

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 05/04/2015
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
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W 000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 4/30, 5/1, and 5/4/2015.</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>	W 000		
W 137 Bldg. 00	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview for 1 of 4 sampled clients (client #4), the facility failed to ensure client #4's clothing was clean and in good repair.</p> <p>Findings include: On 4/30/15 from 12:05pm until 1:12pm, client #4 was observed at the facility</p>	W 137	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? 1. All staff in home and at Community Integration will be in-serviced on protection of client's rights- which include cleanliness, appearance, and dignity of all our clients.</p> <p>How will you identify other residents</p>	06/03/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>owned Day Services Site. Client #4's black sweat shirt had dried food on it from his collar to the front hem of the sweat shirt. Client #4's black sweat shirt had a light green colored substance dried on the front of his black sweat shirt midway between the collar and the hem. At 12:20pm, Day Services Staff (DSS) #1 stated client #4's sweat shirt "was dirty from (client #4 eating) lunch." At 1:00pm, client #4 was prompted to walk to the agency bus with DSS #2. Client #4 got on the bus to leave on a community outing to the local library wearing the same soiled black sweat shirt with dried food on it from the lunch meal.</p> <p>On 4/30/15 at 3:55pm, client #4 arrived to the group home with Group Home Staff (GHS) #2 and GHS #3. Client #4 exited the group home bus wearing the same black sweat shirt with light green colored substance dried on the front of the sweat shirt and rings of dried liquid spills on the front of his sweat shirt. From 3:55pm until 6:20pm, client #4 wore the same soiled sweat shirt and was not prompted or encouraged by staff to change his shirt.</p> <p>On 5/1/15 at 8:45am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 did not</p>		<p>having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>1. All staff in home and at Community Integration will be in-serviced on protection of client's rights- which include cleanliness, appearance, and dignity of all our clients.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>1. Informal tracking sheet will be created and implemented at home and CI for client #4 to ensure his rights are being protected.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1. Res. Mgr will monitor tracking sheet monthly to ensure compliance. 2. QIDP will review tracking sheets monthly to ensure client #4 rights are protected.</p> <p>What date by which the systemic changes will be completed? 6/3/2015</p>	

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W 149 Bldg. 00	<p>have the skill to identify the need to change his shirt when it was soiled. The QIDP indicated client #4 should wear clean clothing daily and while in the community.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 19 BDDS (Bureau of Developmental Disabilities Services) reports reviewed (client #4), the facility neglected to implement its Abuse, Neglect, and/or Mistreatment policy and procedure to immediately report allegations of staff to client mistreatment for client #4 immediately to the administrator and to BDDS in accordance with state law and failed to ensure the client's plan was followed properly to avoid mistreatment of the client.</p> <p>Findings include:</p> <p>On 4/30/15 at 11:16am, the facility's BDDS reports were reviewed and indicated the following:</p>	W 149	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? 1. All staff will be in-serviced on Agency Abuse, Neglect and/or Mistreatment, Policy. 2. All staff will be in-serviced on updated Behavior Support Plan for #4. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1. All staff will be in-serviced on Agency Abuse, Neglect and/or Mistreatment Policy. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur? 1. QIDP has updated client #4 Behavior Support Plan, emphasizing the need for all</p>	06/03/2015

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	<p>-A 2/9/15 BDDS report for an incident on 2/7/15 at 1:15pm indicated client #4 was placed in CPI (Crisis Prevention Intervention - a type of physical restraint intervention) holds during a behavior episode. The BDDS report did not indicate the staff immediately reported the use of restraint on client #4 to the administrator.</p> <p>-A 2/9/15 BDDS report for an incident on 2/1/15 at 1:00pm indicated client #4 was in the kitchen at the group home "attempting to drink Koolaid out of the pitcher and eating food that is not on his pureed diet. When staff asked him to stop and attempted to block him to stop and redirected [client #4] to a different activity he became upset and started to throw items, a toothbrush and rubber bell, and then began to windmill his arms in an attempt to get staff away from him. Staff [GHS (Group Home Staff) #4] attempted to restrain him but he sank to the floor so this was unsuccessful. This outburst lasted 2 minutes. Once [client #4] calmed and complied when asked to get up off the floor and he (was) escorted to his room by [GHS #4 and GHS #5] using HRC (Human Rights Committee) approved transport position restraint to escort [client #4] to his room. Once in his room [client #4] began throwing personal items and attempted to head to</p>		<p>staff to follow plan uniformly-CPI holds are to be used only as a last resort.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? 1. Resident Manager will monitor goal sheets and ABC sheets monthly. 2. QIDP will review goal sheets and ABC sheets monthly. What date by which the systemic changes will be completed? 6/3/2015</p>	

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	<p>roommates side of room. Staff redirected roommate to leave the room and [client #4] began to de-escalate." The report indicated "Staff were trained on [client #4's] BSP (Behavior Support Plan) on 12/19/14...Staff will be trained again on approved CPI holds and BSP for [client #4]." The BDDS report did not indicate the staff immediately reported the use of restraint on client #4 to the administrator.</p> <p>-A 2/28/15 Follow Up BDDS report indicated "Follow up Action: Behavior Support Plan was updated on 2/9/15...(to include) explaining what situation would warrant staff taking something harmful away from [client #4]. Adding underlining that these holds should be used only as a last resort." The follow up BDDS report did not indicate the staff immediately reported the use of restraints on client #4 to the administrator.</p> <p>Client #4's record was reviewed on 5/1/15 at 11:35am. Client #4's 12/2/14 ISP (Individual Support Plan) and 2/9/15 BSP (Behavior Support Plan) indicated the target behavior of Physical Aggression: "[Client #4] will sometimes become physically aggressive if someone tries to take something away from him or takes something he views is his." Client #4's BSP indicated "All staff are trained on state approved Crisis Prevention</p>			

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	<p>Intervention (CPI) holds. These holds are only to be used as a last resort." Client #4's record indicated the use of CPI restraints was documented as a last resort since 2012 in client #4's record. Client #4's 3/20/15 "Physician's orders" indicated he was recommended on a mechanical soft diet. Client #4's record indicated he received a pureed diet at the request of his guardian and because he consumed his food quickly.</p> <p>On 5/1/15 at 12:00noon, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated the CPI is a program used by the facility for client #4 as a "last resort." The QIDP indicated client #4's ISP and BSP program plans documented a behavioral hierarchy and descriptions of holds for staff to use for client #4's behavior management. The QIDP indicated the facility staff failed to follow client #4's BSP in that client #4 should have been offered replacement activities, time to de-escalate before the next request by staff, and staff should have attempted to exchange the items by giving client #4 a different item. The QIDP indicated the staff neglected to immediately report the use of physical restraints on client #4 until 2/9/15. The QIDP stated "I found out by accident," the facility staff had come into the agency</p>			

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	<p>for a meeting and stated "Hey, we had to take [client #4] down" on 4/7/15. The QIDP indicated she began to investigate and discovered client #4 had physical restraints used by the staff twice once on 2/1/15 at 1:00pm and again on 2/7/15 at 1:15pm with no staff recording and reporting of the incidents. The QIDP indicated staff should have reported it immediately to the Administrator and a report should have been reported to BDDS in accordance with state law. The QIDP indicated the staff neglected to follow client #4's plans when they applied physical restraints immediately during his behaviors instead of following his plan. The QIDP stated "the facility staff mistreated [client #4]" when staff used physical restraints on client #4 before his behavior warranted the physical restraints.</p> <p>On 4/30/15 at 11:45am, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated incidents should be immediately reported to BDDS and in accordance with State Law "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 4/30/15 at 11:45am, a review of the facility's records indicated the facility's</p>			

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W 153 Bldg. 00	<p>undated "Handling client Abuse, Neglect, and Injuries of Unknown Origin & BDDS Incident Reporting" policy which indicated "It is Pathfinder Services, Inc. policy to provide a service where clients are free from abuse, neglect, or exploitation. In the event that any of these conditions are suspected, an investigation will immediately be conducted...Any alleged, suspected, or actual abuse-physical, sexual, emotional, or domestic improper treatment, neglect-failure to provide appropriate care, environment, food, medical care, or supervision, exploitation or any other mistreatment must be immediately reported...." The policy and procedure indicated staff should immediately report incidents to the Administrator and to BDDS.</p> <p>9-3-2(a)</p> <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.</p>				

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	<p>Based on record review and interview for 2 of 2 allegations of mistreatment reviewed for client #4, the facility failed to immediately report allegations of mistreatment to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>On 4/30/15 at 11:16am, the facility's BDDS reports were reviewed and indicated the following:</p> <p>-A 2/9/15 BDDS report for an incident on 2/7/15 at 1:15pm indicated client #4 was placed in CPI (Crisis Prevention Intervention - a type of physical restraint intervention) holds during a behavior episode. The BDDS report did not indicate the staff immediately reported the use of restraint on client #4 to BDDS timely.</p> <p>-A 2/9/15 BDDS report for an incident on 2/1/15 at 1:00pm indicated client #4 was in the kitchen at the group home "attempting to drink Koolaid out of the pitcher and eating food that is not on his pureed diet. When staff asked him to stop and attempted to block him to stop and redirected [client #4] to a different activity he became upset and started to throw items, a toothbrush and rubber</p>	W 153	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>1. All staff will be in-serviced on Agency Abuse, Neglect and/or Mistreatment Policy and reporting in timely manner.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>1. All staff will be in-serviced on Agency Abuse, Neglect and/or Mistreatment Policy and reporting in timely manner.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>1. QIDP updated client #4 BSP emphasizing the need to follow plan uniformly-CPI holds are to be used only as a last resort.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1. QIDP will review all accident/incident reports daily and will review goal sheets and ABC sheets monthly.</p> <p>What date by which the systemic changes will be completed? 6/3/2015</p>	06/03/2015			

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	<p>bell, and then began to windmill his arms in an attempt to get staff away from him. Staff [GHS (Group Home Staff) #4] attempted to restrain him but he sank to the floor so this was unsuccessful. This outburst lasted 2 minutes. Once [client #4] calmed and complied when asked to get up off the floor and he (was) escorted to his room by [GHS #4 and GHS #5] using HRC (Human Rights Committee) approved transport position restraint to escort [client #4] to his room. Once in his room [client #4] began throwing personal items and attempted to head to roommate side of room. Staff redirected roommate to leave the room and [client #4] began to de-escalate." The report indicated "Staff were trained on [client #4's] BSP (Behavior Support Plan) on 12/19/14...Staff will be trained again on approved CPI holds and BSP for [client #4]." The BDDS report did not indicate the staff immediately reported the use of restraint on client #4 to BDDS timely.</p> <p>On 5/1/15 at 12:00noon, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #4's ISP and BSP program plans documented a behavioral hierarchy and descriptions of holds for staff to use for client #4's behavior management. The QIDP indicated the staff failed to immediately</p>			

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W 225 Bldg. 00	<p>report the use of physical restraints on client #4 until 2/9/15. The QIDP stated "I found out by accident," the facility staff had come into the agency for a meeting and stated "Hey, we had to take [client #4] down" on 4/7/15. The QIDP indicated she began to investigate and discovered client #4 had physical restraints used by the staff twice once on 2/1/15 at 1:00pm and again on 2/7/15 at 1:15pm with no staff recording and reporting of the incidents. The QIDP indicated staff the restraints should have reported to BDDS in accordance with state law.</p> <p>9-3-2(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #1) who attended facility owned day services, the facility failed to assess client #1's vocational abilities related to his individual work history, work skills, and work interests.</p> <p>Findings include: On 4/30/15 from 12:05pm until 1:12pm,</p>	W 225	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>1. QIDP interviewed client #1 to assess interest in work. 2. QIDP updated client #1 Functional Assessment -Vocational Section to include interview results.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p>	06/03/2015			

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	<p>client #1 was observed at the facility owned day services. From 12:05pm until 1:12pm, client #1 sat in his wheel chair at a table with a book and read.</p> <p>On 5/1/15 at 12:15pm, client #1's record was reviewed. Client #1's 5/28/14 FA (Functional Assessment) and his 5/28/14 ISP (Individual Support Plan) did not include his work history and/or work interests.</p> <p>On 5/4/15 at 12:00noon, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #1 was prompted and offered activities during day services. The QIDP indicated client #1's vocational assessments did not include a work history, work skills, and/or his work interests.</p> <p>9-3-4(a)</p>		<p>1. During clients #1-#7 annual meetings QIDP and ID team will reassess Functional Assessment Tool with emphasis on Vocational section and any interest in employment.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>1.QIDP will set up visit to local Workshop for client #1 to consider interest in working. 2.QIDP will change client #1 schedule to include working at workshop if he shows an interest in employment. 3.QIDP will reassess Vocational Section in Functional Assessment Tool at client #1 annual meeting any interest in employment.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1.Monthly goals will be reviewed by QIDP from workshop if client #1 chooses to work there. 2.QIDP will reassess Vocational Section in Functional Assessment Tool at client #1 annual meetings of any interest in employment.</p> <p>What date by which the systemic changes will be completed? 6/3/2015</p>		

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W 249 Bldg. 00	<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, interview, and record review, for 2 of 4 sampled clients (clients #3 and #4), the facility failed to ensure clients #3 and #4's ISP (Individual Support Plan) and BSP (Behavior Support Plan) were implemented during formal and informal opportunities.</p> <p>Findings include:</p> <p>1. On 4/30/15 at 11:16am, the facility's BDDS reports were reviewed and indicated the following for allegations of abuse, neglect, and/or mistreatment:</p> <p>-A 2/9/15 BDDS report for an incident on 2/7/15 at 1:15pm indicated client #4 was placed in CPI (Crisis Prevention Intervention - a type of physical restraint intervention) holds during a behavior episode.</p> <p>On 5/1/15 at 12:00noon, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility staff</p>	W 249	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>1.Once devise is repaired, All staff will be retrained on client #3 ISP-communication device and goals.</p> <p>2.All staff retrained on PEC picture book use for communication goal in place in client#3; Client #4; client #5 and client #1's ISPs.</p> <p>3.All staff will be retrained on client #4 BSP, and the need for uniform implementation of BSP with CPI holds only as a last resort.</p> <p>4.All staff will be trained on proper securing of sharps key when not using.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>1.All staff will be retrained on Active Treatment and following client's #1-#7 ISP's and BSP's.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient</p>	06/03/2015

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	<p>failed to follow client #4's BSP in that client #4 should have been offered replacement activities, time to de-escalate before the next request by staff, and staff should have attempted to exchange the items by giving client #4 a different item. The QIDP indicated the staff failed to follow client #4's plans when they applied physical restraint immediately during his behaviors instead of following his plan.</p> <p>-A 2/9/15 BDDS report for an incident on 2/1/15 at 1:00pm indicated client #4 was in the kitchen at the group home "attempting to drink Koolaid out of the pitcher and eating food that is not on his pureed diet. When staff asked him to stop and attempted to block him to stop and redirected [client #4] to a different activity he became upset and started to throw items, a toothbrush and rubber bell, and then began to windmill his arms in an attempt to get staff away from him. Staff [GHS (Group Home Staff) #4] attempted to restrain him but he sank to the floor so this was unsuccessful. This outburst lasted 2 minutes. Once [client #4] calmed and complied when asked to get up off the floor and he (was) escorted to his room by [GHS #4 and GHS #5] using HRC (Human Rights Committee) approved transport position restraint to escort [client #4] to his room. Once in</p>		<p>practice does not recur?</p> <ol style="list-style-type: none"> 1.QIDP has contacted company of communication device on instructions to get the machine repaired for client #3. 2.QIDP has contacted Physician that wrote script for communication device, to get a signed letter of diagnosis to accompany device for repair per repair company request. 3.QIDP has contacted the Speech Therapist that recommended the communication device for a letter defining need to accompany device for repairs per repair company request. 4.Once devise is repaired, All staff will be trained on communication device. 5.Continue communication goal documentation as part of client #3 active treatment. 6.QIDP has updated Client #4 Behavior support plan and in-serviced all staff on following it uniformly. 7.Sharps Key will be kept in key cabinet, separated from medication key when not being used. 8.Sharps key will be kept on staff person when being used in the kitchen and then kept in key box when not in use. 9.QIDP has created an informal tracking sheet for all staff to use to document use of communication systems/device (Pec Picture Book; Communication Dynavox; and/or ASL) daily with client #1; #3;#4; & #5. <p>How the corrective action (s) will be</p>				

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	<p>his room [client #4] began throwing personal items and attempted to head to roommate side of room. Staff redirected roommate to leave the room and [client #4] began to de-escalate." The report indicated "Staff were trained on [client #4's] BSP (Behavior Support Plan) on 12/19/14...Staff will be trained again on approved CPI holds and BSP for [client #4]."</p> <p>-A 2/28/15 Follow Up BDDS report indicated "Follow up Action: Behavior Support Plan was updated on 2/9/15...(to include) explaining what situation would warrant staff taking something harmful away from [client #4]. Adding underlining that these holds should be used only as a last resort."</p> <p>Client #4's record was reviewed on 5/1/15 at 11:35am. Client #4's 12/2/14 ISP (Individual Support Plan) and 2/9/15 BSP (Behavior Support Plan) indicated the target behavior of Physical Aggression: "[Client #4] will sometimes become physically aggressive if someone tries to take something away from him or takes something he views is his." Client #4's BSP indicated "All staff are trained on state approved Crisis Prevention Intervention (CPI) holds. These holds are only to be used as a last resort." Client #4's record indicated the use of CPI</p>		<p>monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <ol style="list-style-type: none"> 1. Resident manager will monitor weekly that staff are using the informal tracking sheet to document use of communication materials. 2. Once repaired, QIDP will review goal monthly to ensure communication device is being used. 3. Until communication device is repaired QIDP will review monthly that all staff are using other forms of communication (PEC picture book; ASL) will client #3 at all formal and informal opportunities. 4. Resident Manager will monitor monthly that all staff are using informal tracking sheet for active treatment of communication with clients #1, #3, #4, #5. 5. QIDP will review monthly to ensure informal tracking sheets are being used and documenting active treatment of communication. <p>What date by which the systemic changes will be completed? 6/3/2015</p>	

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	<p>restraints was documented as a last resort since 2012 in client #4's record. Client #4's 3/20/15 "Physician's orders" indicated he was recommended on a mechanical soft diet. Client #4's record indicated he received a pureed diet at the request of his guardian and because he consumed his food quickly.</p> <p>On 5/1/15 at 12:00noon, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP stated the CPI is a program used by the facility for client #4 as a "last resort." The QIDP indicated client #4's ISP and BSP program plans documented a behavioral hierarchy and descriptions of holds for staff to use for client #4's behavior management. The QIDP indicated the facility staff failed to follow client #4's BSP in that client #4 should have been offered replacement activities, time to de-escalate before the next request by staff, and staff should have attempted to exchange the items by giving client #4 a different item. The QIDP indicated she began to investigate and discovered client #4 had physical restraints used by the staff twice once 2/1/15 at 1:00pm and again on 2/7/15 at 1:15pm with no staff recording the use of the restraints. The QIDP indicated the staff failed to follow client #4's plans when they applied physical restraints</p>			

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	<p>immediately during his behaviors instead of following his plan.</p> <p>2. On 4/30/15 from 3:55pm until 6:35pm, on 5/1/15 from 5:40am until 7:40am, observations were conducted at the group home. During the observation periods the medication room door was open and the keys to the locked sharps hung in the same unsecured box on the wall with the medication keys. On 5/1/15 from 5:40am until 7:15am, client #4 walked with out facility staff into and out of the kitchen, opened and closed the kitchen cabinets, opened and closed the kitchen drawers. From 5:40am until 7:15am, the two boxes with sharp items inside were located inside the kitchen cabinet, both boxes were unlocked, and one of the boxes for the secured sharp boxes had the keys hanging from the lock. At 7:15am, client #7 and GHS #6 showed the place where the secured sharps were kept. At 7:15am, client #7 opened the kitchen cabinet and stated "Whoops, that shouldn't be like that." Client #7 relocked both lock sharps boxes, removed the keys from the lock, and replaced the keys inside the medication room box. At 7:15am, GHS #6 stated the keys "should not have been in the lock." GHS #6 indicated the sharps were not kept secure if the boxes were unlocked. GHS #6 indicated client</p>			

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	<p>#4 was unsafe with sharp items and had attempted to hurt himself and other people with sharp objects in the past.</p> <p>Client #4's record was reviewed on 5/1/15 at 11:35am. Client #4's 12/2/14 ISP (Individual Support Plan) and 2/9/15 BSP (Behavior Support Plan) indicated the target behavior of Physical Aggression. Client #4's BSP indicated the sharp objects in the group home should be kept secured because of client #4's past history of using sharp objects as weapons against others.</p> <p>On 5/1/15 at 8:35am, an interview was conducted with the QIDP. The QIDP indicated client #4 required the restriction from access to sharps. The QIDP indicated the sharp boxes should have been locked and were not on 5/1/15 at the group home. The QIDP indicated the staff failed to implement client #4's BSP when opportunities existed.</p> <p>3. On 4/30/15 from 3:55pm until 6:35pm, on 5/1/15 from 5:40am until 7:40am, at the group home, and on 4/30/15 from 1:15pm until 1:45pm, at the workshop, observation and interview were completed with client #3. During the above observation periods client #3 did not have his communication device available to use. On 4/30/15 from</p>						

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	<p>3:55pm until 5:30pm, client #3 pointed to the television sets in different rooms, pointed to remotes, pointed to staff members, and walked from room to room. After several attempts of asking client #3 what he needed, GHS #2 stated "I know" and began to reprogram the living room television. Client #3 smiled. Then GHS #2 asked client #3 "does your television still not work?" Client #3 smiled and shook his head yes. At 5:30pm, GHS #2 indicated she reprogrammed the cable so client #3's television inside his bedroom operated correctly. When asked how she communicated with client #3, GHS #2 stated "Well, we just keep trying different things until we figure out what he wants." During the observation periods client #3 was not encouraged to use a communication talker device. Client #3 was observed to complete cooking skills, pack and unpack his lunch box, consume his meals, complete leisure activities of watching TV, look up recipes, assemble wires at workshop, and sit with other clients. Client #3 pointed with his fingers, made sounds, used facial expressions, and attempted to use finger spelling of partial words to convey his wants and needs. On 5/1/15 at 6:30am, client #3 communicated that his talker communication device was not working and communicated it had been "broken"</p>			

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	<p>most of the winter, before Christmas." Client #3 indicated he preferred to use his talker communication device because it had a voice and indicated it had not been available for him to use. During the observation periods client #3 did not have a picture book and was not encouraged by the facility staff to use a picture book or sign language to communicate his wants and needs.</p> <p>On 5/4/15 at 11:30am, client #3's record was reviewed. Client #3's record indicated a 6/2/10 Speech Therapy progress note which indicated client #3 "becomes frustrated, then agitated when communication attempts fail." Client #3's 7/10/2002 "Hearing/Speech" evaluation indicated client #3 "is able to effectively use his ACC [voice communication] device to communicate needs/wants..." Client #3's 3/15/15 Individual Support Plan (ISP) indicated objectives for client #3 to use sign language, a communication book, and to use phrases on his talker communication device with other people. Client #3's ISP indicated client #3 used an "DynaVox Talking Device" as a communication device. Client #3's 7/28/09 Speech Therapy evaluation indicated a recommendation for the use of sign language.</p>			

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W 331 Bldg. 00	<p>On 5/1/15 at 8:35am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #3 had a DynaVox Talking communication device, the device was broken, and the facility staff should have prompted client #3 to use pictures or sign language to communicate. The QIDP indicated the device had been broken several months and she was trying to have the item repaired.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on interview and record review, for 1 of 4 sampled clients (client #2) with identified medical needs, the facility's nursing services failed to ensure client #2's risk plan included a medical range of client #2's blood pressure and pulse for staff to monitor.</p> <p>Findings include:</p> <p>On 4/30/15 from 3:55pm until 6:35pm, client #2 was observed at the group home. At 5:25pm, GHS (Group Home Staff) #1 administered client #2's oral medications and took his Blood Pressure</p>	W 331	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>1. Residential nurse will update risk plans for Atrial Fibrillation to include a medical range for client #2 blood pressure and pulse. Hypertension risk plan already has the blood pressure range listed on it and will, no need to update.</p> <p>2. All staff will be in-serviced on new risk plan and protocol for when to notify the Res. nurse.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what</p>	06/03/2015

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	<p>(B/P) and pulse on client #2's left wrist while client #2 was sitting down inside the medication room. At 5:30pm, GHS #1 indicated client #2's B/P was 115/78 and pulse was 49 beats per minute. At 5:30pm, GHS #1 indicated the acceptable range for an average person's pulse was 60 to 80 beats per minute. GHS #1 indicated she would take client #2's blood pressure again during the evening. GHS #1 indicated client #2's record had no documented range for his blood pressure or pulse which staff were to monitor was available for review.</p> <p>On 5/1/15 at 6:10am, GHS #6 indicated client #2's pulse was 49 taken at 5:30am on 5/1/15. GHS #6 indicated client #2's pulse and blood pressure had no documented range staff were to monitor. GHS #6 indicated client #2's blood pressure and pulse were documented as taken once on 4/30/15 was available for review.</p> <p>Client #2's record was reviewed on 5/4/15 at 10:40am. Client #2's 4/2015 and 5/2015 MARs (Medication Administration Records) indicated "Pulse, twice daily, monitor pulse twice a day and as needed" and "Blood Pressure, twice daily, monitor blood pressure twice daily in am and pm." Both client #2's Blood Pressure and Pulse did not include</p>		<p>corrective action will be taken?</p> <p>1. All staff will be in-serviced on new risk plan and protocol for when to notify the Res. nurse.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>1. Updated Risk Plans for Atrial Fibrillation to include a medical range for client #2 blood pressure and pulse.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1. Residential Nurse will review MARS monthly.</p> <p>What date by which the systemic changes will be completed?</p> <p>6/3/2015</p>				

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	<p>documented ranges staff were be monitoring on the MARs. Client #2's documented Blood Pressures on the MARs ranged from 95/66 to 139/118. Client #2's documented Pulse ranged from 43 to 82 beats per minute on the MARs.</p> <p>Client #2's 4/8/15 "Hypertension Protocol" indicated "Desired outcome: blood pressure will remain between 100/60 and 130/90" and did not document a pulse range. Client #2's 4/8/15 "Atrial Fibrillation Protocol" indicated "Atrial fibrillation occurs when the hearts two upper chambers beat chaotically and irregularly and are out of coordination with the two lower chambers...Desired outcomes: will be free from s/s (signs and symptoms) of A-Fib...Precursors to the risk: Diabetes." Client #2's Atrial Fibrillation Protocol did not document an acceptable range for client #2's pulse.</p> <p>On 5/1/15 at 8:35am, the Agency Licensed Practical Nurse (LPN) indicated client #2's nursing care plans did not document an acceptable range for client #2's pulse. The LPN indicated client #2's MAR did not have a documented acceptable range for client #2's Blood Pressure and Pulse. The LPN indicated staff had not contacted her regarding</p>			

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W 383 Bldg. 00	<p>client #2's B/P or Pulse ranges. The LPN indicated below sixty (60) beats per minute she should have been called and she was not contacted by the facility staff</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7), the facility staff failed to ensure the medication keys were kept secured and to ensure clients #1, #2, #3, #4, #5, #6, and #7 did not have access to the medication keys.</p> <p>Findings include:</p> <p>On 4/30/15 from 3:55pm until 6:35pm, on 5/1/15 from 5:40am until 7:40am, observations were conducted at the group home. During the observation periods the medication room door was open and the medication keys were inside the unsecured box on the wall.</p> <p>On 5/1/15 from 5:40am until 7:15am, the two sharps boxes were inside the kitchen cabinet were unlocked and one of the</p>	W 383	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>1. Medication keys will be moved and kept locked in a separate combination lock box to ensure client safety when not in use.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>1. All staff will be in-serviced on where the medication keys are to be kept and the protocol for use and storage of medication keys.</p> <p>2. All staff will be in-serviced on Core A/B lesson 3: Principles of Administering Medication. (med. keys should be secured).</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>1. Medication key will be moved and kept locked in a separate</p>	06/03/2015

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	<p>locks had the keys for the secured sharps hanging from the lock. At 7:15am, client #7 opened the kitchen cabinet and stated "Whoops, that shouldn't be like that." Client #7 relocked both secure lock sharp boxes, removed the keys from the lock, and replaced the keys inside the medication room box. At 7:15am, GHS #6 stated the keys were kept inside the same unsecured box inside the medication room with the medication keys. GHS #6 indicated the medication keys were not kept secure and clients #1, #2, #3, #5, #6, and #7 had access to the keys.</p> <p>On 5/1/15 at 8:35am, an interview was conducted with the LPN (Licensed Practical Nurse) and the QIDP (Qualified Intellectual Disabilities Professional). The LPN and the QIDP indicated the medication keys should not have been kept inside the same unsecured box with other keys clients #1, #2, #3, #4, #5, #6, and #7 accessed. The LPN indicated the keys for the medication cart at the group home should be kept secured. The LPN indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>On 5/1/15 at 8:35am, a record review of the facility's undated "Living in the Community" Core A/Core B training for</p>		<p>combination lock box to ensure client safety when not in use.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1. Residential manager will monitor that keys are being locked separately when not in use using an informal tracking sheet: -Once daily for 1 month; -then once weekly for a month; -then once a month for 10 months.</p> <p>Informal tracking will end after 1 year as staff have shown competency of securing medication key away from all other keys during this year.</p> <p>2. Residential Nurse will review informal tracking sheets monthly.</p> <p>What date by which the systemic changes will be completed? 6/3/2015</p>	

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 607 MEADOWDALE DR N MANCHESTER, IN 46962
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W 436 Bldg. 00	<p>medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications keys should be kept secured.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, interview and record review for 1 of 1 sampled client (client #3) who used an adaptive DynaVox (talking device) communication device, the failed to ensure client #3's communication device was in good repair and available for the client to use.</p> <p>Findings include:</p> <p>On 4/30/15 from 3:55pm until 6:35pm, on 5/1/15 from 5:40am until 7:40am, at the group home, and on 4/30/15 from 1:15pm until 1:45pm, at the workshop, observation and interview were completed with client #3. During the observation periods client #3 did not have his communication device available</p>	W 436	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <ol style="list-style-type: none"> 1. QIDP is in the process of getting the Communication devise repaired. 2. QIDP has contacted the physician for documentation of need as part of the repair process. 3. QIDP has contacted the Speech Therapist that recommended the Dynaovx for supporting documentation needed for repair. <ol style="list-style-type: none"> 1.All staff will be retrained on client #3 ISP-communication device and goals once repaired. 2.All staff retrained on PEC picture book use for communication goal in place in client#3; Client #4; client #5 and client #1's ISPs. 	06/03/2015

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	<p>to use. On 4/30/15 from 3:55pm until 5:30pm, client #3 pointed to the television sets in different rooms, pointed to remotes, pointed to staff members, and walked from room to room. After several attempts of asking client #3 what he needed, GHS #2 stated "I know" and began to reprogram the living room television. Client #3 smiled. Then GHS #2 asked client #3 "does your television still not work?" Client #3 smiled and shook his head yes. At 5:30pm, GHS #2 indicated she reprogrammed the cable so client #3's television inside his bedroom operated correctly. When asked how she communicated with client #3, GHS #2 stated "Well, we just keep trying different things until we figure out what he wants." During the observation periods client #3 was not encouraged to use his a communication talker device. Client #3 was observed to complete cooking skills, pack and unpack his lunch box, consume his meals, complete leisure activities of watching TV, look up recipes, assemble wires at workshop, and sit with other clients. Client #3 pointed with his fingers, made sounds, used facial expressions, and attempted to use finger spelling of partial words to convey his wants and needs. On 5/1/15 at 6:30am, client #3 communicated that his talker communication device was not working and communicated it had been "broken</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>1. All staff will be retrained on PEC picture book use for communication goal in place in client #3; Client #4; client #5 and client #1's ISPs.</p> <p>1. Staff will use ever formal and informal opportunity to train clients #3, #4, #5, and #1 on communicating their wants and needs as well as advocating their rights.</p> <p>2. QIDP will use the Functional Assessment Tool for current and new clients to assess and ensure needs of clients are met.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>1. QIDP has contacted company of communication device on instructions to get the machine repaired for client #3.</p> <p>2. QIDP has contacted Physician that wrote script for communication device, to get a signed letter of diagnosis to accompany device for repair per repair company request.</p> <p>3. QIDP has contacted the Speech Therapist that recommended the communication device for a letter defining need to accompany device for repairs per repair company request.</p> <p>4. All staff will be retrained on communication device once repaired.</p> <p>5. Continue communication goal</p>	

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	<p>most of the winter, before Christmas." Client #3 indicated he preferred to use his talker communication device because it had a voice and indicated he had not been available for him to use. During the observation periods client #3 did not have a picture book and was not encouraged by the facility staff to use a picture book or sign language to communicate his wants and needs.</p> <p>On 5/4/15 at 11:30am, client #3's record was reviewed. Client #3's record indicated a 6/2/10 Speech Therapy progress note which indicated client #3 "becomes frustrated, then agitated when communication attempts fail." Client #3's 7/10/2002 "Hearing/Speech" evaluation indicated client #3 "is able to effectively use his ACC [voice communication] device to communicate needs/wants..." Client #3's 3/15/15 Individual Support Plan (ISP) indicated objectives for client #3 to use sign language, a communication book, and to use phrases on his talker communication device with other people. Client #3's ISP indicated client #3 used an "DynaVox Talking Device" as a communication device. Client #3's 7/28/09 Speech Therapy evaluation indicated a recommendation for the use of sign language.</p>		<p>documentation as part of client #3 active treatment.</p> <p>6. Informal tracking sheet will be created by QIDP for all staff to use to document use of communication device (Pec Picture Book; Communication Dynavox; and/or ASL) daily with client #1; #3; #4; & #5.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1. Resident manager will monitor monthly that active treatment with communication device for #3 is being done by staff once device is repaired.</p> <p>2. Resident manager will monitor monthly that staff are using the informal tracking sheet to document use of communication device during formal and informal opportunities.</p> <p>3. QIDP will review goal monthly to ensure communication device is being used after repaired.</p> <p>4. QIDP will review monthly to ensure informal tracking sheets are being used during formal and informal opportunities.</p> <p>What date by which the systemic changes will be completed? 6/3/2015</p>	

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W 440 Bldg. 00	<p>On 5/1/15 at 8:35am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #3 had a DynaVox Talking communication device, the device was broken, and the facility staff should have prompted client #3 to use pictures or sign language to communicate. The QIDP indicated the device had been broken several months and she was trying to have the item repaired.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 3 additional clients (clients #5, #6, and #7) living in the group home, the facility failed to conduct quarterly evacuation drills for the 7:00am-3:00pm and 11:00pm-7:00am shifts of personnel.</p> <p>Findings include:</p> <p>On 4/30/15 at 11:40am, a review of the facility's evacuation drills from 4/2014 through 4/30/2015 was conducted. The review indicated the facility had failed to</p>	W 440	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice?</p> <p>1. An electronic generated automatic reminder has been set up to remind all staff members on the first Wednesday of every month that drills are due to be scheduled for the shift required for that month per state regulations.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>1. For the safety of clients #1-#7, all staff in the home will be attached</p>	06/03/2015			

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	<p>conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, and #7 before 7/4/14 at 1:15pm for the 7:00am-3:00pm shift of personnel. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5, #6, and #7 before 2/26/15 at 5:30am and after 9/3/14 at 4:45am, for the 11:00pm-7:00am shift of personnel.</p> <p>On 5/4/15 at 10:30am, an interview with GHS (Group Home Staff) was conducted. GHS #6 indicated no additional evacuation drills were available for review.</p> <p>On 5/4/15 at 10:40am, an interview with the Administrative Assistant (AA) was conducted. The AA indicated no additional evacuation drills were available for review. The AA indicated the evacuation drills should be held once per shift for each quarter of the year.</p> <p>9-3-7(a)</p>		<p>to the computer generated automatic reminder to ensure that drills are completed.</p> <p>2. All new staff in the home will be added to the automatic reminder for safety drills.</p> <p>What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?</p> <p>1. For the safety of clients #1-#7, all staff in the home will be attached to the computer generated automatic reminder to ensure that drills are completed.</p> <p>2. Residential manager will add any new staff to the automatic computer reminder for safety drills as needed.</p> <p>How the corrective action (s) will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place?</p> <p>1. For the safety of clients #1-#7, all staff in the home will be attached to the computer generated automatic reminder to ensure that drills are completed.</p> <p>What date by which the systemic changes will be completed? 6/3/2015</p>	