

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/20/2013	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783			
(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 the investigation of complaint #IN00134957.</p> <p>Complaint #IN00134957: SUBSTANTIATED, Federal and State deficiencies related to the allegation are cited at W249 and W436.</p> <p>Dates of survey: September 11, 12, 13, 16 and 20, 2013.</p> <p>Provider Number: 15G543 Facility Number: 001057 AIM Number: 100245390</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed September 27, 2013 by Dotty Walton, QIDP.</p>	W000000					

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:  15G543		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/20/2013	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783			
(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			
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client C), the facility failed to implement client C's fall risk plan as written.</p> <p>Findings include:</p> <p>Observations were conducted at the workshop on 9/11/13 from 2:15pm until 3:20pm. From 2:15pm until 2:55pm, client C wore a left leg fracture boot, sat in a wheelchair with arm supports at the classroom table, and Workshop Staff (WKS) #1 stayed next to client C. At 2:30pm, WKS #1 stated client C "would try to get up if [client C was] left alone." WKS #1 indicated client C had a fractured left ankle from a fall and used a wheelchair because chairs with armrest supports had been ordered for the workshop classroom. At 2:45pm, WKS #2 stated client C "was eye sight supervision," indicated workshop staff were to stay within an arm's reach of client C because he would try to get up and walk. At 2:55pm, client C was</p>	W000249	<p>Client C had a fall risk plan in place that noted that he must use a chair with arms when seated to prevent any future falls while sitting. This was due to a recent fall that occurred when he fell asleep in a chair and fell out, resulting in a fracture. The intent of noting the use of chairs with arms in his high risk plan was a preventative measure so that if he were to fall asleep again while seated that he would not be able to fall to either side. When the plan was implemented it was an oversight of not getting arms for the toilet seats. Staff were aware that when a chair with arms is not available, staff should have client C in line of sight to protect him from future falls, as this would allow us to see if he was beginning to fall asleep. This was not being done while client C was using the restroom due to him not being able to use the restroom when others are present. To assure his safety, it was discussed with his staff following the survey the importance of staying within line of site of him while he is restrooming until we</p>	10/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/20/2013	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783			
(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>assisted by WKS #2 to the workshop bathroom. WKS #2 locked client C's wheelchair, prompted him to walk into the bathroom, where the toilet did not have armrest supports, and to prepare to use the toilet. At 2:55pm, WKS #2 exited the bathroom, closed the door with client C inside, and indicated client C could not use the toilet with other people present. At 2:57pm, WKS #2 knocked on the door, entered the bathroom, and exited the bathroom with client C. WKS #2 held client C's arm just above client C's right elbow. Client C walked with an uneven gait to the wheelchair and sat down. At 3:05pm, WKS #2 indicated client C was assisted to the bathroom every two hours, client C's wheelchair and the bathroom toilet inside the classroom did not have safety supports to prevent the potential of client C falling off the stool. At 3:20pm, client C was assisted by the facility staff sitting in a wheelchair without a safety/seatbelt to the facility bus to go home from the workshop.</p> <p>On 9/11/13 at 11:40am, a review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 6/1/13 through 9/11/13 was conducted and included the following:</p> <p>-A 8/16/13 BDDS report for an incident on 8/16/13 at 1:45pm, indicated client C</p>		<p>were able to get the safety arms installed on to the toilet. Staff were directed that if he could not void while we were in the bathroom, that they could stand outside the door, but to keep it cracked just wide enough for us to visually see that he was safe. Having this visual would allow us to get to client C if it appeared that he was leaning and about to fall.. Another email was sent out to his day services staff and his home staff on 10/11/2013 reviewing this. The group home manager will be asked to monitor and assure that staff are following the safety protocol in place, and that when using a restroom that would put him a risk of falling from one side to another, they are keeping a visual on his so that we can step in and protect him if he does begin to lean. This request will be made of them on Friday 10/18/2013. There were arms purchased for the toilet he uses while at day services as well as the toilet at home so that he can safely restroom on his own without fear of falling from the toilet. The arms for both toilets were purchased and installed by 10/18/2013. An email was sent to all group home staff asking that they please review all of their clients high risk plans and assure that they are following all procedures that have been put in to place to protect the clients. They will be reminded how</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783		
(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>was "sitting in a chair watching a movie while at day programming. [Client C] started to drift to sleep and started leaning in his chair as he fell asleep." The report indicated client C "fell out of his chair," landed on his left ankle, and an x-ray determined client C's ankle was fractured.</p> <p>On 9/11/13 at 12:30pm, client C's record review was conducted. Client C's 10/1/12 ISP (Individual Support Plan) indicated he was not a fall risk, was independently ambulatory without assistance, and client C was to have been eye sight staff supervision at all times due to his behaviors of AWOL (Absent without Leave). Client C's 8/21/13 "Fall Prevention Protocol" indicated "...Precursors to the Risk: At times [Client C] does not pay attention to his surroundings, which puts him at a great risk for falls. Proactive preventative supports &amp;(and) strategies to manage the risk: Staff will always have [Client C] in their line of sight. Staff will make sure that all rooms at (sic) house, and at day service are not cluttered with items [Client C] could trip over...[Client C] must always sit in a chair with arms to prevent him from falling out of the chair...."</p> <p>On 9/12/13 at 9:05am, an interview with the Community Supports Director (CSD)</p>		<p>important it is for the health and safety of our clients to follow these plans. This email will be sent on Monday 10/14/213. All staff will be asked to report immediately if they see procedures that are not being followed, as this puts the clients in jeopardy. To assure in the future that this does not occur an email will be sent to all QDDPs letting them know that if there are situations in which a client is in need of sitting in a chair with arms that it be reviewed and specified as to whether this also includes the need for adaptive equipment for the toilet seat to aide in their safety. It will be asked that they review their current plans to assure this is in place for anyone in need, as well as keeping it in mind for any plans written in the future. This email was sent on Monday 10/14/2013. At each quarterly and annual meeting, the QDDP will review the high risk plans to assure that they are still meeting the needs of the clients and that the plans are understood by the staff working with the clients. The QDDP will then make note of this review within the meeting notes.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783		
(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 the QIDP (Qualified Intellectual Disabilities Professional) was completed. The CSD and the QIDP both stated client C was to have a chair with armrest supports "at all times." The CSD indicated the toilet inside the workshop classroom did not have armrest supports and was an oversight by the facility.</p> <p>On 9/20/13 at 2:25pm, an interview with the CSD was conducted. The CSD indicated facility staff should have kept client C within their eye sight, the wheelchair and the toilet should have had armrest supports in place if client C was to have been left alone on the toilet without staff.</p> <p>This federal tag relates to complaint #IN00134957.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783			
(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>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review, and interview, for 1 of 3 sampled clients (client C) who had an identified need for adaptive equipment, the facility failed to furnish armchairs, arm rest supports on the toilet and a seat belt on a wheelchair for client C.</p> <p>Findings include:</p> <p>Observations were conducted at the workshop on 9/11/13 from 2:15pm until 3:20pm. From 2:15pm until 2:55pm, client C wore a left leg fracture boot, sat in a wheelchair with arm supports and without a seat belt at the classroom table, and Workshop Staff (WKS) #1 stayed next to client C. At 2:30pm, WKS #1 stated client C "would try to get up if [client C was] left alone." WKS #1 indicated client C had a fractured left ankle from a fall and used a wheelchair because chairs with armrest supports had been ordered for the workshop classroom. At 2:45pm, WKS #2 stated client C "was eye sight supervision," indicated workshop staff were to stay within an</p>	W000436	Client C had a fall risk plan in place that noted that he must use a chair with arms when seated to prevent any future falls while sitting. This was due to a recent fall that occurred when he fell asleep in a chair and fell out, resulting in a fracture. The intent of noting the use of chairs with arms in his high risk plan was a preventative measure so that if he were to fall asleep again while seated that he would not be able to fall to either side. When the plan was implemented it was an oversight of not getting arms for the toilet seats. Staff were aware that when a chair with arms is not available, staff should have client C in line of sight to protect him from future falls, as this would allow us to see if he was beginning to fall asleep. This was not being done while client C was using the restroom due to him not being able to use the restroom when others are present. To assure his safety, it was discussed with his staff following the survey the importance of staying within line of site of him while he is restrooming until we were able to get the safety arms	10/18/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783		
(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>arm's reach of client C because he would try to get up and walk. At 2:55pm, client C was assisted by WKS #2 to the workshop bathroom. WKS #2 locked client C's wheelchair, prompted him to walk into the bathroom, where the toilet did not have armrest supports, and to prepare to use the toilet. At 2:55pm, WKS #2 exited the bathroom, closed the door with client C inside, and indicated client C could not use the toilet with other people present. At 2:57pm, WKS #2 knocked on the door, entered the bathroom, and exited the bathroom with client C. WKS #2 held client C's arm just above client C's right elbow. Client C walked with a limp to the wheelchair, sat down, and no seat belt was applied. At 3:05pm, WKS #2 indicated client C was assisted to the bathroom every two hours, client C's wheelchair did not have an available seat belt for safety, and the bathroom toilet inside the classroom did not have safety supports to prevent the potential of client C falling off the stool. At 3:20pm, client C was assisted by the facility staff in a wheelchair without a safety/seatbelt to the facility bus to go home from the workshop.</p> <p>On 9/11/13 at 11:40am, a review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 6/1/13 through 9/11/13 was</p>		<p>installed on to the toilet. Staff were directed that if he could not void while we were in the bathroom, that they could stand outside the door, but to keep it cracked just wide enough for us to visually see that he was safe. Having this visual would allow us to get to client C if it appeared that he was leaning and about to fall.. Another email was sent out to his day services staff and his home staff on 10/11/2013 reviewing this. The group home manager will be asked to monitor and assure that staff are following the safety protocol in place, and that when using a restroom that would put him a risk of falling from one side to another, they are keeping a visual on his so that we can step in and protect him if he does begin to lean. This request will be made of them on Friday 10/18/2013. The QDDP and Coordinator will visit the services sites at least twice monthly to assure that propor protocols are being followed. There were arms purchased for the toilet he uses while at day services as well as the toilet at home so that he can safely restroom on his own without fear of falling from the toilet. The arms for both toilets were purchased and installed by 10/18/2013. During the survey visit, client C was still in a wheelchair due to the fracture from his fall. He spent the majority of his time in the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783		
(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>conducted and included the following:</p> <p>-A 8/16/13 BDDS report for an incident on 8/16/13 at 1:45pm, indicated client C was "sitting in a chair watching a movie while at day programming. [Client C] started to drift to sleep and started leaning in his chair as he fell asleep." The report indicated client C "fell out of his chair," landed on his left ankle, and an x-ray determined client C's ankle was fractured.</p> <p>On 9/11/13 at 12:30pm, client C's record review was conducted. Client C's 10/1/12 ISP (Individual Support Plan) indicated he was not a fall risk, was independently ambulatory without assistance, and client C was to have been given eye sight staff supervision at all times due to his behaviors of AWOL (Absent without Leave). Client C's 8/21/13 "Fall Prevention Protocol" indicated "...Precursors to the Risk: At times [Client C] does not pay attention to his surroundings, which puts him at a great risk for falls. Proactive preventative supports &amp; (and) strategies to manage the risk: Staff will always have [Client C] in their line of sight. Staff will make sure that all rooms at (sic) house, and at day service are not cluttered with items [Client C] could trip over...[Client C] must always sit in a chair with arms to prevent him from falling out of the</p>		<p>wheelchair which had arms. We knew that we were in need of purchasing more chairs with arms for his day services location as well as his home for his use once he was able to walk again and no longer need the wheelchair. These chairs were ordered on 08/21/2013. They arrived to the company on 09/26/2013 but the manufacturer shipped the wrong chairs and the chairs delivered did not have any arms. A rush order was made, and the chairs with arms were delivered on 10/02/2013. A chair was sent to client C's home as well as another placed in his day services location. There are extras as well that were ordered so if it is found others are needed in other locations for him, we have those on hand. Client C was not given the okay to start walking on his ankle until his follow up appointment on 10/02/2013, so he was in the wheelchair prior to the additional chairs arriving so he was not in danger of sitting in a regular chair that didn't have the safety measures in place. Client C was placed in the wheelchair to prevent him from walking too much so not to worsen the fracture that occurred after he fell asleep and fell from the chair while watching a movie. A spare wheelchair was used for him during this time as he is typically ambulatory and does not have a wheelchair of his own. The wheelchair he was using was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783		
(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>chair...."</p> <p>On 9/12/13 at 9:05am, an interview with the Community Supports Director (CSD) and the QIDP (Qualified Intellectual Disabilities Professional) was completed. The CSD and the QIDP both stated client C was to have a chair with armrest supports "at all times." The CSD indicated the toilet inside the workshop classroom did not have armrest supports and was an oversight by the facility. The CSD indicated client C should have had a seat belt on his wheelchair for safety.</p> <p>On 9/20/13 at 2:25pm, an interview with the CSD was conducted. The CSD indicated facility staff should have kept client C within their eye sight, the wheelchair should have had a safety belt for security, and the toilet should have had armrest supports in place if client C was to have been left alone on the toilet without staff.</p> <p>This federal tag relates to complaint #IN00134957.</p> <p>9-3-7(a)</p>		<p>a basic wheel chair that did not have a seat belt attached. While the wheelchair was in motion it was not felt that client C was at risk of getting up from the chair, so prior to the survey his IDT did not think about the chair not having a seat belt. Client C was given the okay to start walking as normal again on 10/02/2013, so the wheelchair is no longer in use. We will be looking at getting a seatbelt installed to our spare wheelchair though in case we have clients in the future who are in need of using it. This way we have the safety measure of the seatbelt in place to be used. An email will be sent to all group home staff asking that they please review all of their clients high risk plans and assure that they are following all procedures that have been put in to place to protect the clients. They will be reminded how important it is for the health and safety of our clients. In this email it will also be asked that they review which adaptive equipment is needed for their clients and to please assure that that adaptive equipment is in place. It will be asked that they report immediately anytime needed adaptive equipment for their clients are not present or is not functional so that this can be corrected immediately. This email was sent on Monday 10/14/2013. On Monday 10/14/213, another email was sent to all Group Home Managers</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783		
(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	
			asking that on the 1st of each month they check all adaptive equipment items to assure that they are in place at the home and operational. The group home managers will help to monitor that the needed adaptive equipment is in place and operational. They will report immediately to the QDDP or Coordinator if there are any concerns so that it can be corrected immediately. If there is a time when there is no group home manager, the coordinator will step in to monitor and assure that all adaptive equipment is in place and in working order. To assure in the future that this does not occur an email will be sent to all QDDPs letting them know that if there are situations in which a client is in need of sitting in a chair with arms that it be reviewed and specified as to whether this also includes the need for adaptive equipment for the toilet seat to aide in their safety. It will be asked that they review their current plans to assure this is in place for anyone in need, as well as keeping it in mind for any plans written in the future. This email was sent on Monday 10/14/2013. At each quarterly and annual meeting, the QDDP will review the high risk plans to assure that they are still meeting the needs of the clients and that the plans are understood by the staff working with the clients. It will also be reviewed at these meetings that all adaptive		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G543	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/20/2013
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 164 GLENDEE LN ROANOKE, IN 46783		
(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	
			equipment is in place and operational. The QDDP will then make note of this review within the meeting notes.		