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 05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	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	This visit was for the fundamental annual recertification and state licensure survey. Dates of Survey: April 19, 22, 23, 24, 25, 26, 29, and May 3, 2013. Facility Number: 001004 Provider Number: 15G490 AIMS Number: 100245030 Surveyor: Susan Eakright, QIDP. These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed May 8, 2013 by Dotty Walton, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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 05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	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
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed to exercise operating direction over the facility to provide oversight of financial personal expenditures for 1 of 4 sample clients (client #1), and failed to ensure client #1's recommended contracted activity was used. Findings include: Client #1's record was reviewed on 4/23/13 at 12:10pm. Client #1's 1/30/13 QIDP (Qualified Intellectual Disabilities Professional) quarterly review of client #1's ISP (Individual Support Plan) indicated client #1 had a guardian. Client #1's diagnoses included, but were not limited to: Profound Intellectual Disabilities, Cerebral Palsy, Scoliosis, Corneal Degeneration, and Spasticity. Client #1's 1/30/13 FAT (Functional Assessment Tool) indicated client #1 was non-verbal, used gestures to communicate basic wants/needs, and required assistance to choose activities for participation. Client #1's 1/30/13, 12/6/12, 8/23/12, and 5/17/12 quarterly reviews did not indicate the use of client #1's YMCA membership activities and did not indicate when client	W000104	1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; - A goal will be put into place to provide documentation of how often client is going to the YMCA and guardian will sign a consent form showing he did approve of her YMCA membership and would like her to continue with the membership. 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; - Any client who has a gym membership will have a training goal related to the use of the facility. This will provide encouragement of the use of the membership/facility and documentation showing how often the client is going. Also, any Guardian, Power-of-Attorney, or Healthcare Rep. will be sure to sign the membership registration. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur; - Any client who would like a membership in the future will be sure to have Guardian, POA, or	06/02/2013

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 05/03/2013
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
	#1 was assisted to use her YMCA membership. Client #1's group home activity calendars/schedules and Day Services activity calendars/schedules from 9/2012, 10/2012, 11/2012, 12/2012, 1/2013, 2/2013, 3/2013, and up to 4/23/2013 were reviewed and did not indicate client #1 accessed nor was she assisted to access her YMCA membership included activity options. On 4/25/13 at 9:40am, a record review of client #1's finances was conducted. Client #1's financial records indicated monthly payments of $16.40 for her monthly usage fee of her YMCA membership was expensed. On 4/25/13 at 9:40am, client #1's 2011 "Application for Wabash County YMCA Membership" indicated no signature of client #1 nor client #1's guardian. The YMCA application indicated it was completed by the agency staff and a fee of $16.40 per month was assessed for client #1. On 4/24/13 at 9:05am, an interview with the QIDP was conducted. The QIDP indicated client #1 was at the "YMCA today" with a Day Service staff person. The QIDP indicated client #1 had a personal trust fund at the local bank and client #1 paid for her own YMCA		HCR approval, as well as a training goal put in place. 4. 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; - The Res. Mgr. and QDDP will review the objective worksheet related to the fitness goal once a month. This will ensure the membership is being utilized properly.	

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 05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	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
	membership. The QIDP stated the IDT (Interdisciplinary Team) had discussed with client #1's guardian the YMCA membership because client #1 "loved the water" and it would be good exercise for client #1. The QIDP indicated client #1 had a guardian and no documentation was available for review to indicate client #1's guardian had signed for the expenditure. On 4/16/13 at 5:30pm, a review of the facility's 4/2012 "Protection of Client Personal Funds" policy and procedure was conducted. The policy and procedure indicated "...The guardian must be consulted before any funds are distributed to that client. Pathfinder Services, Inc. will not disperse any personal client funds to any third party without written consent of the client...." 9-3-1(a)			

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 05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	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
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION 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. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to implement client #3's eating goal/objective when opportunities existed. Findings include: On 4/23/13 at 6:45am, Group Home Staff (GHS) #1 administered client #3 "one tablespoon Fiber Pudding (a fiber mixture called power pudding which consists of prune juice, Fiber One Cereal, and applesauce)" for constipation. GHS #1 scooped the Fiber Pudding, the mixture heaped over the edges of the tablespoon, GHS #1 handed the tablespoon to client #3, and client #3 consumed the fiber pudding in one bite. Client #3 coughed, smacked his lips, and moved his tongue in his mouth. No drink was provided and no redirection was given by GHS #1 for client #3 to take small bites. On 4/24/13 at 11:35am, client #3's record was reviewed. Client #3's 5/3/12 ISP	W000249	1. What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; - A formal dining goal will be put in place outlining the specific recommendations from the dietician. There will be a section included that stresses the importance of following dining plan during medication passes too. 2. 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 with dining recommendations could be affected and they will also have formal goals in place. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur; - Res. Mgr. will review dining goal/dining plans with group home staff monthly at house meetings and will stress the importance of ensuring plan is followed with medications as well. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,	06/02/2013

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 05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	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
	(Individual Support Plan) and record indicated 3/13/13 "Physician Orders" to have a mechanical soft diet with ground meat. Client #3's 2/28/13 "Choke/Aspiration Risk Assessment" completed by the registered dietician indicated client #3 was a choking risk because of dysphagia, required "one on one supervision with solids/liquids in tsp. (teaspoon) amounts," and "Offer client 30-60cc (cubic centimeters) fluids after every 2-3 bites to meet assist in safe swallow." On 4/25/13 at 10:15am, an interview with the agency nurse was conducted. The agency nurse indicated client #3 was a choking risk. The agency nurse indicated client #3 should have been prompted to take teaspoon sized bites of food; including during the medication administration. The agency nurse indicated client #3 should have been given water to drink with the fiber pudding. 9-3-4(a)		i.e., what quality assurance program will be put into place; - Res. Mgr. will observe client #3's medication pass once a week and will document her observations to ensure staff are encouraging his dining plan during med. passes.	

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 05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	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
W000391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review, and interview, for 1 of 29 medications observed administered (client #7), the facility failed to ensure each medication was labeled. Findings include: On 4/23/13 at 7:10am, the facility's Group Home Staff (GHS) #1 entered the medication room and selected an unlabeled bottle of "Tussin CF" (cough syrup) from the medication closet top shelf, poured two teaspoons of cough syrup into a medication cup, and administered the medication to client #7. At 7:30am, client #7 stated "I got it in (my) throat." Client #7 indicated he needed the cough syrup. At 7:30am, GHS #1 stated the unlabeled bottle of "Tussin CF" cough syrup was "House Stock" used for all clients in the group home and indicated the unlabeled bottle was also undated when it was opened. At 7:30am, client #7's 4/2013 MAR (Medication Administration Record) indicated "Tussin CF" PRN (as needed) for cough. On 4/23/13 at 7:30am, client #7's 4/17/13 "Physician's Order" indicated: "Give	W000391	1. What corrective action will be accomplished for these residents found to have been affected by the deficient practice. - Keep clients safe and healthy. Follow doctors orders and prescribed. 2. 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 receive medications will have nurse go into home and monitor medications passes quarterly and review medications and labels. Managers review checker passer sheet weekly to ensure that staff are checking each other right after medication pass and to assure doctors orders are being followed as prescribed. Also house manager and or designated staff will check medications weekly for ordering, check that all meds are labled and readable, along with making sure sticker is on med which have date of when opened. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. - Staff will read and sign updated Medication Adminstration Handbook Revised 4/25/13, Medication Administration	06/02/2013

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 05/03/2013
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
	cough syrup & Tylenol (pain reliever) PRN for cough and generalized pain or discomfort." On 4/25/13 at 10:15am, an interview with the agency nurse was conducted. The agency nurse indicated client #7's medication should have had a pharmacy label on it and/or should have had something to identify it belonged to client #7 written on the bottle. The agency nurse indicated if the cough syrup was House Stock the bottle should be labeled as House Stock and a date should have been written on it when the bottle was opened. The agency nurse indicated she was not called on 4/23/13 before client #7 was administered the unlabeled cough syrup medication. On 4/29/13 at 11:15am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #7's cough syrup medication should have had a pharmacy label on the medication to identify when it was opened and that the medication was House Stock. On 4/26/13 at 10:15am, a review of the facility's 3/18/11 "Annual Medication Administration Refresher" policy and procedure was conducted. The policy and procedure indicated "...Do not pass meds		Refresher with Test. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. what quality assurance program will be put into place. - All clients who receive medications will have nurse go into home and monitor medications passes quarterly. Managers review checker passer sheet weekly to ensure that staff are checking each other right after medication pass as a quality assurance and to assure doctors orders are being followed as prescribed.	

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 05/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHFINDER SERVICES INC	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
	from an unlabeled or illegibly labeled container. Contact the nurse as needed." 9-3-6(a)			