

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/21/2015
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NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 CAMDEN CT HUNTINGTON, IN 46750
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W 0000  Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 7/14, 7/15, 7/16, 7/17, 7/20, and 7/21/2015.</p> <p>Facility number: 012414 Provider Number: 15G786 AIMS Number: 200998980</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0249  Bldg. 00	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 1 of 4 clients (client #4), the facility failed to implement client #4's ISP (Individual Support Plan) and BSP (Behavior Support Plan) to ensure staff provided eye sight supervision at the group home when opportunities existed.</p> <p>Findings include:</p>	W 0249	All group home staff at Camden Ct. will be required to reread the ISP for client #4 so that they refresh their knowledge regarding the requirements to serve him and keep him safe. The QDDP will also provide staff with a quick read cheat sheet regarding safety requirements for each of the men living at this home as well as staff re-reading their ISPs. Training will	08/20/2015

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>On 7/14/15 from 3:15pm until 5:55pm, client #4 was observed at the group home with GHS (Group Home Staff) #1 and GHS #2. At 3:55pm, client #4 walked outside the front door. GHS #1 was not within eyesight of client #4. GHS #1 walked from the kitchen to the front door and verbally prompt client #4 to return inside the group home. Client #4 returned inside the group home. At 4:00pm, GHS #1 prompted client #4 to "go outside in the backyard" to the yard swing and client #4 exited the backdoor of the group home without staff, then sat alone on the backyard swing. From 4:00pm until 4:12pm, client #4 was alone in the backyard swing. At 4:12pm, GHS #2 had exited the bedroom with another client, indicated client #4 should not have been outside alone to GHS #1, and GHS #2 exited the backdoor and went to client #4 who was alone in the backyard.</p> <p>Client #4's record was reviewed on 7/16/15 at 11:00am and on 7/20/15 at 3:00pm. Client #4's 10/23/14 ISP (Individual Support Plan) and 4/29/15 BSP (Behavior Support Plan) both indicated client #4 "required" twenty-four hour staff supervision in the group home and had targeted behaviors of Attention seeking behaviors, Property Destruction, and Physical Aggression. Client #4's ISP</p>		<p>be provided to all group home staff regarding supervision of each client. ISP's are reviewed by all staff on an annual basis and staff will be referred to read them more often as needed. Observations will be completed on a weekly basis by the Residential Manger, QDDP or Community Supports Associate Director to insure that the needed supervision is being provided by staff.</p>	

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W 0369 Bldg. 00	<p>indicated he was on "Eye Sight Supervision" by the facility staff because of his behaviors. Client #4's ISP indicated he required staff supervision in the community and around his three house mates. Client #4's ISP indicated he was "not safe on his own in the community as his pedestrian skills aren't sufficient. Staff working with [client #4] need to have line of sight with him unless he is sleeping or toileting."</p> <p>On 7/16/15 at 1:00pm, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN stated client #4 was "line of sight" supervision by the facility staff. The CSA/RN indicated client #4 was not safe alone in the community and did not have pedestrian safety skills.</p> <p>9-3-4(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview, for 1 of 12 medications administered during the morning medication administration (client #3), the</p>	W 0369	The MAR will be corrected to insure that it matches the instructions as stated on the Bubble pack for client #3. All Camden Ct. staff will be retrained	08/20/2015			

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	<p>facility failed to ensure client #3's medication was given without error.</p> <p>Findings include:</p> <p>On 7/15/15 at 6:05am, GHS (Group Home Staff) #3 asked client #3 to come to the medication room for medication administration. GHS #3 compared client #3's "Ferrous Sulfate 325mg (milligrams) 1 tab (tablet) 1 x (once a day) with Breakfast for Anemia" to client #3's 7/2015 MAR (Medication Administration Record), punched out the tablet, and client #3 took the medication. No food or Breakfast was provided. At 7:15am, GHS #1 provided client #3 a pureed diet and client #3 took his first bite of food.</p> <p>On 7/16/15 at 12:00noon, client #3's 6/24/2015 Physician's Order indicated "Ferrous Sulfate 325mg (milligrams) 1 tab (tablet) 1 x (once a day) for Anemia." Client #3's 7/2015 MAR (Medication Administration Record) both indicated "Ferrous Sulfate (Iron) 325mg (milligrams) 1 tab (tablet) 1 x (once a day) with Breakfast for Anemia."</p> <p>On 7/15/15 at 9:40am, a record review was conducted of the facility's policy and procedures, 5/8/2015 "Medication Administration by Staff," which indicated "Check the information on the pharmacy</p>		<p>regarding the necessity for the instructions on the bubble packs to match exactly to the instructions on the MAR, and the procedure to correct this as needed. They will also be retrained as to agency policy regarding medications taken with food. All group home staff will also receive retraining in these areas to refresh their skills. Observations will be completed on a weekly basis by the Residential Manager, QDDP, Nurse, or Community Supports Associate Director.</p>	

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	<p>medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site (for application), and the time...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders.</p> <p>On 7/15/15 at 9:40am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN stated client #3's medication should have been given and then client #3 "should have eaten within a half hour or so." The CSA/RN indicated the facility staff should administer medications according to Core A/Core B medication administration training. The CSA/RN indicated this medication was given in error of his physician's order.</p> <p>On 7/15/15 at 9:40am, a record review of the facility's 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders.</p>			

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W 0391 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation, record review, and interview, for 1 additional client (client #3), the facility failed to remove from use the medication containers without labels from the pharmacy on 7/15/15.</p> <p>Findings include:</p> <p>On 7/15/15 at 6:05am, GHS (Group Home Staff) #3 asked client #3 to come to the medication room. GHS #3 selected client #3's Lip Balm/Carmex .35 ounces 10g (grams) tube of unlabeled medication. The unlabeled medication did not indicate client #3 name, initials, pharmacy label, and/or directions for its use. GHS #3 administered client #3 lip medication onto client #3's lips and replaced the cap. At 6:15am, GHS #3 indicated client #3's lip medication did not have a pharmacy label, did not have client #3's name and/or initials, and did not have directions for its use on the tube. At 6:15am, GHS #3 located a black magic marker and wrote client #3's initials on the end of the tube of</p>	W 0391	The medication for client #3 has been labeled with name and directions. Camden Ct. staff will be retrained regarding the requirement for all medications assigned to a person, to be labeled specifically for that person. All group home staff will also receive retraining regarding this requirement for all residential clients. Weekly observations will be conducted by the Residential Manager, QDDP, Nurse, or Community Supports Associate Director to insure that medications are appropriately labeled for all clients.	08/20/2015

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	<p>unlabeled medication.</p> <p>On 7/16/15 at 12:00noon, client #3's 6/24/2015 Physician's Order indicated and 7/2015 MAR (Medication Administration Record) were reviewed and indicated "Medicated Lip Balm (Carmex) apply as needed to dry, chapped, or cracked lips."</p> <p>On 7/15/15 at 9:40am, an interview with the agency Community Supports Associate Director/Registered Nurse (CSA/RN) was conducted. The CSA/RN indicated client #3's Lip Balm medication was for dry chapped lips and did not have a pharmacy label on the tube of medication. The CSA/RN stated client #3's unlabeled medication should have had "something" on it to indicate it belonged to client #3. The CSA/RN indicated the facility followed the Core A/Core B training for medication administration and the facility policy and procedure for medication administration. The CSA/RN indicated the agency nurse was not contacted until after the medication was administered to client #3 on 7/15/15. The CSA/RN indicated client #3's medication label had been corrected by the agency nurse.</p> <p>On 7/15/15 at 9:40am, a review of the facility's 5/8/2015 "Medication</p>			

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	<p>Administration Handbook" indicated before passing medications all staff will complete the Core A and Core B Medication Administration Curriculum 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.</p> <p>"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>			