

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 6/25, 6/26, 6/27, and 7/1/2014.</p> <p>Facility Number: 001004 Provider Number: 15G490 AIMS Number: 100245030</p> <p>Surveyor: Susan Eakright, QIDP.</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/8/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF 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, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7, and</p>	W000186	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. <b>Residential Manager will fill open positions</b>	07/31/2014

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>#8), the facility failed to provide sufficient staff at the group home to supervise clients #1, #2, #3, #4, #5, #6, #7, and #8 based on the clients' identified needs.</p> <p>Findings include:</p> <p>On 6/25/14 from 3:35pm until 5:30pm, clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed with three (3) Group Home Staff (GHS) to complete meal preparation, medication administration, and scheduled routines at the group home. During the observation period clients #4 and #8 required group home staff assistance with toileting, repositioning, feeding themselves, and movement. At 4:15pm, GHS #1 stated the evening shift of personnel "used to" have four staff to ensure the clients were assisted to go into the community. GHS #1 indicated the evening shift had not had three to four staff because other staff were off because of illness. GHS #1 stated three staff were able "normally in a pinch" to provide supervision and assistance for clients #1, #2, #3, #4, #5, #6, #7, and #8, but clients #4 and #8 had been ill and "required" more staff time. Client #2 was having a medical "decline" and "required" more staff time.</p> <p>On 6/26/14 from 6:30am until 8:20am,</p>		<p><b>with substitutes, while she is in the process of trying to hire permanent staff. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients can be affected due to shortage of staff. Residential Residential Manager will fill open positions with substitutes, while she is in the process of trying to hire permanent staff. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. Residential Manager will immediately communicate staff changes to Community Supports Coordinator and QDDP, so both parties can assist Manager with finding staff coverage. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. Residential Manager will meet with Community Supports Coordinator at least monthly to review staff schedule to ensure the group home is fully staffed.</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>clients #1, #2, #3, #4, #5, #6, #7, and #8 were observed at the group home with two Group Home Staff (GHS). During the observation period clients #1, #2, #3, #5, #6, and #7 were observed to eat their breakfast with GHS #2 and GHS #3 walking into and out of the room. During the observation period clients #1, #2, #3, #5, #6, and #7 were not supervised during dining, walking throughout the group home, to complete hand washing, and for personal hygiene while in the bathroom. From 6:30am until 8:20am, client #4 sat in the recliner in the living room with her oxygen tubing in her nose to breathe. During the observation period client #4 was non verbal, slept, and was not prompted to activity. At 6:42am, GHS #2 indicated clients #4 and #8 required group home staff assistance with toileting, repositioning, and movement. GHS #2 and GHS #3 would stop to check on client #4 as the two staff walked by client #4 throughout the observation period. At 6:42am, GHS #2 and GHS #3 both stated client #4 had slept in the recliner during the overnight hours "so staff can monitor her." At 6:42am, GHS #3 stated clients #4, #6, #7, and #8 were "incontinent and required" staff to prompt and assist clients #4, #6, #7, and #8 to go to the bathroom. At 6:42am, GHS #3 stated clients #1, #2, and #3 had "a protocol" for staff to teach, encourage,</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>and ask clients #1, #2, and #3 to go to the bathroom every two hours. At 7:10am, clients #2, #5, #6, and #7 independently went to the refrigerator to obtain their items for their individual lunch boxes and GHS #3 asked clients #2, #5, #6, and #7 to "wait" for her to assist the clients. At 7:30am, GHS #3 asked clients #2, #5, #6, and #7 to pack their lunches. GHS #3 indicated to clients #2, #6, and #7 that their lunch boxes had not been cleaned out from the day before and she began to assist to clean the lunch boxes. At 7:45am, GHS #2 and GHS #3 stated client #4 "was just released" from the hospital over the weekend and client #8 was sent out "to the hospital emergency room" last night and both hospital visits were due to medical issues. At 7:45am, GHS #2 and GHS #3 stated the group home had two staff with eight clients for "several" months because of illnesses. At 8:20am, client #4 sat sleeping in the living room recliner without activity. At 8:20am, client #8 was in bed. At 8:20am, client #2 was dressed in three layers of clothing waiting to leave for workshop. At 8:20am, clients #1, #3, #5, #6, and #7 sat or stood in the living room without activity waiting to leave for workshop.</p> <p>On 6/26/14 at 9:40am, an interview with the agency nurse was conducted. The agency nurse indicated client #4 should</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>have slept in her bed in her bedroom during the overnight hours. The agency nurse indicated there was no plan and no medical reason for client #4 to have slept in the recliner in the living room. The agency nurse stated client #2 had experienced a "recent" medical decline related to her dementia and required "more" staff assistance to complete her "basic" needs. The agency nurse stated client #4 had "recently" been released from the hospital and "we're monitoring her." The agency nurse indicated client #8 was experiencing a "medical issue since March (2014)" and "we're monitoring" him with his doctors. The agency nurse stated clients #4 and #8 "required" more staff attention to monitor their "well being."</p> <p>On 6/27/14 at 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated the "normal staffing" pattern for the group home was three to four (3-4) staff from 2:30pm until 10:30pm daily three (3) staff from 5:00am until 9:00am, and two on the overnight periods. The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 needed twenty-four (24) hour supervision.</p> <p>On 6/27/14 at 9:00am, an interview with</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the Community Supports Coordinator (CSC), the QIDP was conducted. The CSC and QIDP stated clients #1, #2, #3, #4, #5, #6, #7, and #8 were to have been "supervised by three (3) staff" present on duty at the group home "each morning" and three to four (3-4) staff on duty for the evening shift of personnel. The CSC and QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 were to be supervised during dining and clients #1, #2, #3, #5, #6, #7, and #8 should have been supervised during meals, dining, hygiene, bathing, and prompted to activity. The QIDP indicated staff who usually work at the group home were off on medical leave and the House Manager was working those hours on the schedule.</p> <p>Client #1's record was reviewed on 6/26/14 at 12:10pm. Client #1's 5/7/14 ISP (Individual Support Plan) indicated she required twenty-four hour staff supervision. Client #1's ISP indicated staff were to monitor her dining and location because she had the identified behavior of continuous consumption of food and food theft.</p> <p>Client #2's record was reviewed on 6/27/14 at 11:00am. Client #2's 3/11/14 ISP indicated she required twenty-four hour staff supervision. Client #2's ISP indicated she was a Diabetic and had</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Dementia.</p> <p>Client #3's record was reviewed on 6/27/14 at 9:45am. Client #3's 6/3/14 ISP indicated he required twenty-four hour staff supervision.</p> <p>Client #4's record was reviewed on 6/26/14 at 10:30am. Client #4's 1/29/14 ISP indicated she required twenty-four hour staff supervision. Client #4's record indicated she was at risk to choke, required staff assistance for bathing/dressing/walking, and required staff supervision during dining.</p> <p>On 6/27/14 at 10:30am, a review of the facility's staff schedule from 6/20/14 through 6/26/14 was conducted. The schedule indicated the following:</p> <ul style="list-style-type: none"> <li>-One staff was scheduled each day for the overnight shift hours from 12 midnight to 8:30am on 6/26, 6/25, 6/24, 6/23, 6/22, 6/21, and 6/20/2014.</li> <li>-One staff was scheduled each day for the day time shift hours from 5:00am until 8:30am on 6/27, 6/26, 6/25, 6/23, 6/21, and 6/20/2014.</li> <li>-Two to Three (2-3) staff were scheduled each day for the evening shift hours from 2:30pm until 12:00 midnight on 6/26, 6/24, 6/23, 6/22, 6/21, and 6/20/14.</li> </ul> <p>9-3-3(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000381	<p>483.460(I)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security.</p> <p>Based on observation, record review, and interview, the facility failed to keep medications locked/secured when not administered for 4 of 4 sampled clients (#1, #2, #3, and #4) and four additional clients (clients #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>On 6/25/14 from 3:35pm until 5:30pm and on 6/26/14 from 6:30am until 8:20am, observations and interviews were completed for clients #1, #2, #3, #4, #5, #6, #7, and #8. During both observation periods clients #1, #2, #3, #5, #6, and #7 independently opened/closed the refrigerator in the kitchen to remove/replace food items inside the refrigerator. During both observation periods when the refrigerator was opened/closed an unsecured brown pharmacy bag was observed on the shelf inside the refrigerator at eye level. On 6/26/14 at 7:30am, clients #1, #2, #3, #5, #6, and #7 began to independently pack their lunch food items from the refrigerator into their lunch boxes. On 6/26/14 at 7:30am, the unsecured brown</p>	W000381	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Staff will be re-trained to ensure they are storing refrigerated medication properly as outlined in medication administration handbook. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients in the home can be affected since all clients access the refrigerator. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. Residential Manager will monitor medication storage on a weekly basis and Nurse will monitor quarterly. Residential Manager and Nurse will follow disciplinary action for failure of staff not following proper storage of medications as outlined in medication administration handbook along with any retraining and education needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what</i></p>	07/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>pharmacy bag was observed with Group Home Staff (GHS) #2. GHS #2 removed, opened, and stated the unsecured brown pharmacy bag contained client #2's "Restasis 0.05% Eye Emulsion" medication. GHS #2 stated "all clients and all visitors" in the group home had access to client #2's eye medication which was inside the unsecured pharmacy bag. GHS #2 stated client #2's eye medication "had to be refrigerated" and the pharmacy had sent multiple bottles of the medication that would not fit inside the metal secured lock box inside the refrigerator for refrigerated medications.</p> <p>On 6/27/14 at 9:00am, client #2's 6/2014 MAR (Medication Administration Record) indicated "Restasis 0.05% Eye Emulsion, place 1 (one) drop into both eyes twice daily."</p> <p>On 6/27/14 9:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated refrigerated medications should be locked inside the refrigerator.</p> <p>On 6/27/14 at 9:00am, a record review was completed of the facility's policy and procedures, 1/3/2014 "Medication Administration by Staff" which indicated "...all medications should be in a locked</p>		<p><i>quality assurance program will be put into place. Residential Manager will monitor medication storage on a weekly basis and Nurse will monitor quarterly.</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000436	<p>container" and secured when not being administered.</p> <p>On 6/27/14 at 9:00am, an interview with the agency nurse was conducted. The agency nurse indicated medications should be kept locked/secured when medications were not administered. The agency nurse indicated the facility followed "Living in the Community" for medication administration.</p> <p>On 6/27/14 at 9:00am, a record review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication should be kept secure when not administered.</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, record review, and interview, for 2 additional clients (clients #7 and #8) with adaptive equipment, the</p>	W000436	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. <b>Client's</b>	07/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>facility failed to teach client #7 to wear his prescribed eye glasses, and for clients #7 and #8 the facility failed to ensure their wheelchairs were in good repair.</p> <p>Findings include:</p> <p>1. On 6/25/14 from 3:35pm until 5:30pm, on 6/26/14 from 6:30am until 8:20am, and on 6/26/14 from 8:30am until 9:35am, observations and interviews were completed for client #7. During the three observation periods client #7 did not wear his prescribed eye glasses. During the three observation periods client #7 completed medication administration, hand washing, read the newspaper/magazine, watched television, took out the trash bags to the outside trash bins, read a book, and completed a word search puzzle at the workshop. During the three observation periods client #7 did not wear his prescribed eye glasses and was not prompted or encouraged to wear his prescribed eye glasses. At 4:50pm, client #7 completed medication administration with Group Home Staff (GHS) #1 and client #7 did not wear his prescribed eye glasses. GHS #1 asked client #7 to show the surveyor his prescribed eye glasses after he completed medication administration. Client #7 left the medication room, moved his wheelchair into his bedroom,</p>		<p><b>wheelchairs will be repaired. Client with glasses had a revision to his goal to wear his eyeglasses during waking hours. Retraining will be provided to staff to ensure adaptive equipment repairs are reported immediately to Residential Manager. Retraining will also be provided on adaptive equipment goals to be sure staff are training clients on when to use adaptive equipment, such as glasses. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All clients who have adaptive equipment could be affected. All repairs will be completed and re-training will be provided. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. Residential Manager will keep an adaptive equipment log and will review the log weekly to ensure any needed repairs are completed to adaptive equipment. Residential Manager will also review adaptive equipment goals monthly to ensure staff are providing necessary training to clients with adaptive equipment. How the corrective action(s) will be monitored to</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>removed a pair of prescribed eye glasses from his dresser drawer, and put the eye glasses on. Client #7 then took off his prescribed eye glasses, put the eye glasses back into his drawer, and left his room.</p> <p>On 6/27/14 at 10:00am, client #7's 4/8/14 ISP (Individual Support Plan) indicated he wore prescribed eye glasses.</p> <p>On 6/27/14 10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #7 wore prescribed eye glasses. The QIDP indicated client #7 should have been prompted and encouraged to wear his prescribed eye glasses.</p> <p>2. On 6/25/14 from 3:35pm until 5:30pm and on 6/26/14 from 6:30am until 8:20am, observations and interviews were completed for clients #7 and #8. During both observation periods client #7's wheelchair had one of two (1 of 2) missing arm rests which exposed the bare metal frame against client #7's arm. During both observation periods client #7's wheelchair with one arm rest had the vinyl pad torn which exposed the foam padding. During both observation periods client #8 used his wheelchair to access the group home. During both observation periods client #8's wheelchair</p>		<p><i>ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</i> <b>Residential Manager will turn in adaptive equipment log and goals into QDDP monthly for review.</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>had a metal bar which extended next to his wheelchair leg rests without the protective cover and exposed a one inch (1") piece of sharp metal near client #8's feet.</p> <p>On 6/27/14 at 10:00am, client #7's 4/8/14 ISP (Individual Support Plan) indicated he used a wheelchair to access the group home and community.</p> <p>On 6/26/14 at 12:30pm, client #8's 5/1/14 ISP indicated he used a wheelchair to access the group home and community. Client #8's 5/1/14 FAT (Functional Assessment Tool) indicated he used a wheelchair for mobility. Client #8's 3/31/14 "Medical Exam: Reason for visit: Wheelchair Modification" indicated his wheelchair had a wheelchair tray, new arm rests, and "supports" added to client #8's chair to increase his independence.</p> <p>On 6/27/14 at 10am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated clients #7 and #8 used their wheelchairs to access the group home and the community. The QIDP indicated client #7 and #8's wheelchairs should have been in good repair. The QIDP indicated client #7's wheelchair had a missing arm rest and the remaining arm rest needed to be</p>				

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

PRINTED: 08/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  07/01/2014
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>repaired. The QIDP indicated she was unaware client #8's wheelchair needed to be repaired.</p> <p>9-3-7(a)</p>				