

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G033		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 456 W MARKET ST WABASH, IN 46992			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 15, 16, 17, 18, and 19, 2013.</p> <p>Provider Number: 15G033 Facility Number: 000593 AIM Number: 100233370</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed April 24, 2013 by Dotty Walton, Medical Surveyor III.</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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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review, and interview for 4 of 7 clients (clients #1, #3, #5, and #7), the facility failed to administer medications without error and as prescribed by the clients' personal physician.</p> <p>Findings include:</p> <p>1. On 4/15/13 at 12:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 4/15/12 through 4/15/13 were reviewed and indicated the following for client #1's medication errors.</p> <p>-A 9/11/12 BDDS report for an incident on 9/4/12 at 9:00pm, indicated "Medication errors. Client order is Gabapentin 800mg (milligrams) tab po tid (by mouth three times daily) for Bipolar (disorder)." The report indicated client #1 was "given an extra dose of Gabapentin (800mg) on 9/4/12 at 9:00pm. [Client #1's Gabapentin 800mg medication] dose missed on 9/5 thru 9/7/12 at 6am." The report indicated client #1's medication card of Gabapentin 800mg was "put in the wrong time slot and then staff realized and pulled from time slot and put away</p>	W000368	<p>W368</p> <p>1. What corrective action will be accomplished for these residents found to have been affected by the deficient practice? A. Keep clients safe and healthy. Prevention of any future medication errors.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A. All clients who receive medications will have nurse go into home and monitor medications passes quarterly. Managers review checker passer sheet weekly to ensure that staff are checking each other right after medication pass to assist in no medication errors.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur? A. Staff will read and sign updated Medication Administration Handbook Revised 4/25/13, Medication Administration Refresher with Test,</p> <p>4. How the corrective action will</p>	05/19/2013	

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	<p>with extra medications and failed to check all other time slots to ensure medication was there." The report indicated staff were retrained on medication administration procedures.</p> <p>Client #1's record was reviewed on 4/17/13 at 10:55am. Client #1's 3/18/13 "Physician's Orders" indicated Gabapentin (Neurontin) 300mg (milligrams) for Bipolar Disorder/behaviors, "Take one capsule by mouth twice daily" at 6:00am and 9:00pm, signed by client #1's physician.</p> <p>2. On 4/15/13 at 12:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 4/15/12 through 4/15/13 were reviewed and indicated the following for client #3's medication errors.</p> <p>-A 7/25/12 BDDS report for an incident on 7/24/12 at 9:00pm, indicated facility "Staff who passed the 6pm medications was distracted during medication pass and passed the 9pm medications instead of the 6pm medications. Different staff who was passing 9pm medications gave the same client (#3) her 9pm medications. Client 6pm meds (medications) omitted and 9pm medications given twice." The report did not indicate the names nor the dosages of client #3's 6:00pm or 9:00pm</p>		<p>be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place? A. All clients who receive medications will have nurse go into home and monitor medications passes quarterly. Managers review checker passer sheet weekly to ensure that staff are checking each other right after medication pass as a quality assurance to ensure staff are checking each other right after medication pass to prevent medication errors..</p> <p>5. What is the date by which the systemic changes will be completed May 19th.</p>				

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	<p>medications on 7/24/12.</p> <p>3. On 4/15/13 at 12:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 4/15/12 through 4/15/13 were reviewed and indicated the following for client #5's medication errors.</p> <p>-A 10/30/12 BDDS report for an incident on 10/29/12 at 3:30pm, indicated "After receiving cycle medications for next month for this client, (the) group home manager stated that an additional medication card of Effexor (for depression) was sent of 75mg (milligrams) po (by mouth) daily and this card needed to be sent back (to the pharmacy) because the client (#5) is only on Effexor 150mg po daily." The report indicated the agency nurse called the pharmacy to inquire. The pharmacy indicated the pharmacy had a "8/27/12 Physician's Order for Effexor 225mg po daily so 150mg with 75mg equals 225mg po daily." The report indicated on 8/28/12 the pharmacy sent 2 tablets of Effexor 75mg to finish the month of August, 2012 with the medication increase of Effexor 225mg medication card for the month of September, 2012. The report indicated the "Group Home Manager failed to transcribe medication to [client #5's 8/2012 and 9/2012] MAR</p>			

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	<p>and failed to ensure medication was put with other medications in the med. cabinet for that month." The report indicated "Medication increase was never given until today [10/30/12]."</p> <p>Client #5's record was reviewed on 4/19/13 at 8:50am. Client #5's 3/18/13 "Physician's Order" indicated "Effexor 75 (milligrams) & 150mg, take one capsule by mouth once daily for depression. Take with 75mg capsule to equal 225mg (daily)."</p> <p>4. On 4/15/13 at 12:15pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 4/15/12 through 4/15/13 were reviewed and indicated the following for client #7's medication errors.</p> <p>-A 5/14/12 BDDS report for an incident on 5/13/12 at 6pm, indicated "Staff gave this client another clients' medication which was Calcium (a nutritional supplement) 500mg with vitamin D and Depakote (a medication used for seizure control or behaviors) 500mg." The report indicated staff took the medications to the dining room while the clients were eating supper, and staff "became distracted by another client who was having a severe behavior" then gave the medications to client #7.</p>				

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	<p>An interview with the agency's LPN (License Practical Nurse) was conducted on 4/19/13 at 8:50am. The Agency LPN indicated the facility followed the Core A/Core B Medication Training for staff to administer medications. The agency LPN indicated facility staff should follow each clients' physician's orders when administering medications in the group home. The LPN indicated client #7 was not on the medications of Calcium 500mg with Vitamin D nor Depakote 500mg. The Agency LPN indicated clients #1, #3, #5, and #7's physician orders were not followed when facility staff did not administer each clients' medication according to their physician's order.</p> <p>On 4/19/13 at 9:00am, a record review was completed of the undated facility's policy and procedures and indicated facility staff should follow physician's orders to administer medications to clients who lived in the group home.</p> <p>On 4/19/13 at 9:00am, the 2004 "Core A/Core B Medication Training" review indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician's orders.</p>			

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

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FORM APPROVED

OMB NO. 0938-0391

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	9-3-6(a)				

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 1 of 3 medications administered during the 4:00pm medication administration (clients #1), the facility failed to ensure client #1's medication was given without error.</p> <p>Finding include:</p> <p>On 4/15/13 at 3:15pm, Group Home Staff (GHS) #1 requested client #1 to come to the medication room, GHS #1 unlocked the medication cabinet, removed client #1's medication card of "Ibuprofen 600mg (milligrams) (for Arthritis pain) tab 3 x (three times) daily, take 1 tablet by mouth 3 times daily with food," and client #1 took the medication then left the medication room. No food was observed provided at the medication administration time. At 3:30pm, client #1 left the group home for a community meeting. At 3:37pm, client #1 arrived at the community meeting on the facility bus with GHS #1. At 4:16pm, client #1 selected a single chocolate chip cookie to eat and at 4:16pm, client #1 consumed her first bite of a cookie at the community meeting. At 4:16pm, client #1 indicated</p>	W000369	<p>W369</p> <p>1. What corrective action will be accomplished for these residents found to have been affected by the deficient practice? A. Keep clients safe and healthy. Follow Doctors orders and prescribed.</p> <p>2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? A. All clients who receive medications will have nurse go into home and monitor medications passes quarterly. Managers review checker passer sheet weekly to ensure that staff are checking each other right after medication pass and to assure doctors orders are being followed as prescribed.</p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur. A. Staff will read and sign updated Medication Administration Handbook Revised 4/25/13, Medication Administration Refresher with Test.</p>	05/19/2013			

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	<p>the last time she had something to eat was 11:00am during lunch at workshop. At 6:25pm, client #1 consumed her first bite of the evening meal at the group home.</p> <p>Client #1's 4/2013 MAR (Medication Administration Record) was reviewed on 4/15/13 at 3:20pm. Client #1's 4/2013 MAR indicated "Ibuprofen 600mg (milligrams) (for Arthritis pain) tab 3 x (three times) daily, take 1 tablet by mouth 3 times daily with food."</p> <p>Client #1's 4/9/13 "Physician's order" indicated "Ibuprofen 600mg (milligrams) (for Arthritis pain) tab 3 x (three times) daily, take 1 tablet by mouth 3 times daily with food."</p> <p>An interview with the agency's LPN (License Practical Nurse) was conducted on 4/19/13 at 8:50am. The Agency LPN indicated the facility followed the Core A/Core B Medication Training for staff to administer medications. The agency LPN indicated when a medication was ordered "with food" there should be no more than 30 minutes between the time the client takes the medication until food was provided by the facility staff. The agency LPN indicated facility staff should have followed client #1's physician's orders to administer their medications.</p>		<p>4. How the corrective action will be monitored to ensure the deficient practice will not recur. what quality assurance program will be put into place? A. All clients who receive medications will have nurse go into home and monitor medications passes quarterly. Managers review checker passer sheet weekly to ensure that staff are checking each other right after medication pass as a quality assurance to ensure staff are checking each other right after medication pass and assure doctors orders are being followed as prescribed...</p> <p>5. What is the date by which the systemic changes will be completed May 19th.</p>				

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	<p>On 4/16/13 at 3:30pm, the 2004 "Core A/Core B Medication Training" review indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician's orders.</p> <p>9-3-6(a)</p>				