

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2012	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT HUNTINGTON, IN 46750			
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: May 21 and 22, 2012.</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>Facility Number: 012414 Provider Number: 15G786 AIM Number: 200998980</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on May 25, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000					

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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W0149	<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.</p> <p>Based on record review and interview, facility day program staff failed to follow the facility's policy on abuse and neglect by failing to protect 1 of 4 clients (client #3) who lived in the home and attended the facility owned/operated day program.</p> <p>Findings include:</p> <p>Facility records were reviewed on 5/21/12 at 2:34 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time frame between 5/21/11 and 5/21/12. The reports indicated the following:</p> <p>A BDDS report dated 8/1/11 at 8:30 A.M. indicated an incident at the facility owned/operated day program: "The actual date of the incident is unknown, but today, 8/1/11, a client (peer #1) went to the Community Integration Coordinator (CIC), and made an allegation against a staff person. [Name of CIC] had been on vacation the week of July 25 so the client (peer #1) waited until her return. This client (peer #1) told [name of CIC] that she had witnessed a staff person [name of day program staff (DPS) #8] hit [client #3's] hand and neck area when [client #3]</p>	W0149	<p>Our organization does have an Abuse and Neglect Policy, and a newer policy implemented entitled Reporting Reasonable Suspicion of a Crime. We did have an incident where an allegation of abuse was made on 8/1/11. The Day Services staff was suspended immediately and an investigation started. The outcome of the investigation resulted in the termination of the day services staff. Our organization did an annual Prevention of Abuse and Neglect training which was led by our Community Supports Director and our Community Supports Associate Director. At this training, both our Abuse and Neglect policy and our Reporting Reasonable Suspicion of a Crime policy were reviewed with all of our Community Supports Staff. That policy will continue to be followed and updated as needed. These trainings were held on 10/12/2011, 10/13/2011, 10/17/201, and 10/21/2011. All Community Support staff (which includes both residential and day services) were required to attend one of the training sessions. All Community Supports staff will be required to attend the annual Prevention of Abuse and Neglect training in October again.</p>	06/21/2012			

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	<p>was picking at his neck. She (peer #1) stated that [client #3's] neck was red afterward. She (peer #1) also stated she witnessed [DPS #8] pulling on [client #3's] gait belt and making him sit down in a chair." The report indicated DPS #8 was suspended immediately and an investigation started.</p> <p>A follow-up BDDS report dated 8/5/11 indicated: "[Client #3] is non-verbal and profoundly DD (developmentally disabled) and was not able to give input into the investigation...All co-workers in the Community Integration Department who come in contact with [DPS #8] were interviewed in the investigation. There was no staff witness to the event. Several staff did say that they have witnessed [DPS #8's] tone of voice being harsh with the clients in the past...the client reporting (peer #1) never varied in her story and was adamant about what she saw... Because of this and that we could not disprove the incident, the determination was made to terminate [DPS #8's] employment. This was done this afternoon."</p> <p>The facility policy Handling Client Abuse, Neglect, Injuries of Unknown Origin & BDDS Incident Reporting dated October 5, 2011 was reviewed on 5/22/12 at 12:55 P.M. and indicated: " Any</p>		<p>Additionally the Day Services staff will be required to attend a refresher training on Prevention of Abuse and Neglect by June 21 st . This training will be done by the agency Nurse. The Group Home Managers, Residential Coordinators and Day Services Coordinator will continue to watch for any inappropriate behavior or interactions from our staff, and will address these immediately to assure the safety of our clients.</p>				

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	<p>alleged, suspected, or actual abuse ... neglect...exploitation or any other mistreatment must be immediately reported...In the event of suspected abuse, neglect, exploitation or mistreatment of a client by a staff or other individual, the facility will assure that the staff or other individuals do not have contact with the client until the situation is resolved and there is no risk to the client."</p> <p>An interview was conducted with the Community Support Coordinator (CSC) on 5/22/12 at 1:12 P.M.. When asked about the incident between [DPS #8] and [client #3] the CSC stated, "Yes, it was against facility policy, and she was terminated." The CSC indicated client #3 had no injuries as a result of the incident. The CSC indicated all staff were retrained on appropriate staff/client interactions.</p> <p>9-3-2(a)</p>				

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed to establish a system of notification of medication changes which insured all medications were administered in compliance with physician's orders for 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>Facility records were reviewed on 5/21/12 at 2:34 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time frame between 5/21/11 and 5/21/12. The reports indicated the following:</p> <p>A BDDS report dated 5/17/12 at 12:00 P.M. indicated: "On 4/30/12, [client #1] was seen by his psychiatrist and his Ritalin LA for Attention Deficit Hyperactivity Disorder (ADHD) 20 mg (milligrams) BID (twice a day) was discontinued and replaced with Concerta (ADHD) QD (once per day). An email was sent out to all parties that work with [client #1] letting them know of the change. The day service staff misunderstood that the noon dose was being discontinued and thought they would be receiving a noon dose of</p>	W0368	<p>All Day Services and staff at this group home will be required to attend a mandatory Medication Administration retraining with the Nurse. This will be completed by June 21 st . The Medication Administration handbook was revised on 5-14-12 and that policy will be followed an updated as needed..</p> <p>Ongoing Medication Administration training and refresher training will be provided to all staff who pass medications. This will be done by the agency nurses. Disciplinary action will be taken with staff who commit errors as outlined in the Medication Administration handbook.</p>	06/21/2012			

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	<p>Concerta and continued to give the Ritalin each work day until May 16 when they ran out...it was explained to them they that the med (Ritalin) should have been stopped on 5/1/12. The doctor was called to let them know of the error. No new orders received at this time. [Client #1] has had some increased irritability and breakthrough seizures, but it is unknown if this med error caused it. Staff received retraining...."</p> <p>Client #1's record was reviewed on 5/22/12 at 11:42 A.M. including a Psychotropic Medication Follow-up dated 4/30/12 indicating client #1 was to "Stop Ritalin LA, start Concerta 27 mg PO (by mouth) QAM (every morning) for 7 (seven) days then increase to Concerta 36 mg PO QAM, continue Risperdal (anti-psychotic) 0.5 mg PO BID. The Medication Administration Record (MAR) for the day program dated for 4/17/12 through 5/16/12 indicated client #1 had received Methylphenidate (generic for Ritalin) 20 mg at noon on 5/1/12, 5/2/12, 5/3/12, 5/4/12, 5/7/12, 5/8/12, 5/9/12, 5/10/12, 5/11/12, 5/14/12, 5/15/12 and 5/16/12.</p> <p>The Community Support Coordinator (CSC) was interviewed on 5/22/12 at 1:15 P.M. The CSC stated "They get an email of the medication change." The CSC</p>						

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	<p>indicated client #1 had received Ritalin LA 20 mg at noon at the day program in error for 12 (twelve) days. The CSC indicated the facility owned/operated day program staff had received the email, but had misunderstood the change, and had failed to get clarification.</p> <p>9-3-6(a)</p>				

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W0392	<p>483.460(m)(3) DRUG LABELING Drugs and biologicals packaged in containers designated for a particular client must be immediately removed from the client's current medication supply if discontinued by the physician.</p> <p>Based on record review and interview, the facility failed to establish a system to insure immediate removal of discontinued medications from the current medication supply to prevent medications being given in error for 1 of 2 sampled clients (client #1's) after the medications were discontinued by his physician.</p> <p>Findings include:</p> <p>Facility records were reviewed on 5/21/12 at 2:34 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the time frame between 5/21/11 and 5/21/12. The reports indicated the following:</p> <p>A BDDS report dated 5/17/12 at 12:00 P.M. indicated: "On 4/30/12, [client #1] was seen by his psychiatrist and his Ritalin LA for Attention Deficit Hyperactivity Disorder (ADHD) 20 mg (milligrams) BID (twice a day) was discontinued and replaced with Concerta (ADHD) QD (once per day). An email was sent out to all parties that work with [client #1] letting them know of the</p>	W0392	<p>During the mandatory Medication Administration retraining of the staff at this group home, it will be stressed that all meds that are changed or discontinued, will have that medication immediately removed from the med cabinet and turned into the Nurse for destruction. This training will also be completed with Day Services staff for medications given during the day. This training will be completed by June 21 st and will be given by the nurse. This training will be given to all staff who pass medications. Training will be ongoing for all staff regarding medication administration and procedures to follow during med changes or discontinuations to prevent further errors.</p>	06/21/2012			

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	<p>change. The day service staff misunderstood that the noon dose was being discontinued and thought they would be receiving a noon dose of Concerta and continued to give the Ritalin each work day until May 16 when they ran out...it was explained to them that the med (Ritalin) should have been stopped on 5/1/12. The doctor was called to let them know of the error. No new orders received at this time. [Client #1] has had some increased irritability and breakthrough seizures, but it is unknown if this med error caused it. Staff received retraining...."</p> <p>Client #1's record was reviewed on 5/22/12 at 11:42 A.M. including a Psychotropic Medication Follow-up dated 4/30/12 indicating client #1 was to "Stop Ritalin LA, start Concerta 27 mg PO (by mouth) QAM (every morning) for 7 (seven) days then increase to Concerta 36 mg PO QAM, continue Risperdal (anti-psychotic) 0.5 mg PO BID." The Medication Administration Record (MAR) for the day program (facility owned/ operated day program) dated for 4/17/12 through 5/16/12 indicated client #1 had received Methylphenidate (generic for Ritalin) 20 mg at noon on 5/1/12, 5/2/12, 5/3/12, 5/4/12, 5/7/12, 5/8/12, 5/9/12, 5/10/12, 5/11/12, 5/14/12, 5/15/12 and 5/16/12.</p>						

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	<p>The Community Support Coordinator (CSC) was interviewed on 5/22/12 at 1:15 P.M. The CSC stated "They get an email of the medication change." The CSC indicated client #1 had received Ritalin LA 20 mg at noon at the day program in error for 12 (twelve) days. The CSC indicated the day program staff had received the email, but had misunderstood the change, and had failed to get clarification. The CSC indicated the medication card of Ritalin for (client #1) had remained at the day service program after the medication had been discontinued.</p> <p>9-3-6(a)</p>			