

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G731	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2014
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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 495 THOMAS RD HUNTINGTON, IN 46750
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 6/11, 6/12, 6/13, 6/18, and 6/19/2014.</p> <p>Provider Number: 15G731 Facility Number: 011263 AIM Number: 200838690</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/25/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review, and interview, for 2 of 2 sampled clients (clients #3 and #4) who had personal money entrusted to the facility and had personal money kept by staff at the facility owned workshop, the facility failed to ensure a full accounting of client #3 and #4's personal funds and failed to</p>	W000140	<p>Break money will no longer be given to Day Services. Break money will be given to each of the ladies as needed and staff will continue to work with them to develop responsibility to carry and use their money. This will ensure a full accounting of their funds. Any other individuals who currently have money left in Day</p>	07/18/2014

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.

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	<p>follow their policy and procedure for client finances.</p> <p>Findings include:</p> <p>On 6/12/14 at 11:10am, client #3 and #4's personal funds and bank statements were reviewed with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP counted out client #3 and #4's cash from their personal funds accounts in their individual cash bags and cash ledger records. No pop/canteen money was recorded. The QIDP provided client #3 and #4's monthly receipts which indicated a monthly receipt for a \$10.00 withdrawal for "Break" money documented on client #3 and #4's ledgers for 6/2014, 5/2014, and 4/2014. The QIDP stated the facility did not track client #3 and #4's "pop (workshop break)" funds and no records for these funds were available for review. When asked if the facility owned workshop had a record of client #3 and #4's pop/break money, the QIDP stated "No, [clients #3 and #4's] pop/break money was not tracked." The QIDP indicated client #3 and #4's funds from their personal fund accounts were given to the staff at the facility owned workshop by the facility staff from the group home. The QIDP indicated clients #3 and #4 did not carry their money and did not dispense their</p>		<p>Services will also begin to carry their own money each day. The Petty Cash Guidelines will be reviewed and revised to indicate that money will not be left with Day Services unless there is a daily accounting of the money. The Community Supports Coordinator will do spot checks each month on client petty cash ledgers to insure that break money is taken out in amounts for each day rather than a weekly or larger amount.</p>	

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	<p>own money.</p> <p>On 6/12/14 at 11:30am, an interview with the QIDP and the Community Supports Coordinator (CSC) was conducted. The QIDP and CSC both indicated clients #3 and #4's pop/break funds were not accounted for by the facility. The CSC indicated the facility did not follow the agency's policy and procedure to ensure a full accounting of each client's personal funds.</p> <p>On 6/13/14 at 10:00am, the facility's policy and procedure 7/26/2011 "Personal Account and Petty Cash Guidelines" indicated "Many of our customers require assistance in handling their money. In providing this service, it is our responsibility to provide controls to safeguard their monies...You are expected to obtain an original store receipt for every purchase...For personal accounts, when receipts are unavailable for things such as for church offerings, purchases at a concession stand, etc. a hand written receipt must be created and initialed by both staff and client. All transactions should be recorded on the personal account sheet including money taken out for clients' personal use...."</p> <p>9-3-2(a)</p>			

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W000149	<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 1 of 1 allegation of abuse, neglect, and/or mistreatment (for client #4), the facility neglected to ensure staff were on duty and providing staff supervision at the group home for client #4.</p> <p>Findings include:</p> <p>On 6/11/14 at 1:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 09/2013 through 6/3/14 and indicated the following:</p> <p>-A 5/22/14 BDDS report for an incident on 5/21/14 at 2:15pm, indicated client #4 was left at the group home alone without staff on duty. The report indicated the agency "received a call from [client #4's] residential staff at 2:25pm letting us know that they arrived home and [client #4] was standing on the sidewalk outside waving as staff pulled up the drive...There appeared to be no other staff there at the home with [client #4]." The report indicated the agency contacted client #4's group home day service staff</p>	W000149	<p>This situation occurred on 5-21-14. It was reported per regulations. An investigation was completed. Staff involved were provided retraining regarding the Prevention of Abuse and Neglect. A system was developed and put into place to account for all clients of each Day Service location and any trips or transportation away from the site.</p> <p>An informal checklist will be used by all staff doing transportation or trips to insure that all clients are present and accounted for. The Community Supports Coordinator or Community Integration Coordinator will do at least monthly spot checks to insure that the informal checklists are being utilized. Annual and as needed training will be provided to all Community Supports staff regarding the Prevention of Abuse and Neglect.</p>	07/18/2014			

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	<p>"to inquire where [client #4] was. They looked in the van, and very quickly let us know that [client #4] was not there. They quickly returned to the home following this call." The report indicated client #4's day service staff "noted that [client #4] had gotten into the van with them (the staff) to leave for the day. [Client #4] kept repeating I can't stay here today...The day staff let [client #4] know...[client #4] would need to ride in (the van) with them as normal as there were no other staff there at the house. The staff had to go and assist another client out of the home and into the van. When they (the staff) got them (other clients who attended at home day services) loaded up, they left for the agency. It appears that when [client #4] knew the staff were busy helping a peer [client #4] sneaked off of the van and hid until their van pulled away. They (the staff) noted that they left around 2:15pm."</p> <p>On 6/11/14 at 2:10pm, an interview with the CSC (Community Supports Coordinator) was conducted. The CSC indicated client #4 had been left at home alone on 5/21/14 without staff supervision. The CSC indicated the facility followed the BDDS policy for abuse/neglect/mistreatment and indicated client #4 was not being supervised by</p>			

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	<p>facility staff when client #4 was left home alone without staff on duty at the group home. The CSC stated "It was neglect" when client #4 was left home alone without staff supervision on 5/21/14.</p> <p>On 6/11/14 at 2:30pm, a record review was conducted of the 6/11/2002 BDDS "Incident Reporting" policy and procedure indicated "...Neglect, includes failure to provide appropriate care, food, medical care, or supervision...."</p> <p>On 6/11/14 at 1:42pm, a review of the facility's records indicated the facility's 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...."</p>			

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W000249	<p>9-3-2(a)</p> <p>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.</p> <p>Based on record review and interview, for 1 of 1 client who was left home alone (client #4), the facility failed to implement client #4's ISP (Individual Support Plan) and BSP (Behavior Support Plan) to ensure staff provided client #4 with supervision at the group home based on her identified needs.</p> <p>Findings include:</p> <p>On 6/11/14 at 1:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports and investigations were reviewed from 09/2013 through 6/3/14 and indicated the following:</p> <p>-A 5/22/14 BDDS report for an incident on 5/21/14 at 2:15pm, indicated client #4 was left at the group home alone without staff on duty. The report indicated the agency "received a call from [client #4's]</p>	W000249	<p>This situation occurred on 5-21-14. It was reported per regulations. An investigation was completed. Staff involved were provided retraining regarding the implementation of the ISP and in providing supervision and continuous active treatment for each individual in the day service. Spot checks will be done at least monthly by the Community Supports Coordinator or the Community Integration Coordinator to insure that adequate supervision and continuous active treatment is being provided. This will cover both areas of identifying any other individuals from deficient practice and making sure this practice does not recur.</p> <p>Annual and as needed training will also be provided to all Community Supports staff regarding implementing the ISP and providing Active Treatment.</p>	07/18/2014

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	<p>residential staff at 2:25pm letting us know that they arrived home and [client #4] was standing on the sidewalk outside waving as staff pulled up the drive...There appeared to be no other staff there at the home with [client #4]." The report indicated the agency contacted client #4's group home day service staff "to inquire where [client #4] was. They looked in the van, and very quickly let us know that [client #4] was not there. They quickly returned to the home following this call." The report indicated client #4's day service staff "noted that [client #4] had gotten into the van with them (the staff) to leave for the day. [Client #4] kept repeating I can't stay here today...The day staff let [client #4] know...[client #4] would need to ride in (the van) with them as normal as there were no other staff there at the house. The staff had to go and assist another client out of the home and into the van. When they (the staff) got them (other clients who attended at home day services) loaded up, they left for the agency. It appears that when [client #4] knew the staff were busy helping a peer [client #4] sneaked off of the van and hid until their van pulled away. They (the staff) noted that they left around 2:15pm."</p> <p>On 6/11/14 at 2:10pm, an interview with</p>			

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	<p>the CSC (Community Supports Coordinator) was conducted. The CSC indicated client #4 had been left at home alone on 5/21/14 without staff supervision. The CSC indicated client #4 required twenty-four hour staff supervision, did not possess community safety skills, and had a history of AWOL (Absent Without Leave) behaviors. The CSC indicated the facility staff failed to implement client #4's ISP and BSP for client #4's identified needs. The CSC indicated client #4 should not have been left at home alone on 5/21/14.</p> <p>Client #4's record was reviewed on 6/12/14 at 1:20pm. Client #4's 7/18/13 ISP (Individual Support Plan) indicated goals/objectives to identify the value of coins, have knowledge of the community, and required twenty-four hour staff supervision. Client #4's 7/18/13 FAT (Functional Assessment Tool) indicated she did not possess independent pedestrian safety skills. Client #4's 4/28/14 BSP indicated "Primary maladaptive behavior and rate of occurrence: [Client #4] has been known to walk off from her home without telling anyone. This behavior is part of [client #4's] history prior to her placement in November of 2006...Walking off has also occurred during her day service hours... [Client #4] has walked off or went</p>			

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W000391	<p>outside without alerting staff...On days when she appears to be pacing...stating she does not want to go to day services, staff need to monitor [client #4] closely, as this may be when she decides to leave the home...Rationale: [Client #4] has poor safety/pedestrian skills. She does not stop at crosswalks for traffic or oncoming cars. [Client #4] could eventually get lost, as she would become disoriented and confused as to where she was, even if in town...In the past, staff has asked her if she wanted to go for a walk, she says no, and once she sees staff busy with other housemates, [client #4] will take off walking...."</p> <p>9-3-4(a)</p> <p>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 additional client (client #5), the facility failed to remove from use the medication containers without labels from the pharmacy.</p> <p>Findings include: On 6/11/14 at 5:42pm, GHS (Group Home Staff) #2 asked client #5 to come</p>	W000391	<p>The medication label was smudged but was still legible as to the directions in which it was to be given. However, staff also know that a label needs to be completely intact or to request it be replaced by the Residential Nurse. This label was replaced the morning of 6-12-14. Retraining will be provided to the house staff as to refresh their memory regarding the proper labeling of medication bottles.</p>	07/18/2014

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	<p>to the medication area. GHS #2 selected client #5's Blood Sugar Omega (for high cholesterol) bottle of medication. The label on the medication indicated "Blood Sugar Omega, 2 tabs (tablets) 2 times per day with "(the ink was smudged and the label was unable to be read) and supper" and the entire label could not be read. GHS #2 administered client #5 two tablets of the medication. At 5:42pm, GHS #2 stated she could not read the "entire" label, but could read the "part" about with supper" meal.</p> <p>On 6/12/14 at 5:36am, GHS #3 asked client #5 to come to the medication area. GHS #3 selected client #5's Blood Sugar Omega for high cholesterol bottle of medication. The label on the medication indicated "Blood Sugar Omega, 2 tabs (tablets) 2 times per day with "(the ink was smudged and the label was unable to be read) and supper." The entire label could not be read. GHS #3 administered client #5 two tablets of the medication. At 5:36am, GHS #3 indicated she could not read the entire label and compared the medication to client #5's MAR (Medication Administration Record). GHS #3 indicated she would call the agency nurse later to inquire.</p> <p>On 6/12/14 at 6:02am, client #5's 6/2014 MAR (Medication Administration</p>		<p>Labels for all of the medications will be checked to insure they are legible.</p> <p>All staff will be reminded of the section in the Medication Administration Handbook regarding labels so that they can correct any that could impact client safety.</p> <p>Annual and as needed refresher training regarding medication administration and handling will be provided to all Community Supports staff.</p> <p>The Residential Nurses will do at least monthly spot checks in the homes to insure that all medication labels are not damaged or otherwise rendered illegible.</p>	

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	<p>Record) and client #5's 3/24/14 "Physician's Order" were reviewed and indicated "Blood Sugar Omega, 2 tabs (tablets) 2 times daily with breakfast and supper for high cholesterol."</p> <p>On 6/12/14 at 8:15am, an interview with the agency Registered Nurse (RN) was conducted. The RN indicated client #5's Blood Sugar Omega was for high cholesterol. The RN indicated client #5's Blood Sugar Omega bottle did not have a pharmacy label on the medication that could be read. The RN stated client #5's medication bottle label was "compromised" and "could not be read" to administer client #5's medication. The RN indicated the facility followed the Core A/Core B training for medication administration and the facility policy and procedure for medication administration. The RN indicated the agency nurse was not contacted until after the medication was administered to client #5 on 6/11/14 and 6/12/14. The RN indicated client #5's medication label had been corrected by the agency nurse on 6/12/14.</p> <p>On 6/12/14 at 10:10am, a review of the facility's 1/3/14 "Medication Administration Handbook" indicated before passing medications all staff will complete the Core A and Core B Medication Administration Curriculum</p>			

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W000436	<p>which includes but is not limited to the following information: "All staff adhere to the six rights of medication administration...Read the label 3 times before med is poured," after med is poured and before med is given. "General Considerations to Remember when Administering Medications: Never administer a medication from an unlabeled or illegibly labeled container. Notify the nurse if there is a label concern...."</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 4 of 4 sampled clients (clients #1, #2, #3, and #4) with adaptive equipment, the facility failed to teach and encourage clients #1, #2, #3, and #4 to wear their prescribed eye glasses when opportunities existed.</p> <p>Findings include: On 6/11/14 from 3:10pm until 7:10pm,</p>	W000436	<p>Clients # 1, 2, 3 & 4 are prescribed eye glasses in order to properly see. While staff track each morning that the needed adaptive equipment is in place, they failed to provide additional reminders during the evening hours. A formal goal will be put into place for each of the ladies to have education provided to them regarding the proper wearing of their eye glasses, If there is other adaptive equipment that is not being used</p>	07/18/2014

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(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, and #3 wore their prescribed eye glasses. On 6/11/14 from 3:10pm until 3:45pm, client #4 did not wear her prescribed eye glasses. From 3:45pm until 7:10pm, client #4 did not wear and was not encouraged to wear her prescribed eye glasses. During the observation period client #4 prepared and packed her lunch with group home staff. Client #4 selected her carrots for a snack by putting her entire head into the refrigerator to look at the large bag of carrots. Client #4 walked up and down the staircase inside the facility. Client #4 watched television by sitting on the floor within one foot of the television screen. Client #4 attempted to pump the soap container inside the bathroom and her hand did not connect with the pump control the first three times she attempted. Client #4 left in the facility van for a community outing for a picnic.</p> <p>On 6/12/14 from 5:15am until 7:45am, observation was completed at the group home with clients #1, #2, #3, and #4. From 5:15am until 7:45am, client #4 did not wear her prescribed eye glasses and was not encouraged to wear them by the facility staff. Client #4 walked up and down the facility staircase, watched television positioning herself within one foot of the television screen, walked in circles, prepared and ate her breakfast.</p>		<p>as ordered by the doctor at this house, we will put written goals into place to provide clients the education needed to properly use the equipment for their benefit. Training will be provided to all Community Supports staff to remind them that all adaptive equipment should be used as ordered. While the client has the right to refuse, staff will be trained that they need to provide regular reminders and education to the client. QDDP's will monitor this on their regular visits to each group home to insure that the reminders and education is being provided.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G731		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/19/2014	
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	<p>At 6:10am, client #4 completed medication administration and wore her prescribed eye glasses. From 5:15am until 7:20am, client #1 did not wear her prescribed eye glasses, walked up and down the facility staircase, prepared and ate her breakfast, and dressed. At 6:17am, client #1 wore her eye glasses and completed medication administration. From 5:15am until 7:45am, client #3 did not wear her prescribed eye glasses. From 5:24am until 6:17am, client #2 did not wear her prescribed eye glasses and client #2 walked up and down the facility staircase.</p> <p>On 6/12/14 at 12:05pm, client #1's record was reviewed. Client #1's 6/20/13 ISP (Individual Support Plan) did not indicate a goal/objective to wear her prescribed eye glasses and indicated client #1 "is scheduled to wear her glasses during all waking hours as desired." Client #1's 2/17/14 visual assessment indicated client #1's prescribed eye glasses should have been worn "during all awake hours."</p> <p>On 6/12/14 at 10:25am, client #2's record was reviewed. Client #2's 1/21/14 ISP (Individual Support Plan) did not indicate a goal/objective to wear her prescribed eye glasses and indicated client #2 "is to wear her glasses during all waking hours." Client #2's 9/17/12 visual</p>						

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	<p>assessment indicated client #2's prescribed eye glasses should have been worn "during awake hours."</p> <p>On 6/12/14 at 12:50pm, client #3's record was reviewed. Client #3's 8/22/13 ISP did not indicate a goal/objective to wear her prescribed eye glasses and indicated client #3 "is scheduled to wear her glasses during awake hours as desired." Client #3's 10/21/13 visual assessment indicated client #3's prescribed eye glasses should have been worn "during awake hours."</p> <p>On 6/12/14 at 1:20pm, client #4's record was reviewed. Client #4's 7/18/13 ISP indicated a goal/objective to wear her prescribed eye glasses "more frequently." Client #4's 6/18/12 visual assessment indicated client #4's prescribed eye glasses should have been worn "as desired."</p> <p>On 6/19/14 at 8:30am, and on 6/19/14 at 8:48am, an interview with the CSC (Community Services Coordinator) was conducted. The CDC indicated clients #1, #2, #3, and #4 wore prescribed eye glasses to see. The CDC indicated clients #1, #2, and #3 did not have goals/objectives to teach the clients when to wear their prescribed eye glasses and staff should have taught and encouraged</p>			

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	clients #1, #2, #3, and #4 to wear their eye glasses during formal and informal opportunities. 9-3-7(a)				