found a bruise on client C's right knee on 2/9/16 which was 2 by 2 1/2 in size. The facility's investigation indicated "Unknown how bruises happened. [Client C] bruises easily due to her age, thin skin and being on aspirin. Investigation outcome was that bruise happened between 8pm on feb. (February) 8th to 6am on feb. 9th. A padded barrier was added around the kitchen table leg, where [client C] likes to sit at the table. This was added as a precautionary measure." The facility's investigation indicated 6 facility staff were interviewed and no additional clients were interviewed in regard to client C's injury. The facility's 2/9/16 investigation did not include how client C received the injuries to her upper arm on 2/8/16.</p> <p>Interview with (Qualified Intellectual Disabilities Professional) QIDP #1 and #2 on 2/18/16 at 12:10 PM indicated they had investigated client C's 2/8/16 injuries of unknown source. QIDP #1 and #2 indicated all the staff were interviewed in regard to the client's injuries and they did not know how the client received the injuries. QIDP #1 stated none of the staff admitted to "pulling the client up by her</p>			

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	<p>arms" when assisting the client to stand. QIDP #2 indicated she did not question staff on how they assisted the client to ambulate as the client had a gait belt. QIDP #1 and #2 indicated no clients were interviewed in regard to client C's 2/8 and/or 2/9/16 injuries of unknown source.</p> <p>2. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's 10/25/15 reportable incident report indicated "[Client A] was eating lunch without incident until she began her fruit for dessert. [Client A] was attempting to eat her fruit without chewing when she started to make squeaking noises and staff realized she was choking. Staff asked if she needed help and [client A] nodded. Staff did the heimlich maneuver and [client A] spit out an unchewed piece of fruit. Staff then cut the remaining fruit into smaller pieces and [client A] finished her lunch without incident. [Client A] has a dining plan but when she chooses not to chew food, sometimes will still choke, depending on the food. Staff constantly remind [client A] to chew but she will often refuse. Staff will continue to follow the dining plan and monitor [client A] when she is eating." The facility's 10/25/15 reportable incident</p>			

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	<p>report and/or facility's 2/15 to 2/16 investigations indicated the facility did not conduct an investigation in regard to the 10/25/15 choking incident for possible neglect as the reportable incident report did not indicate if staff were seated next to the client, prompted the client to chew and/or followed client A's dining plan as written. The facility's reportable incident report did not indicate how many staff were working/present when client A choked on 10/25/15 to ensure the group home was sufficiently staffed to monitor the clients.</p> <p>Client A's record was reviewed on 2/17/16 at 11:30 AM. Client A's undated Choking/Dining Protocol indicated client A had incidents of choking in the past (3/18/09, 1/23/09 and on 8/11/13). The client's dining plan indicated "...Staff will sit with [client A] at the dinner table during meals. All meats and sandwiches will be cut into bites for [client A] and staff will encourage her to put the eating utensil down between bites. Staff will give cues to swallow food prior to taking drinks and chew thoroughly. Staff may use gentle verbal prompting such as slow down and chew thoroughly...."</p> <p>Interview with QIDP #1 and #2 on 2/18/16 at 12:10 PM indicated they did not conduct a formal investigation in</p>			

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	<p>regard to client A's 10/25/15 choking incident. QIDP #1 and #2 indicated they thought a staff person was next to the client when she choked. QIDP #1 indicated only 2 staff were working at the time of the choking incident.</p> <p>3. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's 7/13/15 Client Accident/Incident Report indicated on 7/13/15 at 6:00 AM, client G was found to have a bruise and a rug burn on his right hip and knee. The facility's incident report indicated the bruise measured .5 by .5 (inches) and the rug burn measured "2 x (by) 1.5" (inches). The facility's internal incident report indicated client G's mother was called and interviewed as the client had returned from a home visit. The facility's internal incident report indicated client G's mother indicated the client been outside in the shed crushing cans by himself. The facility's internal incident report did not indicate how the mother indicated the client received the injuries as the incident report did not indicate client G fell down. The facility's internal incident reports and/or investigations from 2/15 to 2/16 indicated the facility did not conduct a thorough investigation in regard to the client's suspicious injuries of unknown source.</p>			

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	<p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 on 2/17/16 at 11:00 AM indicated the facility documented its investigation on the internal incident report.</p> <p>4. The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's 7/13/15 internal Client Accident/Incident Report indicated a bruise was found on client C's "lower bicep-right arm" which measured as .5 by .5 inch. The facility's internal incident report indicated in the section entitled "Suggestions to avoid reoccurrence" indicated "use (sic) gait belt. Do not help up by arm." The incident report indicated the origin of injury was known. The facility's internal incident report indicated in the Comments section "same (sic) exact type of bruise as last reported. Same arm, about same size. Looks like someone helped [client C] up by arm instead of gait belt." The facility's 7/13/15 internal incident report and/or the facility's investigations reviewed from 2/15 to 2/16 indicated the facility did not conduct a thorough investigation in regard to client C's injuries as the investigation did not indicate who was interviewed and/or include any recommendations.</p>			

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W 0159 Bldg. 00	<p>Interview with QIDP #1 on 2/17/16 at 11:00 AM indicated she did not locate any documented investigation in regard to client C's injuries of unknown source.</p> <p>This federal tag relates to complaint #IN00185515.</p> <p>9-3-2(a)</p> <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 2 of 4 sampled clients (A and C) and for 1 additional client (E), the Qualified Intellectual Disabilities Professional (QIDP) failed to monitor clients' programs in regard to assessing clients for the need for a clothing protector, and/or to ensure the use of a sound monitor was incorporated into a client's fall plan.</p> <p>Findings include:</p> <p>1. During the 2/18/16 observation period between 6:00 AM and 8:15 AM, at the group home, a sound monitor sat on a end table located in the living room.</p>	W 0159	<p>On 3-25-16, the QDDP and nurse reviewed all of Client C's incident reports and there were no reports of Client C falling out of bed. Therefore Client C does not need to use a sound monitor during the night to monitor falling out of bed. Client C's Fall Risk plan was reviewed on 3/25/16 and it was noted by the QMRP and nurse that a sound monitor was not added because there was no need of a sound monitor. Note: the sound monitor is used for another client in the home and the client's Risk Plan was reviewed on 3/15/16 and use of a sound monitor is mentioned in her Risk Plan. The QDDP and nurse will continually review each clients Fall Risk Plans on a quarterly or as needed basis for</p>	04/01/2016	

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	<p>Interview with staff #3 on 2/18/16 at 7:15 AM indicated the sound monitor in the living room was for client C. Staff #3 indicated the sound monitor was to alert staff when the client got up at night so staff could assist the client. Staff #3 indicated client C had a history of falls.</p> <p>Client C's record was reviewed on 2/17/16 at 1:30 PM. Client C's undated Fall Prevention Plan indicated client C had a history of falls. The risk plan indicated "...[Client C] has limited mobility. She cannot move quickly, especially at when awoke (sic) at night. [Client C] takes medications which can alter her blood pressure and make her drowsy. [Client C] has a balance problem while standing, walking and with changing gait patterns when walking through a doorway...." Client C's undated fall plan did not indicate client C had a history of falling out of bed at night. Client C's undated risk plan and/or 1/26/16 Individual Support Plan (ISP) did not indicate a sound monitor was to be utilized to monitor client C at night to prevent falls.</p> <p>Interview with the Qualified Intellectual Disabilities Professional (QIDP) #1 and #2 on 2/18/16 at 12:10 PM indicated the monitor in the living room was for client</p>		<p>needs of updating methods of protection. The QDDP and nurse will continually review each client's incident reports for needs of monitoring falls. All staff were trained on 3-30-16 on the use of clothing protectors and on the use of the sound monitor. Eating Assessments have been updated for each of the group home clients to assess the need for a clothing protector. Results showed that only one client is in need of a clothing protector. A clothing protector will only be used for clients that have been assessed to have need of a clothing protector. The QDDP will continually monitor compliance during monthly morning and evening meal observations. Staff have been trained on who needs to use a clothing protector. The use of a clothing protector will be based on eating assessments completed yearly for each client.</p>		

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	<p>C. QIDP #1 indicated it was used due to client C's falling out of bed in her bedroom. QIDP #1 and #2 indicated they thought the use of the monitor was part of client C's fall risk plan.</p> <p>2. During the 2/16/16 observation period between 4:40 PM and 6:30 PM, at the group home, clients A and E had spaghetti, salad, garlic bread and fruit cocktail for dinner. Clients A and E did not wear a clothing protector when they ate their dinner meal. Clients A and E did not have any spillage on their shirts.</p> <p>During the 2/18/16 observation period between 6:00 AM and 8:15 AM, at the group home, staff #3 placed a clothing protector on clients A and E at the dining room table before they ate their breakfast. Clients A and E's breakfast consisted of biscuits and gravy, milk and juice. Clients A and E did not have any spillage on their shirts.</p> <p>Client A's record was reviewed on 2/17/16 at 11:30 AM. Client A's 1/12/16 ISP and/or record did not indicate client A required the use and/or needed a clothing protector.</p> <p>Client E's record was reviewed on 2/19/16 at 12:10 PM. Client E's 9/29/15 ISP and/or record did not indicate client</p>				

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W 0186 Bldg. 00	<p>E required the use and/or need for a clothing protector.</p> <p>Interview with staff #1 on 2/18/16 at 8:35 AM stated client A wore a clothing protector "Probably to protect clothes. She can get a lot of spillage. [Client E] does not require one."</p> <p>Interview with QIDP #1 and #2 on 2/18/16 at 12:10 PM indicated clients A and E had not been assessed for the need for a clothing protector. QIDP #1 indicated the facility staff had the clients put on a clothing protector to not get food on their work clothes.</p> <p>9-3-3(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and for 3 additional clients (E, F and G), the facility failed to ensure sufficient staff worked to meet the</p>	W 0186	The QDDP has reviewed all Risk Plans and Incident Reports and concluded that when there are two or more clients in the home with gait belts at least three staff need to be actively working in the home during each shift. The	04/01/2016			

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	<p>needs of the clients.</p> <p>Findings include:</p> <p>During the 2/18/16 observation period between 6:00 AM and 8:15 AM, at the group home, there were 2 staff (staff #2 and #3) present in the group home with clients A, B, C, D, E, F and G. At 6:25 AM, a third staff came in (staff #1). Staff #1 spent the majority of their time in the office area and did not assist/participate in direct care of the clients from 6:25 AM to 6:55 AM, when the first day shift staff came in. During the above observation period, clients B, C and G wore gait belts and required staff to be near them/hold the gait belts when the clients ambulated/walked. Client B ambulated with a roller walker. Facility staff had to hold the gait belt and assist client B with her walker. Client B had an unsteady gait and the client's legs were wobbly when walking. During the 2/18/16 observation period, Upon arrival to the group home, staff #3 was in the kitchen assisting client F in cooking the breakfast meal while staff #2 was assisting clients to get up and get dressed for the day. Client C was sitting in a recliner chair in the living room with her feet up/elevated and client G was sitting at a small table in the dining room coloring. Client A was sitting on the couch in the living room.</p>		<p>house manager will work as a direct care staff whenever a third staff is not available and when there is need for extra staffing in the home or on community outings. The house manager and Assistant Director will continually monitor the staffing schedules. The QDDP will continually review incident reports to monitor if falls are occurring because of insufficient staffing. The QDDP will monitor client goal progress monthly and compare unmet objectives to insufficient staffing reports. The QDDP will include her findings for each client in their monthly reports. The Assistant Director will review these reports monthly. During evacuation drills, the clients who use gait belts will be provided a wheelchair to assist with quicker and safer evacuations. The QDDP will continually monitor evacuation drills for failure to evacuate within 3 minutes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
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	<p>At 6:10 AM, staff #2, who was assisting client B in the bathroom, left client B in the bathroom with the door open. Staff #2 walked to the other side of the house to awaken client E. Staff #2 when going through the living room, prompted client A to return to the couch to sit down. Client A had stood up to go to the dining room table. Client B was dressed and sitting on the toilet. Client B leaned forward and bent over to tie her shoe strings. Client B's walker was to the side but in front of the client. Client B was unsteady when she leaned forward and bent over as the client's hands/arms made a waving motion when she attempted to bend over. No staff was present in the bathroom with client B. Once staff #2 was finished working with client E, staff #2 returned to the bathroom where client B was. Client B was sitting on the toilet waiting for the staff to return. Facility staff #2 physically assisted client B to stand and held client B's gait belt as client B walked to the dining room table. Client A stood and walked over to the dining room table and stood there. Staff #2 walked over to client A and physically assisted client A to sit down at the table. Staff #2 then physically assisted client G to stand and walk to the dining room table utilizing the client's gait belt while staff #3 was in the kitchen with client F finishing up breakfast and client D was</p>			

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	<p>talking to staff #2. Staff #3 verbally prompted client D, who was independent in ambulation, to leave the kitchen and to have a seat in the living room. Client D did not leave the kitchen and continued to talk with staff #2. Staff #3 then assisted client G to stand to walk to the back of the house to wash his hands. Client C remained sitting in the recliner chair in the living room with her feet up/elevated. At 6:19 AM, staff #3 went into the living room to assist client C to stand up. Staff #3 put the recliner's footrest down and pressed a button which lifted the chair up and forward to allow client C to stand up. Staff #3 then utilized client C's gait belt to physically assist the client to walk to the dining room table to sit down. The dining room had 2 dining tables and one staff sat at each table. At 6:45 AM, client A was finished eating her breakfast. Staff #2 was assisting client G to serve himself more biscuits and gravy when client A went to stand up and staff #2 stated "If done, wait for me." Client A stood still until staff #2 came to walk with the client to the kitchen to place her dishes in the sink. Client A then started to walk toward the back of the house. Staff #3 verbally prompted client A to sit down on the couch until everyone was finished eating. Client A told staff #3 she had to use the bathroom. Client A went to the back bathroom and returned quickly</p>			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
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	<p>to the couch and sat down. Clients G and C were assisted to stand and to go back to their rooms by staff #3 as staff #2 stayed in the dining room/kitchen areas. Client B continued to sit at the table waiting for staff to assist her to walk into the kitchen to take her dishes from 6:45 AM to 6:55 AM when staff #4 came in and got the client up from the table. After which, client B was physically assisted to sit on a low seated exercise bike which the client could use with her legs. At 7:20 AM, client B stopped and announced she was done. Staff #2 was in the kitchen assisting with clean up, staff #3 was reading letters to client G and staff #4 was at the back of the house with client C. At 7:30 AM, staff #3 brought client B her walker and assisted the client to stand up and ambulate to the couch in the living room. Client B required one on one staff to stand/ambulate from one area to another.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's internal incident reports, reportable incident reports and/or investigations indicated the following (not all inclusive):</p> <p>-1/14/16 "[Client C] was sitting in the recliner at home. Staff was in the kitchen</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
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	<p>and looked up and [client C] was standing alone in the living room. Staff called to her to stand still and hurried to her, but she fell backwards and hit her head on the floor before staff could arrive to her. Staff was able to assist [client C] to an upright position. She received a bump to the back of her head approximately the size of a quarter...Her risk plan will be updated to include when [client C] is sitting in her recliner, the foot rest will be utilized as a safety measure so [client C] will ask for assistance before getting out of the chair...."</p> <p>-12/5/15 Client A got up too fast from a seated position and fell in the dining room causing a "rug burn" to the client's Left knee cap.</p> <p>-7/20/15 "[Client B] was in her room for the evening, sitting on her bed. She apparently dropped a paper on the floor and slid off the bed to get it. She fell and hit her left buttock on the wheel of her walker, causing a scrape on her skin. She did not alert staff to her needs and did not tell them that she fell. Her roommate told staff that [client B] was on the floor when [client D] went into the room. [Client B's] fall plan states that she will ask staff for help when needing to get up or ambulate due to unsteady gait, even</p>			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
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	<p>with her walker. [Client B] did not alert staff or ask for assistance...[Client B] has been reminded numerous times to ask for help from staff when she needs to get up or get something off of the floor. [Client B] struggles with remembering to call for staff as needed." The reportable incident report indicated the incident occurred at 9:00 PM.</p> <p>-3/23/15 "[Client B] was in the restroom on the toilet when staff [staff #5] stepped out to ask [staff #1] what sort of help [client B] needed in the bathroom. When staff returned [client B] was on the floor on her hands and knees." In the section entitled "Suggestions to avoid reoccurrence" indicated "Staff should stay in the bathroom with [client B] at all times."</p> <p>The facility's fire drills were reviewed on 2/17/16 at 10:38 AM. The facility's fire drills indicated the following (not all inclusive):</p> <p>-1/14/16 The facility had a fire drill at 6:00 PM. The report indicated "We only 2 staff and 3 clients that need their gate (sic) belts and have walkers. [Client C] refusing to get up and pushing herself backwards in the chair. [Client B] use (sic) her new walker and it took a long time to get her out of the house. [Client</p>			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
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	<p>G] had to sit in his chair until one of us got done with the other 2 clients that needed our help." The Comments section indicated "[Client C] has been refusing to get up and go to our safe spot for our drills to the point that she has pulled staff backwards because we have our hand holding onto her gatebelt (sic) trying to get her to stand up and move to the designated areas. We cannot push [client B] to walk any faster that what she is capable of which at a slow pace."</p> <p>-12/20/15 The facility had a fire drill at 1:00 PM. The report indicated in the Comments section "Was challenging with gate (sic) belts and only 2 staff."</p> <p>-9/20/15 The facility had a fire drill at 1:34 PM. The report indicated "Hard to get the clients out safe when we have a walker and 4 gait belts." The fire drill report indicated 2 staff worked at the time of the drill.</p> <p>-6/21/15 The facility had a fire drill at 12:15 PM. The report indicated 5 clients were present during the fire drill with 2 staff. The report indicated in the Comments section "If all 8 clients were present we would have needed 3 staff due to the fact [client C] needed to staff to help her to the mailbox."</p>						

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
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	<p>Client A's record was reviewed on 2/17/16 at 11:30 AM. Client A's 12/1/15 Quarterly Physician Review indicated client's A's diagnoses included, but were not limited to, Spasticity and Hemiplegia (weakness of the left side of the body). Client A's 1/12/16 Individual Support Plan (ISP) indicated client A had a history of falls as the client had a risk plan for falls.</p> <p>Client C's record was reviewed on 2/17/16 at 1:30 PM. Client C's 1/26/16 ISP indicated client C had a history of falls. The ISP indicated "...[Client C] will utilize foot rest in the up position in her recliner for her safety and not staff's convenience...[Client C] will always have a gait belt on during waking hours and will always be a one on one assist at home. Depending on her stability at home, she may also need to be a two person assist as well...."</p> <p>Client B's record was reviewed on 2/17/16 at 2:34 PM. Client B's 3/11/15 ISP indicated client B's diagnoses included, but were not limited to, Hereditary Spastic Paraplegia and Cerebral Palsy. Client B's undated Fall Risk Prevention Protocol indicated "...She currently walks with the aid of a walker, leg braces, and she uses a gait belt. [Client B] had an electric cart</p>			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
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	<p>(wheelchair) that is left at [name of day program]. [Client B's] parents state she falls frequently at home without injuries...." Client B's undated risk plan indicated "...Staff must utilize the gait belt at all times. [Client B] will use the walker at all times. Staff will walk next to her with standby assist when walking and when going up and down any inclines or curbs...."</p> <p>Confidential interview A indicated the group home had been working with 2 staff to 7 clients. Confidential interview A stated there had been an "increase in falls and behavior" at the group home. Confidential interview A stated "Then they want to know why the clients are falling." Confidential interview A indicated 2 staff were not able to meet the needs of the clients. Confidential interview A indicated clients B, C and G required staff physical assistance when ambulating. Confidential interview A indicated the group home had 4 clients who had a gait belt up until 2/1/16 when a client moved/went to program (waiver). Confidential interview A indicated the facility was in the process of trying to get more staff at the group home.</p> <p>Interview with client B on 2/17/16 at 9:12 AM indicated client B required staff assistance when ambulating. When</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
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	<p>asked how many staff worked during the morning shift, client B stated "Two." When asked if two staff were able to meet the needs of the other clients and her, client B stated "Not sure if enough staff."</p> <p>Interview with staff #1 on 2/18/16 at 8:35 AM indicated the facility was short of staff but they were in the process of hiring someone. Staff #1 indicated clients B, C and G required staff to client assistance when they were up ambulating. Staff #1 indicated client B would have to sit and wait until staff could assist her.</p> <p>Interview with QIDP (Qualified Intellectual Disabilities Professional) #1 and #2 on 2/18/16 at 12:10 PM indicated 2 staff worked on the overnight shift and 2 to 3 staff worked when clients were on transport. QIDP #1 and #2 indicated the third staff person had an inservice she needed to attend on 2/18/16 so the facility was short of staff on the morning shift. QIDP #1 and #2 indicated the facility had hired a full time staff to work to ensure 3 staff worked when clients A, B, C, D, E, F and G were at home. QIDP #1 and #2 indicated the new hire still needed to go through the facility's training before working at the group home.</p>			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
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W 0227 Bldg. 00	<p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, interview and record review for 1 of 4 sampled clients (C), the client's Individual Support Plan (ISP) failed to indicate the client had a specific behavioral objective to teach the client to ask for assistance.</p> <p>Findings include:</p> <p>During the 2/16/16 observation period between 4:40 PM and 6:30 PM, at the group home, client C wore a gait belt around her waist and sat in a recliner chair with her legs/feet elevated except to come to the table for her dinner meal. Once client C was finished eating facility staff assisted client C to walk back to her recliner utilizing the client's gait belt. Facility staff assisted the client into the chair and placed the footrest of the recliner into an up position. During the 2/16/16 observation period, client C did not attempt and/or try to get out of the recliner with the footrests up.</p>	W 0227	Client C's Risk Plan has been updated to include how often staff will approach Client C when she is in her recliner (staff are to ask if she is ready to get out of chair) and a limit to how long she is to remain in the chair each time she uses it. Client C will have a new objective to teach her how to ask for help when she is seated in her recliner. The staff will record in daily progress notes how long Client C remains in her recliner and the QDDP will monitor compliance during morning and evening monthly observations and review of goal progress. There were no other clients affected by this deficient practice. The QDDP reviewed other clients Risk Plans on 3-25-16 and none were in need of monitoring use of recliner or other chairs.	04/01/2016	

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	<p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's 1/14/16 reportable incident report indicated "[Client C] was sitting in the recliner at home. Staff was in the kitchen and looked up and [client C] was standing alone in the living room. Staff called to her to stand still and hurried to her, but she fell backwards and hit her head on the floor before staff could arrive to her. Staff was able to assist [client C] to an upright position. She received a bump to the back of her head approximately the size of a quarter...Her risk plan will be updated to include when [client C] is sitting in her recliner, the foot rest will be utilized as a safety measure so [client C] will ask for assistance before getting out of the chair...."</p> <p>Client C's record was reviewed on 2/17/16 at 1:30 PM. Client C's 1/26/16 ISP indicated client C had a history of falls. The ISP indicated "...[Client C] will utilize foot rest in the up position in her recliner for her safety and not staff's convenience...." Client C's 1/26/16 ISP did not include a specific objective to teach the client to ask for help.</p> <p>Confidential interview B indicated client C had a history of falls when she would</p>			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
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W 0262 Bldg. 00	<p>stand and attempt to walk on her own. When asked if client C was able to get out of the recliner on her own, confidential interview B stated "No she is a one person assist, but she could probably get out if she rocked back and forth." Confidential interview B indicated client C's footrest was to be up when the client was sitting in the recliner.</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 and #2 on 2/18/16 at 12:10 PM indicated client C was a fall risk. QIDP #1 and #2 indicated client C was not to be in the recliner for a long period of time. QIDP #1 indicated client C's legs/feet were to be elevated when she was in the recliner due to past falls. QIDP #1 and #2 indicated client C's ISP did not address the client's identified training need.</p> <p>9-3-4(a)</p> <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. Based on observation, interview and record review for 1 of 4 sampled clients (C), the facility failed to ensure its</p>	W 0262	The QDDP updated Client C's Risk Plan on 3-25-16 to include how long she should remain in the recliner. The QDDP has	04/01/2016			

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	<p>Human Rights Committee (HRC) reviewed and/or approved the use of elevating a recliner's footrest to ensure it was not a restraint/violation of a client's rights.</p> <p>Findings include:</p> <p>During the 2/16/16 observation period between 4:40 PM and 6:30 PM, at the group home, client C wore a gait belt around her waist and sat in a recliner chair with her legs/feet elevated except to come to the table for her dinner meal. Once client C was finished eating facility staff assisted client C to walk back to her recliner utilizing the client's gait belt. Facility staff assisted the client into the chair and placed the footrest of the recliner into an up position. During the 2/16/16 observation period, client C did not attempt and/or try to get out of the recliner with the footrests up.</p> <p>The facility's reportable incident reports, internal incident reports and/or investigations were reviewed on 2/16/16 at 2:21 PM. The facility's 1/14/16 reportable incident report indicated "[Client C] was sitting in the recliner at home. Staff was in the kitchen and looked up and [client C] was standing alone in the living room. Staff called to her to stand still and hurried to her, but</p>		<p>implemented on 3-25-16 a new goal for Client C to learn to ask for assistance when she is seated in the recliner. The HRC reviewed and approved Client C's new Fall Risk Plan on 3-25-16 concerning the use of her recliner and its restrictions. The HRC will review Client C's restrictive plan progress at each HRC quarterly meeting. The QDDP will continually monitor Client C's incident reports for incidents concerning the recliner and for staff compliance to following the Fall Plan. Goal progress for Client C's objective to ask for assistance when seated in the recliner will be monitored through review of monthly documentation and by monthly morning and evening observations by the QDDP. The QDDP will record results of compliance in the clients monthly reports. No other clients were affected by this deficiency. The QDDP will continually monitor for compliance and report any deficiencies to the Assistant Director.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016	
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	<p>she fell backwards and hit her head on the floor before staff could arrive to her. Staff was able to assist [client C] to an upright position. She received a bump to the back of her head approximately the size of a quarter...Her risk plan will be updated to include when [client C] is sitting in her recliner, the foot rest will be utilized as a safety measure so [client C] will ask for assistance before getting out of the chair...."</p> <p>Client C's record was reviewed on 2/17/16 at 1:30 PM. Client C's 1/26/16 Individual Support Plan (ISP) indicated client C had a history of falls. The ISP indicated "...[Client C] will utilize foot rest in the up position in her recliner for her safety and not staff's convenience...."</p> <p>Client C's undated Fall Prevention Protocol indicated "...[Client C] has been getting out of the recliner independently at home with recurring falls. While sitting in the recliner, the foot rest will be up for [client C's] safety. Under no circumstances will the foot rest be left up as a restraint or as a convenience for staff...." Client C's 1/26/16 ISP, risk plans and/or record did not indicate the facility had its HRC committee review and/or approve the use of the recliner footrest as a possible restraint since client C was not able to get out of the chair</p>						

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	<p>without staff's assistance.</p> <p>Confidential interview B indicated client C had a history of falls when she would stand and attempt to walk on her own. When asked if client C was able to get out of the recliner on her own, confidential interview B stated "No she is a one person assist, but she could probably get out if she rocked back and forth." Confidential interview B indicated client C's footrest was to be up when the client was sitting in the recliner.</p> <p>Interview with staff #1 on 2/18/16 at 8:35 AM indicated client C sat in her recliner with her footrest up due to edema. Staff #1 stated client C "Used to get out of the chair." Staff #1 indicated she was not sure client C could get out of the chair with her feet elevated/up. Staff #1 stated facility staff knew client C was not to be placed in the chair for staff convenience and/or to be used as a "restraint."</p> <p>Interview with Qualified Intellectual Disabilities Professional (QIDP) #1 and #2 on 2/18/16 at 12:10 PM indicated client C was a fall risk. QIDP #1 and #2 indicated client C was not to be in the recliner for a long period of time. When asked when client C's legs were to be elevated, QIDP #1 stated "At all times when relaxing." QIDP #1 indicated</p>			

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	<p>client C's legs/feet were to be elevated when she was in the recliner due to past falls. QIDP #1 and #2 also indicated client C's legs were to be elevated due to the client's edema in her lower legs/feet. QIDP #1 and #2 indicated the facility's HRC did not review and/or approve the use of the footrests a possible restraint.</p> <p>9-3-4(a)</p>				