

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G491	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  11/25/2015
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NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 356 E MOUND ST KNOX, IN 46534
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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
W 0000  Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 23, 24, and 25, 2015.</p> <p>Provider number: 15G491 AIM number: 100245050 Facility number: 001005</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/4/15.</p>	W 0000		
W 0259  Bldg. 00	<p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Based on record review and interview, the facility failed to ensure the Comprehensive Functional Assessments for 2 of 4 sampled clients (clients #3 and #4) were reviewed at least annually.</p> <p>Findings include:</p>	W 0259	<p>A Comprehensive Functional Assessment was completed for Client #3 on 11.25.15. A Comprehensive Functional Assessment was completed for Client #4 on 11.25.15.</p> <p>On 12.15.16, The QDDP was trained on the importance of completing a Comprehensive</p>	12/15/2015

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>the facility failed to assure the facility's Human Rights Committee monitored the restrictive techniques in the Behavior Management Plan of 1 of 2 sampled clients with Behavior Management Plans (client #3).</p> <p>Findings include:</p> <p>Client #3's records were reviewed on 11/24/15 at 9:24 A.M. A review of the client's 9/26/14 Behavior Management Plan indicated the client was being administered Celexa (mood stabilizing and anti-psychosis medication) for targeted behaviors. Further review of the client's Behavior Management Plan indicated the plan addressed client #3's behaviors of physical aggression, refusals, and inappropriate social skills.</p> <p>The facility's records were reviewed on 11/24/15 at 10:30 A.M. Review of the facility's Human Rights Committee minutes from 9/26/14 to 11/24/15 indicated the facility's Human Rights Committee had not monitored the use of the plan since 11/19/14.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 11/24/15 at 10:35 A.M. QIDP #1 indicated the facility's Human Rights Committee had not monitored client #3's</p>		<p>approved by the Human Rights Committee on 12.14.15</p> <p>On 12.15.16 the QDDP was trained on the procedures for obtaining Human Rights Approval for Behavior Management Plans and psychotropic medication.</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	Behavior Management Plan since 11/19/14.  9-3-4(a)				