

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 07/23/2013
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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 annual recertification and state licensure survey.</p> <p>Dates of Survey: July 17, 18, 22, and 23, 2013.</p> <p>Facility number: 0011263 Provider number: 15G731 AIM number: 200838690</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 30, 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.

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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based upon record review and interview, the facility's governing body failed to provide oversight and direction over the facility to ensure staff did not neglect to protect 1 of 4 sampled clients (client #4), from ingesting excessive food after a history of excessive consumption of food had been identified, and failed to provide monitoring to ensure corrective action was implemented.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/18/13 at 9:01 AM and included the following:</p> <p>1. A report dated 1/26/13 at 1:00 PM indicated client #4's diagnosis included, but was not limited to, Prader Willi Syndrome "which leads to uncontrollable eating...The locking mechanism on the food (unspecified where) was found to be broken (unspecified when)...Upon staff checking [client #4's] room, it was found that she had taken items to her room and consumed them. This was smoked sausage, a jar of peanut butter, a tub of icing and a package of hot dog buns."</p>	W000104	<p>After the incident that occurred in January where client # 4 got a hold of food that she should not have had access to, we discovered that there was a broken lock on the refrigerator that allowed her to gain access. We immediately implemented a lock tracking at the home where staff were required to check the locks on the refrigerator, freezer, and cabinets twice daily to assure that they were locked and in working condition. During this incident we also discovered that while staff noted they were watching client # 4, they were not using the bracelet as the plan states needs to be done to give staff that reminder that they are responsible for her observation. An email was sent out on 01/26/2013 reminding staff that it is a requirement that someone must be wearing the bracelet at all times. All staff were then retrained on client # 4's behavior plan on 02/19/2013 at a house meeting to assure they understood what we all as staff were to be doing. When it was found that room checks had not been done for 7 days at the beginning of March we took immediate action and suspended all of the employees that had been working during those 7 days</p>	08/19/2013			

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	<p>After lunch, client #4 began to vomit, was taken to the hospital and it was determined her stomach and intestine were "greatly" distended and blocked. She was transferred to another hospital and a tube was placed to suction food and liquid from her stomach. Client #4 was monitored to ensure the procedure was effective or if surgery was needed. The plan to resolve section of the BDDS report indicated the lock would be repaired and routine checks were implemented by staff to ensure it was not damaged. The report indicated client #4 would remain in the hospital for a day or two. A follow up report dated 1/31/13 indicated client #4 was "doing well," was discharged from the hospital on 1/30/13, and would return to her primary care physician in one week and her GI (gastro-intestinal) physician in 2 months. The report indicated client #4 had a behavior plan (date unspecified) to address her behavior of excessive eating, and one staff was assigned to wear a bracelet to remind them to monitor client #4's whereabouts to keep her safe. "Staff were not following this procedure when the incident occurred." The report indicated staff would be retrained regarding client #4's plan and tracking sheets were developed for staff to sign and hold them accountable for client #4's whereabouts, and to ensure locks to the</p>		<p>as we investigated in to the issue. When doing our investigation in March of 2013 it became apparent that even though they had the training, the staff didn't have a good understanding of how not following the plan can drastically affect client # 4's health and wellbeing. During the time of the staff's suspension, client # 4's behavior management plan was revised to assure that it was clear and precise and easily understandable for the staff to follow. Prior to returning to the home to work, all employees were retrained on the plan on 03/20/2013 and 03/21/2013. Following the training, all employees were given a written test to assure their understanding of the behavior management plan and the implications that it has on client # 4's health. To assure that the room checks are getting done as they are required, the Manager and assistant manager started checking the tracking prior to the end of their shift to assure it had been done. If it has been done, they initial off noting that they saw it was completed. If it has not been done yet for the day, prior to them leaving their shift, they do the room check to assure there has been no food that client # 4 had a chance to get during that day. In March we started requiring that all tracking be turned in the QDDP at the end of the month to assure that it was being completed as required for client #</p>				

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	<p>food were secure. Daily room checks were to be completed to ensure client #4 "has not gotten food and hid it in her bedroom." A follow up report dated 2/1/13 indicated staff working in the home at the time of the incident with client #4 ingesting food was not wearing a bracelet per her plan.</p> <p>A BDDS report dated 2/28/13 indicated client #4 vomited after her 8 PM snack and reported to staff her stomach was upset. Client #4 was taken to the hospital as "when she vomits, it could be serious." At scan at the hospital indicated a blockage between client #4's stomach and her intestine. Client #4 was transferred to another hospital and fluid was drained from her stomach. A follow up report dated 3/5/13 indicated client #4 was released without conclusive findings as to what caused her blockage and vomiting. The report indicated she would follow up with her family doctor on 3/8/13 and her GI physician on 4/8/13.</p> <p>A BDDS report dated 3/13/13 indicated client #4 had 2 previous hospitalizations as a result of her eating "uncontrollably" and staff had been trained on the importance of the procedures in client #4's behavior plan including a daily room search. A room search was completed on 3/13/13 and when it was documented, it</p>		<p>4's health and safety. The QDDP will make visits to the service sites for client # 4 at least 3 times per month to assure that her plan is being run as written. The coordinator will do random stop-ins at the home at least twice per month to assure that the staff are following the plan as written and completing documentation as is required. Client # 4's tracking sheets are carried with her from home to day services each day. Along with doing the home visits, the QDDP and Coordinator will also do random checks of her tracking sheets at least once per week to assure the tracking is getting done and any concerns are getting reported. Starting August 20 th , 2013 the coordinator and the QDDP will start scheduling these visits on their calendar each month so that no visits are missed. The QDDP and coordinator will also keep a log of when they visit the sites to assure that it is getting done regularly. To assure that all of the homes are getting the oversight needed an email will be sent to all the QDDPs and Coordinators by 08/19/2013 requesting that they keep a log of all of their visits to their sites. This log will be turned in to the coordinators at the end of each month to assure that visits are being made to the group homes for client and staff oversight.</p>				

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	<p>was noted staff had failed to complete room searches on 3/3/13, 3/4/13, 3/6/13, 3/9/13, 3/10/13, 3/11/13 and 3/12/13. Administrative staff had not been notified of the lack of searches. The plan to resolve section of the report indicated all 9 staff that were on duty during the days when searches had not been completed were suspended. A follow up report dated 3/21/13 indicated "the allegation of neglect of correctly implementing [client #4's] behavior plan was substantiated. We also believe that this failure was not done with the intention to harm, but because staff did not understand the seriousness of how the room checks would assist in keeping [client #4] safe." The report indicated staff would be retrained and protective measures for client #4 would be revised. The report indicated staff would now complete written return demonstration of their knowledge of training on BMPs (Behavior Management Plans), High Risk Plans, and Dietary Requirements.</p> <p>Objective worksheets for client #4's room checks were reviewed on 7/18/13 at 2:30 PM. The April, 2013 worksheet indicated on April 3 a spoon in a small yellow bag and baggie were found inside client #4's closet, on 4/24/13 a granola bar wrapper, on 4/27/13 an empty baggie. The May, 2013 worksheet indicated on 5/1/13, a</p>			

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	<p>banana peel was found outside client #4's window, on 5/19/13, hamburger buns were found in the bathroom, and on 5/27/13, a half a loaf of bread was found in the closet. The June, 2013 worksheets for client #4 indicated a juice box was found in her room on 6/30/13.</p> <p>The Community Supports Coordinator (CSC) was interviewed on 7/18/13 at 10:35 AM. When asked about monitoring by administrative staff of the group home to ensure client #4's plan was implemented, she indicated the QIDP (Qualified Intellectual Disabilities Professional) visited the home monthly, and stated she herself visited the home "once every couple of months." She indicated she would stop in more frequently for short visits.</p> <p>The (CSC) was interviewed on 7/18/13 at 11:20 AM. She indicated the facility had implemented additional checks of the tracking sheets for the locks in the home and of the daily checks of client #4's room. She indicated there was no written investigation as to how the items ended up in client #4's room in April, May, and June, 2013 despite client #4's level of staff supervision, though the incidents were discussed by facility staff as to how to prevent future incidents. She indicated the CSC and QIDP now review the</p>			

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	<p>tracking sheets to ensure the checks were being conducted and documented.</p> <p>The CSC was interviewed again on 7/18/13 at 2:40 PM. She indicated staff had failed to implement client #4's plan to provide daily checks of her room to prevent her from ingesting excessive food, and the failure to do so violated the facility's policy and procedures to protect clients from neglect. She indicated the governing body which included her position, was responsible for ensuring the implementation of policy and procedures to protect clients.</p> <p>The Community Supports Associate Director/Nurse was interviewed on 7/23/13 at 9:31 AM and indicated the house manager had been working a limited schedule at the time of the failure by staff to check client #4's room on a daily basis.</p> <p>9-3-1(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 upon record review and interview for 3 of 6 allegations reviewed, the facility failed to implement policy and procedures which prohibited client neglect to protect 1 of 4 sampled clients (client #4) from ingesting excessive food after a history of excessive consumption of food had been identified, failed to implement effective corrective action to prevent client #4 from eating excessive food, and failed to ensure policy and procedures to prevent abuse and neglect included the requirement to implement corrective action.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/18/13 at 9:01 AM and included the following:</p> <p>1. A report dated 1/26/13 at 1:00 PM indicated client #4's diagnosis included, but was not limited to, Prader Willi Syndrome "which leads to uncontrollable eating...The locking mechanism on the food (unspecified where) was found to be broken (unspecified when)...Upon staff checking [client #4's] room, it was found</p>	W000149	Our organization does have an Abuse and Neglect Policy in place. We did have an incident where multiple staff failed to follow client # 4's behavior plan, which ultimately put her health at risk. Once this issue was brought to our attention, an immediate suspension of these employees took place while an investigation was done. When doing our investigation in March of 2013 it became apparent that even though they had the training, the staff didn't have a good understanding of how not following the plan could drastically affect client # 4's health and wellbeing. While we did feel the actions were neglectful, we felt that this may have been due to lack of training and felt that with more adequate training the staff would be able to follow the plan and assure client # 4's safety. During the time of the staff's suspension, client # 4's behavior management plan was revised to assure that it was clear and precise and easily understandable for the staff to follow. Prior to returning to the home to work, all employees were retrained on the plan on 03/20/2013 and 03/21/2013. Following the training, all employees were given a written	08/19/2013			

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	that she had taken items to her room and consumed them. This was smoked sausage, a jar of peanut butter, a tub of icing and a package of hot dog buns." After lunch, client #4 began to vomit, was taken to the hospital and it was determined her stomach and intestine were "greatly" distended and blocked. She was transferred to another hospital and a tube was placed to suction food and liquid from her stomach. Client #4 was monitored to ensure the procedure was effective or if surgery was needed. The plan to resolve section of the BDDS report indicated the lock would be repaired and routine checks were implemented by staff to ensure it was not damaged. The report indicated client #4 would remain in the hospital for a day or two. A follow up report dated 1/31/13 indicated client #4 was "doing well," was discharged from the hospital on 1/30/13, and would return to her primary care physician in one week and her GI (gastro-intestinal) physician in 2 months. The report indicated client #4 had a behavior plan (date unspecified) to address her behavior of excessive eating, and one staff was assigned to wear a bracelet to remind them to monitor client #4's whereabouts to keep her safe. "Staff were not following this procedure when the incident occurred." The report indicated staff would be retrained		test to assure their understanding of the behavior management plan. All employees are trained on our abuse and neglect policy upon hire. Our staff are then retrained each October on our policy and are given a written test to assure they have a good understanding of our policy. This retraining is a requirement so all staff have to be retrained if they want to retain employment. Since this will not be done until October, the coordinator will send an email out to all employees by 08/19/2013 reminding them of our policy and the importance of making sure that we respecting our clients and keeping them safe. They will be reminded that we need to make sure we are following all protective measures that are put in to place for our clients or it could be seen as neglectful and disciplinary action will be taken. The group home managers, QDDPs and the coordinators will continue to watch for any issues with staff not implementing safety procedures for the clients we serve, and will report any issues immediately to assure the safety of our clients. To assure that the room checks are getting done as they are required in client # 4's plan, the Manager and assistant manager started checking the tracking prior to the end of their shift to assure it had been done. If it has been done, they initial off noting that they saw it was completed. If it				

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	<p>regarding client #4's plan and tracking sheets were developed for staff to sign and hold them accountable for client #4's whereabouts, and to ensure locks to the food were secure. Daily room checks were to be completed to ensure client #4 "has not gotten food and hid it in her bedroom." A follow up report dated 2/1/13 indicated staff working in the home at the time of the incident with client #4 ingesting food was not wearing a bracelet per her plan.</p> <p>A BDDS report dated 2/28/13 indicated client #4 vomited after her 8 PM snack and reported to staff her stomach was upset. Client #4 was taken to the hospital as "when she vomits, it could be serious." At scan at the hospital indicated a blockage between client #4's stomach and her intestine. Client #4 was transferred to another hospital and fluid was drained from her stomach. A follow up report dated 3/5/13 indicated client #4 was released without conclusive findings as to what caused her blockage and vomiting. The report indicated she would follow up with her family doctor on 3/8/13 and her GI physician on 4/8/13. There was no further evidence of an investigation to determine the cause of client #4's illness.</p> <p>A BDDS report dated 3/13/13 indicated client #4 had 2 previous hospitalizations</p>		<p>has not been done yet for the day, prior to them leaving their shift, they do the room check to assure there has been no food that client # 4 had a chance to get during that day. In March we started requiring that all tracking be turned in the QDDP at the end of the month to assure that it was being completed as required for client # 4's health and safety. The QDDP will make visits to the service sites for client # 4 at least 3 times per month to assure that her plan is being run as written. The coordinator will do random stop-ins at the home at least twice per month to assure that the staff are following the plan as written and completing documentation as is required. Client # 4's tracking sheets are carried with her from home to day services each day. Along with doing the home visits, the QDDP and Coordinator will also do random checks of her tracking sheets at least once per week to assure the tracking is getting done and and any concerns are getting reported. Starting August 20 th , 2013 the coordinator and the QDDP will start scheduling these visits on their calendar each month so that no visits are missed. The QDDP and coordinator will also keep a log of when they visit the sites to assure that it is getting done regularly.</p>		

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	<p>as a result of her eating "uncontrollably" and staff had been trained on the importance of the procedures in client #4's behavior plan including a daily room search. A room search was completed on 3/13/13 and when it was documented, it was noted staff had failed to complete room searches on 3/3/13, 3/4/13, 3/6/13, 3/9/13, 3/10/13, 3/11/13 and 3/12/13. Administrative staff had not been notified of the lack of searches. The plan to resolve indicated all 9 staff that were on duty during the days when searches had not been completed were suspended. A follow up report dated 3/21/13 indicated "the allegation of neglect of correctly implementing [client #4's] behavior plan was substantiated. We also believe that this failure was not done with the intention to harm, but because staff did not understand the seriousness of how the room checks would assist in keeping [client #4] safe." The report indicated staff would be retrained and protective measures for client #4 would be revised. The report indicated staff would now complete written return demonstration of their knowledge of training on BMPs (Behavior Management Plans), High Risk Plans, and Dietary Requirements.</p> <p>Objective worksheets for client #4's room checks were reviewed on 7/18/13 at 2:30 PM. The April 2013 worksheet indicated</p>			

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	<p>on April 3 indicated a spoon in a small yellow bag and baggie were found inside client #4's closet, on 4/24/13 a granola bar wrapper, on 4/27/13 an empty baggie. The May 2013 worksheet indicated on 5/1/13, a banana peel was found outside client #4's window, on 5/19/13, hamburger buns were found in the bathroom, and on 5/27/13, a half loaf of bread was found in the closet. The June 2013 worksheets for client #4 indicated a juice box was found in her room on 6/30/13.</p> <p>The Community Supports Coordinator (CSC) was interviewed on 7/18/13 at 11:20 AM. She indicated the facility had implemented additional checks of the tracking sheets for the locks in the home and of the daily checks of client #4's room. She indicated there was no written investigation as to how the items ended up in client #4's room in April, May, and June, 2013 despite client #4's level of staff supervision, though the incidents were discussed by facility staff as to how to prevent future incidents.</p> <p>The CSC was interviewed again on 7/18/13 at 2:40 PM. She indicated staff had failed to implement client #4's plan to provide daily checks of her room to prevent her from ingesting excessive food, and the failure to do so violated the facility's policy and procedures to protect</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 07/23/2013
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	<p>clients from neglect.</p> <p>The Community Supports Associate Director/Nurse was interviewed on 7/23/13 at 9:31 AM and indicated the failure to report the lapses in daily room checks to the administrator was a violation of policy and procedures. She indicated the house manager had been working a limited schedule at the time of the failure to check client #4's room on a daily basis and client #4's plan had been revised in 3/13 to more clearly define procedures to check client #4's room on a daily basis.</p> <p>The facility's Handling Abuse, Neglect, Injuries of Unknown Origin and BDDS Incident reporting Suspected Abuse, Neglect or Mistreatment policy and procedures dated 10/5/11 was reviewed on 7/18/13 at 10:15 AM. The policy and procedures indicated neglect was prohibited and suspected neglect should be reported immediately and investigated. The policy did not include the requirement for corrective action.</p> <p>9-3-2(a)</p>			

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to ensure staff notified the administrator client #4's behavior plan had not been implemented.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/18/13 at 9:01 AM and included the following:</p> <p>1. A report dated 1/26/13 at 1:00 PM indicated client #4's diagnosis included, but was not limited to, Prader Willi Syndrome "which leads to uncontrollable eating...The locking mechanism on the food (unspecified where) was found to be broken (unspecified when)...Upon staff checking [client #4's] room, it was found that she had taken items to her room and consumed them. This was smoked sausage, a jar of peanut butter, a tub of icing and a package of hot dog buns." After lunch, client #4 began to vomit, was taken to the hospital and it was</p>	W000153	<p>In the incidents of staff failing to follow client # 4's behavior plan and not doing the daily room checks that are required, it became clear in our investigation that the staff were not looking at this as an issue for client # 4's health and safety. Because they were not looking at it from this perspective, they did not report the missed room checks so that the incidents could be investigated. Following our investigation, when we met with all the staff again on 03/19/2013 and 03/20/2013 we made sure they understood that not doing the room checks were considered neglectful as they were needed to assure client # 4's safety. Staff were made aware that they would need to notify us immediately if these were not getting done. To assure that the room checks are getting done as they are required, the Manager and assistant manager started checking the tracking prior to the end of their shift to assure it had been done. If it has been done, they initial off noting that they saw it was completed. If it has not been done yet for the day, prior to them leaving their shift, they do the</p>	08/19/2013			

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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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	determined her stomach and intestine were "greatly" distended and blocked. She was transferred to another hospital and a tube was placed to suction food and liquid from her stomach. Client #4 was monitored to ensure the procedure was effective or if surgery was needed. The plan to resolve section of the BDDS report indicated the lock would be repaired and routine checks were implemented by staff to ensure it was not damaged. The report indicated client #4 would remain in the hospital for a day or two. A follow up report dated 1/31/13 indicated client #4 was "doing well," was discharged from the hospital on 1/30/13, and would return to her primary care physician in one week and her GI (gastro-intestinal) physician in 2 months. The report indicated client #4 had a behavior plan (date unspecified) to address her behavior of excessive eating, and one staff was assigned to wear a bracelet to remind them to monitor client #4's whereabouts to keep her safe. "Staff were not following this procedure when the incident occurred." The report indicated staff would be retrained regarding client #4's plan and tracking sheets were developed for staff to sign and hold them accountable for client #4's whereabouts, and to ensure locks to the food were secure. Daily room checks were to be completed to ensure client #4		room check to assure there has been no food that client # 4 had a chance to get during that day. In March we started requiring that all tracking be turned in the QDDP at the end of the month to assure that it was being completed as required for client # 4's health and safety. The QDDP will make visits to the service sites for client # 4 at least 3 times per month to assure that her plan is being run as written. The coordinator will do random stop-ins at the home at least twice per month to assure that the staff are following the plan as written and completing documentation as is required. Client # 4's tracking sheets are carried with her from home to day services each day. Along with doing the home visits, the QDDP and Coordinator will also do random checks of her tracking sheets at least once per week to assure the tracking is getting done and and any concerns are getting reported. Starting August 20 th , 2013 the coordinator and the QDDP will start scheduling these visits on their calendar each month so that no visits are missed. The QDDP and coordinator will also keep a log of when they visit the sites to assure that it is getting done regularly. To assure that all employees are getting allegations or suspicions reported immediately, the coordinator will send an email out by 08/19/2013 to all group home employees reminding them of our				

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	<p>"has not gotten food and hid it in her bedroom." A follow up report dated 2/1/13 indicated staff working in the home at the time of the incident with client #4 ingesting food was not wearing a bracelet per her plan.</p> <p>A BDDS report dated 2/28/13 indicated client #4 vomited after her 8 PM snack and reported to staff her stomach was upset. Client #4 was taken to the hospital as "when she vomits, it could be serious." At scan at the hospital indicated a blockage between client #4's stomach and her intestine. Client #4 was transferred to another hospital and fluid was drained from her stomach. A follow up report dated 3/5/13 indicated client #4 was released without conclusive findings as to what caused her blockage and vomiting. The report indicated she would follow up with her family doctor on 3/8/13 and her GI physician on 4/8/13.</p> <p>A BDDS report dated 3/13/13 indicated client #4 had 2 previous hospitalizations as a result of her eating uncontrollably and staff had been trained on the importance of the procedures in client #4's behavior plan including a daily room search. A room search was completed on 3/13/13 and when it was documented, it was noted staff had failed to complete room searches on 3/3/13, 3/4/13, 3/6/13,</p>		<p>Abuse and Neglect policy which states that all suspicions of client mistreatment, abuse, and neglect must be reported immediately. They will be reminded of whom these reports can be made to so that the allegations can be investigated immediately. To assure that all allegations or alleged violations are being thoroughly investigated and documented once in incident is reported, the coordinator will send an email to all coordinators by 08/19/2013 reminding them that any time there is an allegation that is brought to our attention; we must do a through investigation. This investigation will include interviewing staff, interviewing clients (as is feasible for the situation), and documenting these conversations. With each investigation they will be directed to create a summary that goes over the details of the investigation and what was determined from the investigation. Any corrective action taken will need to be outlined in the summary as well. The coordinators will be responsible for assuring these investigations get done and thoroughly documented as well as reporting the incidents though a BDDS report and to APS.</p>		

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	<p>3/9/13, 3/10/13, 3/11/13 and 3/12/13. Administrative staff had not been notified of the lack of searches. The plan to resolve indicated all 9 staff that were on duty during the days where searches had not been completed were suspended. A follow up report dated 3/21/13 indicated "the allegation of neglect of correctly implementing [client #4's] behavior plan was substantiated. We also believe that this failure was not done with the intention to harm, but because staff did not understand the seriousness of how the room checks would assist in keeping [client #4] safe."</p> <p>Objective worksheets for client #4's room checks were reviewed on 7/18/13 at 2:30 PM. The April 2013 worksheet indicated on April 3 indicated a spoon in a small yellow bag and baggie were found inside client #4's closet, on 4/24/13 a granola bar wrapper, on 4/27/13 an empty baggie. The May 2013 worksheet indicated on 5/1/13, a banana peel was found outside client #4's window, on 5/19/13, hamburger buns were found in the bathroom, and on 5/27/13, a half loaf of bread was found in the closet. The June 2013 worksheets for client #4 indicated a juice box was found in her room on 6/30/13.</p> <p>The Community Supports Associate Director/Nurse was interviewed on</p>				

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	<p>7/23/13 at 9:31 AM and indicated the failure to report the lapses in daily room checks to the administrator was a violation of policy and procedures. She indicated the house manager had been working a limited schedule at the time of the failures to complete daily checks of client #4's room.</p> <p>9-3-2(a)</p>			

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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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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based upon record review and interview, the facility failed to document a thorough investigation for 1 of 4 sampled clients (client #4), regarding how evidence of food items were found in her room despite her program which included staff supervision to prevent her from obtaining food items without staff knowledge.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/18/13 at 9:01 AM and included the following:</p> <p>A BDDS report dated 2/28/13 indicated client #4 vomited after her 8 PM snack and reported to staff her stomach was upset. Client #4 was taken to the hospital as "when she vomits, it could be serious." At scan at the hospital indicated a blockage between client #4's stomach and her intestine. Client #4 was transferred to another hospital and fluid was drained from her stomach. A follow up report dated 3/5/13 indicated client #4 was released without conclusive findings as to what caused her blockage and vomiting. The report indicated she would follow up</p>	W000154	<p>There are times that while doing client # 4's room searches there is evidence found that she may have gotten a hold of something that she should not have had. During these times the team is good about communicating this, and we do have discussions as to what may have happened that allowed her to find the food items. While we have these discussions we do not do formal investigations. On 08/07/2013 the coordinator, QDDP, group home manager, and assistant manger sat down to brainstorm how we would do these investigations and how they would be implemented. On 08/19/2013 an email will be sent to the whole group home explaining our investigation process. If any evidence of food is found while doing client # 4's room search, the staff will document this on the tracking sheet as they are now, but they will also call the coordinator to report this. This will let the coordinator know that an investigation will need to be done. An investigation form will be created by 08/19/2013 that will be used while completing these investigations. The form will have a standard set of questions that will be asked of all staff that worked with client # 4 within the</p>	08/19/2013			

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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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	<p>with her family doctor on 3/8/13 and and her GI physician on 4/8/13. There was no further evidence of an investigation to determine the cause of client #4's illness.</p> <p>A BDDS report dated 3/13/13 indicated client #4 had 2 previous hospitalizations as a result of her eating uncontrollably and staff had been trained on the importance of the procedures in client #4's behavior plan including a daily room search.</p> <p>Objective worksheets for client #4's room checks were reviewed on 7/18/13 at 2:30 PM. The April 2013 worksheet indicated on April 3 indicated a spoon in a small yellow bag and baggie was found inside client #4's closet, on 4/24/13 a granola bar wrapper, and on 4/27/13 an empty baggie. The May 2013 worksheet indicated on 5/1/13, a banana peel was found outside client #4's window, on 5/19/13 hamburger buns were found in the bathroom, and on 5/27/13, a half loaf of bread was found in the closet. The June 2013 worksheets for client #4 indicated a juice box was found in her room on 6/30/13. There was no evidence of an investigation to determine how the food items got into client #4's room despite the locks on food in the home, client #4's 1 on 1 supervision level and daily room checks.</p>		<p>past 24 hours of the food item being found in her possession. In this investigation, we will also be looking at all tracking forms to assure that all tracking had been done and the plan was being followed as written. The investigation form will also have a place for us to note client # 4's blood sugar. Her blood sugar is often a key indicator as to whether she has recently eaten anything in addition to what is on her menu. Once the investigation is done, the coordinator will create a summary over what was determined in the investigation, and whether it was felt there were issues with the staff of the home not following the plan as written. If this were to be the case, immediate corrective action will be taken. Any evidence of food being found in her possession that she should not have had will be formally investigated starting on 08/19/2013. To assure that all aspects of client # 4's behavior plan is being followed, the QDDP will make visits to the service sites for client # 4 at least 3 times per month to assure that her plan is being run as written. The coordinator will do random stop-ins at the home at least twice per month to assure that the staff are following the plan as written and completing documentation as is required. Client #4's tracking sheets are carried with her from home to day services each day. Along with</p>				

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	<p>The Community Supports Coordinator (CSC) was interviewed on 7/18/13 at 11:20 AM. She indicated the facility had implemented additional checks of the tracking sheets for the locks in the home and of the daily checks of client #4's room. She indicated there was no written investigation as to how the items ended up in client #4's room in April, May, and June 2013 despite client #4's level of staff supervision, though the incidents were discussed by facility staff as to how to prevent future incidents. She indicated it had not been determined what caused client #4's vomiting and blockage on 2/28/13 despite her history of intestinal blockage after eating ingesting excessive amounts of food.</p> <p>9-3-2(a)</p>		<p>doing the home visits, the QDDP and Coordinator will also do random checks of her tracking sheets at least once per week to assure the tracking is getting done and and any concerns are getting reported. Starting August 20 th , 2013 the coordinator and the QDDP will start scheduling these visits on their calendar each month so that no visits are missed. The QDDP and coordinator will also keep a log of when they visit the sites to assure that it is getting done regularly. To assure that all allegations or alleged violations are being thoroughly investigated and documented, the coordinator will send an email to all coordinators by 08/19/2013 reminding them that any time there is an allegation that is brought to our attention; we must do a through investigation. This investigation will include interviewing staff, interviewing clients (as is feasible for the situation), and documenting these conversations. With each investigation they will be directed to create a summary that that goes over the details of the investigation and what was determined from the investigation. Any corrective action taken will need to be outlined in the summary as well. The coordinators will be responsible for assuring these investigations get done and thoroughly documented.</p>		

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based upon record review and interview, for 1 of 4 sampled clients (client #4), the facility failed to implement corrective action of implementing client #4's plan to prevent ingesting excessive food after a history of excessive consumption of food had been identified.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/18/13 at 9:01 AM and included the following:</p> <p>1. A report dated 1/26/13 at 1:00 PM indicated client #4's diagnosis included, but was not limited to, Prader Willi Syndrome "which leads to uncontrollable eating...The locking mechanism on the food (unspecified where) was found to be broken (unspecified when)...Upon staff checking [client #4's] room, it was found that she had taken items to her room and consumed them. This was smoked sausage, a jar of peanut butter, a tub of icing and a package of hot dog buns." After lunch, client #4 began to vomit, was taken to the hospital and it was determined her stomach and intestine were "greatly" distended and blocked.</p>	W000157	<p>After the incident that occurred in January where client # 4 got a hold of food that she should not have had access to, we discovered that there was a broken lock on the refrigerator that allowed her to gain access. We immediately implemented a lock tracking at the home where staff are required to check the locks on the refrigerator, freezer, and cabinets twice daily to assure that they were locked and in working condition. During this incident we also discovered that while staff noted they were watching client # 4, they were not using the bracelet as the plan states needs to be done to give staff that reminder that they are responsible for her observation. An email was sent out on 01/26/2013 reminding staff that it is a requirement that someone must be wearing the bracelet at all times. All staff were then retrained on client # 4's behavior plan on 02/19/2013 at a house meeting to assure they understood what we all as staff were to be doing. When it was found that room checks had not been done for 7 days at the beginning of March we took immediate action and suspended all of the employees that had been working as we investigated in to the issue. When doing our</p>	08/19/2013			

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	<p>She was transferred to another hospital and a tube was placed to suction food and liquid from her stomach. Client #4 was monitored to ensure the procedure was effective or if surgery was needed. The plan to resolve section of the BDDS report indicated the lock would be repaired and routine checks were implemented by staff to ensure it was not damaged. The report indicated client #4 would remain in the hospital for a day or two. A follow up report dated 1/31/13 indicated client #4 was "doing well," was discharged from the hospital on 1/30/13, and would return to her primary care physician in one week and her GI (gastro-intestinal) physician in 2 months. The report indicated client #4 had a behavior plan (date unspecified) to address her behavior of excessive eating, and one staff was assigned to wear a bracelet to remind them to monitor client #4's whereabouts to keep her safe. "Staff were not following this procedure when the incident occurred." The report indicated staff would be retrained regarding client #4's plan and tracking sheets were developed for staff to sign and hold them accountable for client #4's whereabouts, and to ensure locks to the food were secure. Daily room checks were to be completed to ensure client #4 "has not gotten food and hid it in her bedroom." A follow up report dated</p>		<p>investigation in March of 2013 it became apparent that even though they had the training the staff didn't have a good understanding of how not following the plan can drastically affect client # 4's health and wellbeing. During the time of the staff's suspension, client # 4's behavior management plan was revised to assure that it was clear and precise and easily understandable for the staff to follow. Prior to returning to the home to work, all employees were retrained on the plan on 03/20/2013 and 03/21/2013. Following the training, all employees were given a written test to assure their understanding of the behavior management plan and the implications that it has on client # 4's health. To assure that the room checks are getting done as they are required, the Manager and assistant manager started checking the tracking prior to the end of their shift to assure it had been done. If it has been done, they initial off noting that they saw it was completed. If it has not been done yet for the day, prior to them leaving their shift, they do the room check to assure there has been no food that client # 4 had a chance to get during that day. When meeting with all employees on 03/20/2013, it was expressed to them that if there were any other issues with client # 4's plan not being ran as written further disciplinary action will be</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 07/23/2013	
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	<p>2/1/13 indicated staff working in the home at the time of the incident with client #4 ingesting food was not wearing a bracelet per her plan.</p> <p>A BDDS report dated 2/28/13 indicated client #4 vomited after her 8 PM snack and reported to staff her stomach was upset. Client #4 was taken to the hospital as "when she vomits, it could be serious." At scan at the hospital indicated a blockage between client #4's stomach and her intestine. Client #4 was transferred to another hospital and fluid was drained from her stomach. A follow up report dated 3/5/13 indicated client #4 was released without conclusive findings as to what caused her blockage and vomiting. The report indicated she would follow up with her family doctor on 3/8/13 and her GI physician on 4/8/13.</p> <p>A BDDS report dated 3/13/13 indicated client #4 had 2 previous hospitalizations as a result of her eating uncontrollably and staff had been trained on the importance of the procedures in client #4's behavior plan including a daily room search. A room search was completed on 3/13/13 and when it was documented, it was noted staff had failed to complete room searches on 3/3/13, 3/4/13, 3/6/13, 3/9/13, 3/10/13, 3/11/13, and 3/12/13. Administrative staff had not been notified</p>		<p>taken which could include termination. The QDDP receives the tracking for client # 4 each month and is looking closely at the tracking to assure that staff are following through with the requirements of the plan. If the QDDP finds any discrepancies in the tracking, she is sharing this with the coordinator immediately so that immediate action can be taken. To assure that all aspects of client # 4's behavior plan is being followed, the QDDP will make visits to the service sites for client # 4 at least 3 times per month to assure that her plan is being run as written. The coordinator will do random stop-ins at the home at least twice per month to assure that the staff are following the plan as written and completing documentation as is required. Client #4's tracking sheets are carried with her from home to day services each day. Along with doing the home visits, the QDDP and Coordinator will also do random checks of her tracking sheets at least once per week to assure the tracking is getting done and and any concerns are getting reported. The coordinator will be sending an email to all group home managers, coordinators, and QDDPs reminding them that if there are issues with staff not following plans as written and in not doing this it is putting our clients health and safety as risk that immediate</p>				

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	<p>of the lack of searches. A follow up report dated 3/21/13 indicated "the allegation of neglect of correctly implementing [client #4's] behavior plan was substantiated. We also believe that this failure was not done with the intention to harm, but because staff did not understand the seriousness of how the room checks would assist in keeping [client #4] safe." The report indicated staff would be retrained and protective measures for client #4 would be revised. The report indicated staff would now complete written return demonstration of their knowledge of training on BMP's (Behavior Management Plans), High Risk Plans, and Dietary Requirements.</p> <p>Objective worksheets for client #4's room checks were reviewed on 7/18/13 at 2:30 PM. The April 2013 worksheet indicated on April 3 indicated a spoon in a small yellow bag and baggie was found inside client #4's closet, on 4/24/13 a granola bar wrapper, and on 4/27/13 an empty baggie. The May 2013 worksheet indicated on 5/1/13, a banana peel was found outside client #4's window, on 5/19/13, hamburger buns were found in the bathroom, and on 5/27/13, a half a loaf of bread was found in the closet. The June 2013 worksheets for client #4 indicated a juice box was found in her room on 6/30/13.</p>		<p>corrective action must be taken. It will be noted that these incidents must be reported to the coordinator immediately so the incident can be investigated. This email will be sent on 08/19/2013. The coordinator then will be charged with investigating any concerns in this area. Following any investigation the coordinator will keep their notes and create a formal summary of what was discovered in their investigation and what action was taken. An email will be sent to the QDDPs as well by 08/19/2013 noting that if they find areas of the behavior plan that are not working and the client is still being able to get to items or do the things that are putting them at risk, that a team meeting must be called and changes made to the plan to try to correct for this. QDDPs will also be reminded that they will need to make sure that behavior plans are being reviewed at each quarterly and annual meeting to assure that the plans are still effective for the clients that they are written for.</p>				

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	<p>The Community Supports Coordinator (CSC) was interviewed on 7/18/13 at 11:20 AM. She indicated the facility had implemented additional checks of the tracking sheets for the locks in the home and of the daily checks of client #4's room. She indicated the CSC and QIDP now review the tracking sheets to ensure the checks were being conducted and documented.</p> <p>The CSC was interviewed again on 7/18/13 at 2:40 PM. She indicated staff had failed to implement client #4's plan to provide daily checks of her room to prevent her from ingesting excessive food, and the failure to do so violated the facility's policy and procedures to protect clients from neglect.</p> <p>The Community Supports Associate Director/Nurse was interviewed on 7/23/13 at 9:31 AM and indicated client #4's plan was revised after the failure of staff to complete daily checks in March. She indicated staff had failed to report the lapses in daily room checks to the administrator and the house manager had been working a limited schedule at the time of the lapse and staff had not been supervised as frequently to ensure compliance to client #4's plan. She indicated client #4's plan had been revised</p>			

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	<p>in 3/13 to more clearly define procedures to check client #4's room on a daily basis.</p> <p>9-3-2(a)</p>			

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based upon record review and interview, the facility failed to ensure staff were sufficiently trained to implement 1 of 4 sampled clients (client #4's) plan to prevent her from ingesting excessive food.</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 7/18/13 at 9:01 AM and included the following:</p> <p>1. A report dated 1/26/13 at 1:00 PM indicated client #4's diagnosis included, but was not limited to, Prader Willi Syndrome "which leads to uncontrollable eating...The locking mechanism on the food (unspecified where) was found to be broken (unspecified when)...Upon staff checking [client #4's] room, it was found that she had taken items to her room and consumed them. This was smoked sausage, a jar of peanut butter, a tub of icing and a package of hot dog buns." After lunch, client #4 began to vomit, was taken to the hospital and it was</p>	W000189	<p>All employees are trained on client behavior plans prior to starting to work with that client. All the employees at Thomas Road had been trained on client # 4's behavior plan, but when doing our investigation in March of 2013 it became apparent that even though they had the training the staff didn't have a good understanding of how not following the plan can drastically affect client # 4's health and wellbeing. During the time of the staff's suspension, client # 4's behavior management plan was revised to assure that it was clear and precise and easily understandable for the staff to follow. Prior to returning to the home to work, all employees were retrained on the plan on 03/20/2013 and 03/21/2013. Following the training, all employees were given a written test to assure their understanding of the behavior management plan. On 08/07/2013 the coordinator, QDDP, group home manager, and assistant manager sat down to brainstorm ideas on how to assure staff are retaining the information from the behavior plan, as there is a lot of information present. Starting in</p>	08/20/2013			

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	determined her stomach and intestine were "greatly" distended and blocked. She was transferred to another hospital and a tube was placed to suction food and liquid from her stomach. Client #4 was monitored to ensure the procedure was effective or if surgery was needed. The plan to resolve section of the BDDS report indicated the lock would be repaired and routine checks were implemented by staff to ensure it was not damaged. The report indicated client #4 would remain in the hospital for a day or two. A follow up report dated 1/31/13 indicated client #4 was "doing well," was discharged from the hospital on 1/30/13, and would return to her primary care physician in one week and her GI (gastro-intestinal) physician in 2 months. The report indicated client #4 had a behavior plan (date unspecified) to address her behavior of excessive eating, and one staff was assigned to wear a bracelet to remind them to monitor client #4's whereabouts to keep her safe. "Staff were not following this procedure when the incident occurred." The report indicated staff would be retrained regarding client #4's plan and tracking sheets were developed for staff to sign and hold them accountable for client #4's whereabouts, and to ensure locks to the food were secure. Daily room checks were to be completed to ensure client #4		August of 2013 we will be holding mandatory trainings 3 times per year in which we will go over client # 4's behavior management plan. After each training, a written test will be given to assure that staff have a good understanding of the plan and what it is that they need to do to assure her safety. To assure we do not have any other issues with staff not being trained to effectively run the behavior plans when working with our clients, the coordinator will send an email to all group home managers reminding them that prior to a staff working with the clients they need to be trained on all behavior plans. They will also be reminded that any time there is a change or an update to the behavior plan, a retraining will need to be done to assure that all staff are aware of the changes. This email will be sent out by 08/19/2013. To assure that staff are understanding the plan and how it needs to be ran, we will begin to do competency based trainings with our employees with the behavior plans. The coordinator will get with all of the QDDPs and request that with each behavior plan they develop and plan specific test that will be administered following the training to assure that staff are walking away from the training with the knowledge that is needed to effectively work with the client. This will be a big task and will				

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	<p>"has not gotten food and hid it in her bedroom." A follow up report dated 2/1/13 indicated staff working in the home at the time of the incident with client #4 ingesting food was not wearing a bracelet per her plan.</p> <p>A BDDS report dated 3/13/13 indicated client #4 had 2 previous hospitalizations as a result of her eating "uncontrollably" and staff had been trained on the importance of the procedures in client #4's behavior plan including a daily room search. A room search was completed on 3/13/13 and when it was documented, it was noted staff had failed to complete room searches on 3/3/13, 3/4/13, 3/6/13, 3/9/13, 3/10/13, 3/11/13 and 3/12/13. Administrative staff had not been notified of the lack of searches. The plan to resolve indicated all 9 staff that were on duty during the days where searches had not been completed were suspended. A follow up report dated 3/21/13 indicated "the allegation of neglect of correctly implementing [client #4's] behavior plan was substantiated. We also believe that this failure was not done with the intention to harm, but because staff did not understand the seriousness of how the room checks would assist in keeping [client #4] safe." The report indicated staff would be retrained and protective measures for client #4 would be revised.</p>		<p>take some time to implement properly. The competency based training for client # 4 was put in to place in March of 2013. The QDDPs will be asked that they prioritize by starting with their most complex plans. Our goal will be to have competency based trainings in place for all of our behavior plans by January 1st of 2014. With each training then once the tests are in place, we will be certain the staff are walking away with the knowledge that is required and needed to safely serve the clients we work with.</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 07/23/2013
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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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	<p>The report indicated staff would now complete written return demonstration of their knowledge of training on BMP's (Behavior Management Plans), High Risk Plans, and Dietary Requirements.</p> <p>The Community Supports Coordinator (CSC) was interviewed on 7/18/13 at 11:20 AM. She indicated the facility had implemented additional checks of the tracking sheets for the locks in the home and of the daily checks of client #4's room. She indicated the house manager now reviewed the tracking sheets daily and the QIDP (Qualified Intellectual Disabilities Professional) reviewed the tracking sheets monthly.</p> <p>Staff corrective action for the incidents of missed room checks in March 2013 were reviewed on 7/18/13 at 11:25 AM and indicated all staff working in the home had been retrained on client #4's plan to prevent her ingestion of excessive food.</p> <p>The CSC was interviewed again on 7/18/13 at 2:40 PM. She indicated staff had failed to implement client #4's plan to provide daily checks of her room to prevent her from ingesting excessive food in March 2013, and the failure to do so was not viewed as neglect, but as a training issue. She indicated all staff involved in the incident had been</p>			

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	retrained on client #4's plan and measures to prevent her from access to excessive food items. 9-3-3-(a)			

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 07/23/2013
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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on interview and record review for 1 of 4 sampled clients (client #1), the facility failed to ensure specific physical techniques for physical intervention and their hierarchy for use were identified in the plan to manage her behavior of agitation.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 7/18/13 at 12:05 PM. Client #1's 10/31/12 Behavior Management Program (BMP) indicated a target behavior of agitation. The plan indicated "Only as a last resort, in cases where [client #1] is unable to control herself and is at risk for injuring herself or others, staff may use approved CPI (behavior management system) intervention techniques, which have been approved." Attached to the plan was an illustrated guide to physical interventions including kick block, one-hand wrist grab release, two-hand wrist grab release, one-hand hair pull release, two hand hair pull release, front choke hold release, back choke release, bite release, children's</p>	W000289	<p>Within client # 1's Behavior Management Plan it did note that CPI could only be used as a last resort, and noted that only the approved holds could be used. Pictures of the approved holds were attached to the plan for staff to reference. The plan itself did not give the names of the holds or lay out the hierarchy of the order that techniques should be used. By 08/20/2013 the QDDP will update client #1's Behavior Management Plan to assure there is a hierarchy of techniques to be used for staff to follow when working with this client. The hierarchy will give direction to follow steps in order such as verbal redirection, physical proximately, removing peers from the area, gentle guiding by a light touch, and use of CPI techniques as needed for the type of physical aggression being displayed. The names of these techniques will be included in the plan as well so there is no confusion as to what CPI holds can be used. The coordinator will send an email to all QDDPs by 08/12/2013 asking that they review their plans to assure that they have a clear hierarchy of steps for the staff to</p>	08/20/2013	

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	<p>control position, team control position, transport position, and interim control position. The BMP did not indicate which physical interventions to use or a hierarchy for the interventions use.</p> <p>The Community Supports Coordinator was interviewed on 7/18/13 at 2:40 PM. She indicated client behavior plans didn't usually contain which physical techniques to use or specific hierarchy for their use.</p> <p>9-3-5(a)</p>		<p>follow in each plan and that the approved CPI holds are clearly stated within the plan. It will be asked that they review and have their plans updated as needed by 08/20/2013. The QDDPs will be given guidance by the coordinator that as they create new plans in the future they will need to assure that there is a clear hierarchy present for staff to follow so they know which steps need to be tried prior to using CPI techniques.</p>		

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility's nursing services failed for 1 additional client, (client #7) to ensure the MAR (medication administration record) matched the medication label and physician's orders.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 7/17/13 from 5:10 PM until 6:27 PM. Staff #7 gave client #7 75 milliliters of potassium chloride after she finished her supper. The medication label indicated client #7 was to receive the medication before meals.</p> <p>The medication administration (MAR) for 7/13 was reviewed on 7/17/13 at 5:50 PM. The MAR indicated client #7 was to receive potassium chloride with meals.</p> <p>Staff #7 was interviewed on 7/17/13 at 5:51 PM and indicated the medication label didn't match the MAR. She indicated the nurse had been contacted regarding the discrepancy and indicated client #7 was to be given the medication after meals. Staff #7 indicated the label on the medication and the MAR should match.</p>	W000331	<p>On 07/26/2013 we were able to receive a copy of the written orders for client # 7's potassium. The written order did note that the potassium was to be taken with food. The Medication Administration Record was changed on 07/26/2013 so that the wording on the medication administration record and medication label matched. All other medications were checked and the labels and the medication administration read correctly. The coordinator will send an email to all group home managers by 08/19/2013 asking that they check all medication labels to assure that the labels reflect what the medication administration records read. If there are any discrepancies they are in need of contacting the nurse ASAP to get guidance to get this correct. It will also be asked that after checking on 08/19/2013 that they at the beginning of each month look at the medications that have come for the month and confirm that the labels and the medication administration records are still correct and read with the same directions.</p>	08/19/2013			

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NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 495 THOMAS RD HUNTINGTON, IN 46750		
(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	
	The Community Supports Associate Director/Nurse was interviewed on 7/18/13 at 2:40 PM. She indicated the medication label should match the MAR. 9-3-6(a)				

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W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on interview and record review for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) living in the group home, the facility failed to ensure evacuation drills were conducted every ninety (90) days for each shift of personnel.</p> <p>Findings include: The facility evacuation drills for clients #1, #2, #3, #4, #5, #6, #7 and #8 were reviewed on 7/18/13 at 12:45 PM and indicated there were no evacuation drills documented for the 10:00 AM to 6:00 AM shift from 8/28/12 to 5/22/13 for the 4th quarter of 2012 and the first quarter of 2013.</p> <p>The Community Supports Coordinator was interviewed on 7/18/13 at 2:40 PM and indicated there were no additional evacuation drills to review for those time frames.</p> <p>9-3-7(a)</p>	W000440	<p>We failed to complete fire drills during our overnight shifts in the months of November 2012 and February 2013. An email was sent to all staff on 07/19/2013 letting staff know that it was discovered that we missed those drills, reminding them how important it is that these drills get done, and asked that they help brainstorm ways to assure that they do not get missed in the future. The Group Home Manager has added to the staff checklists that the fire drill and tornado drill must be scheduled and planned in to the calendar by the 5 th of the month. Staff have been notified that the drills are to be done by the 20 th of the month and once they are completed they are to email the coordinator, group home manager, and the group home assistant manager to let us know of the completion. An automatically generated email will be going out to the group home staff on the 20 th of each month reminding the employees of the site that if the drills have not yet been done that they are due. Emailed instructions of this new procedure were emailed to the staff on 07/31/2013. The QDDP started a calendar on 08/01/2013 in which she now is checking off when the drills have come in be reviewed to assure that we are</p>	08/19/2013	

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			getting them each month. The coordinator will send an email to all group home employees by 08/19/2013 reminding them that the drills must be done each month. They will be reminded that they need to be using the drill calendar to assure that the drills are being done within the correct time frames each month. It will be asked of Group Home Managers to assure that the make sure by the end of the month that the calendars have been filled out and the drills have been completed.		