

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G532	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/24/2016
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NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 107 BINKLEY KNOX, IN 46534
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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: 2/16, 2/17, 2/18 and 2/24/16.</p> <p>Facility number: 001046 Provider number: 15G532 AIM number: 100245310</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/4/16.</p>	W 0000		
W 0125  Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and 4 additional</p>	W 0125	Pathfinder Services, Inc. has purchased a new building which will house day services programs. This building is in the	04/01/2016

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>clients (#5, #6, #7 and #8), the facility failed to ensure clients #1, #2, #3, #4, #5, #6, #7 and #8's rights were not violated by allowing other homes to use their home for day services. The facility failed to ensure client #2's rights were not violated by removing the client's television and radio from his room with no plan on how client #2 would get items back.</p> <p>Findings include:</p> <p>1. During the 2/17/16 observation period from 5:25am until 8:03am at the group home clients #1, #2, #3, #4, #5, #6, #7 and #8 were all getting ready for the day. At 8:03am all clients except client #3 left the home to attend an outside day service or a doctor's appointment. At 8:06am the front door to the home opened with no knock and a client with a staff person walked in. The client's staff person did not say anything; she walked in and waved and left the home. The client introduced himself and said "I live at [name of group home]". He sat down at the kitchen table and was looking at his valentine's cards. He was asked if he wanted to play a card game with client #3. The RM (Residential Manager) stated "[Name of second client] must not be coming today, she must have an appointment".</p>		<p>process of being remodeled. Remodeling is projected to be finished sometime in June and day services are projected to start in the new building on July 1, 2016. In the meantime, Day Services has been moved to the Pathfinder Services Plymouth office building. Client #2's behavior support plan has been updated to include a new plan for monitoring PICA behavior, emergency removal of personal belongings that client is using for PICA behavior and earning back personal items that have been removed due to PICA behavior.</p>				

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	<p>An interview with the RM was conducted on 2/17/16 at 8:07am. When asked how many individuals who don't live in the home come to the home for day services, the RM stated "We have 4 total but they come on different days."</p> <p>2. During the observation period on 2/16/16 between 4:45pm and 6:30pm and the observation period on 2/17/16 between 5:25am and 8:03am, client #2's bedroom had a bed, a sensory ball, and a cabinet in his bedroom. During the 2/17/16 observation at 6:40 am client #2 came out of the office with his toothbrush and razor. In the RM's (Residential Manager) office client #2's TV and radio were behind the RM's desk.</p> <p>An interview with the RM was conducted on 2/17/16 at 6:40am. When asked why client #2 had to get his toothbrush and razor from the office, the RM stated "all of [client #2's] stuff is currently in the office because he has been chewing on stuff. His toothbrush and razor are kept in here because he gags himself with them".</p> <p>Client #2's record was reviewed on 2/18/16 at 12:13pm. Client #2's 10/19/15 BSP (Behavior Support Plan) indicated client #2 had the following targeted</p>			

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	<p>behaviors: Impulsivity (refusal to participate in daily activities, refusal to go to or return from work or other activities), Hyperactivity (hovering around people, jumping up and down, clapping hands, and speech that is more difficult to understand), Lack of focus, Agitation (yelling at or about others, or about various topics), Anger (throwing objects, breaking items, kicking, biting, hitting, throwing objects at others, hitting self-usually in the head), Pica (putting inedible items in his mouth) and mood swings (worrying about something or someone, a sad face/affect, looking down, telling people he is mad or upset about a topic, and crying). Client #2's BSP indicated when client #2 was displaying PICA behaviors staff will "calmly ask [client #2] to stop, and give the item to staff." Client #2's BSP did not indicate client #2's personal TV, radio and personal hygiene items would be removed from his room. Client #2's BSP did not indicate how client #2 would get his personal belongings returned to him.</p> <p>Client #2's 12/12/15 QIDP (Qualified Intellectual Disability Professional) note indicated "behavior plan will be modified to include a plan for [client #2] to get his belongings back in his room as behaviors decrease."</p>			

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W 0154 Bldg. 00	<p>An interview with the QIDP was conducted on 2/18/16 at 2:28pm. When asked how the IDT (Interdisciplinary Team) discussed the removal of client #2's belongings, the QIDP stated "I had several emails between the team and IDT (interdisciplinary team) notes regarding the emergency removal of the personal belongings and how he will get his items back that I will provide for review." The facility was unable to provide any updated plans that were completed prior to the date of the 2/18/16 interview.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 4 of 6 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct an investigation in regard to incidents of client to client</p>	W 0154	Staff have been trained to properly investigate incidents. All reportable incidents of unknown source will include the following information:1. Who was involved.2. Who were the	03/31/2016			

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	<p>aggression/abuse (#2) and injuries of unknown source (#4).</p> <p>Findings include</p> <p>1. The facility's reportable incidents, investigations, and internal accident reports were reviewed on 2/16/16 at 2:35pm. Client #2's 10/5/15 consumer health related incident report indicated "another consumer became upset and scratched [client #2's] neck. 1, 1 in (inch) scratch and 1 4 in scratch on back left side of neck (skin broken (sic))."</p> <p>Client #2's record was reviewed on 2/18/16 at 12:13pm. Client #2's 11/23/15 behavior tally slip indicated "[client #2] hit consumer [client initials] with a box."</p> <p>An interview with the QIDP (Qualified Intellectual Disability Professional) was conducted on 2/18/16 at 2:28pm. When asked if client #2's client to client aggression was investigated, the QIDP stated "I'll have to check." The QIDP was unable to provide any investigations for review.</p> <p>2. Client #4's record was reviewed on 2/18/16 at 10:32am. Client #4's May 2015 Residential Medical/Progress Notes indicated the following (not all inclusive):</p>		<p>witnesses interviewed and what were the findings of interviews3. Where did the incident happen.4. Where was each staff when it happened.5. What was the client doing when it happened.6. What were each of the staff doing when it happened.7. How did the incident happen8. What is the plan to prevent a repeat of the incident.</p>				

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	<p>-5/26/15 at 3pm: "[Client #4] has a 1/2" x 3" (1/2 inch by 3 inch) bruise on 'L' (Left Side) 6" under armpit."</p> <p>Client #4's October 2015 Residential Medical/Progress Notes indicated the following (Not all inclusive):</p> <p>-10/1/15 at 8pm: "[Client #4] has 1 larger bruise and 3 small ones on her bottom side of her left forearm."</p> <p>Client #4's Residential Medical/Progress Notes and/or the facility's investigations did not indicate how client #4 got the bruises on her forearm or the bruise under her armpit.</p> <p>An interview with the QIDP (Qualified Intellectual Disability Professional) was conducted on 2/18/16 at 2:28pm. When asked how client #4 received the bruises on her forearm and bruise under her armpit, and if the bruises were investigated, the QIDP stated "I'll have to check." The QIDP was unable to provide any further documentation for review.</p> <p>9-3-2(a)</p>			

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W 0222  Bldg. 00	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include cognitive development. Based on interview and record review for 1 of 4 sampled clients (#2), the facility failed to assess the client's ability to make informed consent decisions in regard to the client's psychotropic medications and restrictive behavior plans.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/18/16 at 12:13pm. Client #2's 12/1/15 physician's orders indicated client #2 received Lithium Carbonate (mood swings), Intuniv (ADHD: Attention Deficit Hyperactivity Disorder), Depakote Sodium ER (mood swings) and Risperidone (psychiatric medication for behaviors).</p> <p>Client #2's 5/20/15 Individual Support Plan (ISP) indicated client #2 was his own guardian.</p> <p>Client #2's 10/19/15 Behavior Support Plan (BSP) indicated client #2 displayed "Impulsivity, hyperactivity, lack of focus, agitation (yelling at or about others), Anger (throwing objects, breaking items, kicking, biting, hitting, throwing objects at others, hitting self usually on the head),</p>	W 0222	Client #2 was reassessed to determine if he has the capacity to make informed consent decision in regard to the his psychotropic medications and restrictive behavior plans. It concluded that his parents, who are his advocates, continue to help him make decisions about his health care. There were no other clients affected by this deficiency, as the others in the home have either advocates or guardians who assist them with making decisions. Each year each client will be reassessed to determine if he or she has the capacity to make informed consent decisions and to assess whether their advocates or guardians are actively assisting them.	04/01/2016			

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	<p>Mood swings, and PICA (putting inedible things in his mouth)." Client #2's BSP indicated the facility staff could utilize CPI (restraint techniques) if "[client #2] starts to become physically aggressive to others and will not calm down after staff attempt redirection one time to another area". Client #2's BSP indicated "... [Client #2] has autism, so repetition, providing concise and concrete visual/verbal information, and giving enough time to process provided information is essential for [client #2] to understand and process his wants and needs."</p> <p>Client #2's 5/20/15 Functional Assessment Tool indicated the facility did not assess the client's ability to make and/or give written informed consent for the client's restrictive program and/or medications.</p> <p>An interview with the QIDP (Qualified Intellectual Disability Professional) was conducted on 2/18/16 at 2:28pm. When asked if client #2's ability to make informed decisions/choices and/or ability to give written informed consent had been completed/assessed, the QIDP stated "I'll have to get it for you." The QIDP was unable to provide an assessment for review.</p>						

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W 0262  Bldg. 00	<p>9-3-4(a)</p> <p>483.440(f)(3)(i) PROGRAM MONITORING &amp; CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on interview and record review for 1 of 4 sampled clients (#2) with restrictive programs, the facility failed to have its Human Rights Committee (HRC) periodically review and/or approve the client's restrictive program.</p> <p>Findings include:</p> <p>During the observation period on 2/16/16 between 4:45pm and 6:30pm and the observation period on 2/17/16 between 5:25am and 8:03am, client #2's bedroom had a bed, a sensory ball, and a cabinet in his bedroom. During the 2/17/16 observation at 6:40 am client #2 came out of the office with his toothbrush and razor. In the RM's (Residential Manager) office client #2's TV (Television) and radio were behind the RM's desk.</p> <p>An interview with the RM was conducted on 2/17/16 at 6:40am. When asked why client #2 had to get his toothbrush and razor from the office, the RM stated "all of [client #2's] stuff is currently in the office because he has been chewing on stuff. His toothbrush and razor are kept in here because he gags himself with them".</p>	W 0262	At each HRC meeting the Human Rights Committee will review and/or approve restrictive programs in behavior support plans. At each HRC meeting the Human Rights Committee will review pschoytopic medication dosages, reasons for medication and/or changes in medication dosages. Client #2 was reassessed to determine if he has the capisity to make informed consent decision in regard to the his pyschotropic medications and restrictive behavior plans. Client #2's behavior support plan no longer utilizes CPI techniques.	04/01/2016

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	<p>Client #2's record was reviewed on 2/18/16 at 12:13pm. Client #2's 12/1/15 physician's orders indicated client #2 received Lithium Carbonate (mood swings), Intuniv (ADHD- Attention Deficient Hyperactive Disorder), Depakote Sodium ER (mood swings) and Risperidone (psychiatric medication for behaviors).</p> <p>Client #2's 5/20/15 Individual Support Plan (ISP) indicated client #2 was his own guardian.</p> <p>Client #2's 10/19/15 Behavior Support Plan (BSP) indicated client #2 displayed "Impulsivity, hyperactivity, lack of focus, agitation (yelling at or about others), Anger (throwing objects, breaking items, kicking, biting, hitting, throwing objects at others, hitting self usually on the head), Mood swings, and PICA (putting inedible things in his mouth)". Client #2's BSP indicated the facility staff could utilize CPI (restraint techniques) if "[client #2] starts to become physically aggressive to others and will not calm down after staff attempt redirection one time to another area".</p> <p>Client #2's record did not indicate the HRC (Human Rights Committee) had reviewed the CPI (restraint technique) that was included in client #2's BSP or the removal of client #2's electronic devices from his bedroom.</p> <p>An interview with the QIDP (Qualified Intellectual Disability Professional) was conducted on 2/18/16 at 2:28pm. When asked if they obtained HRC approval for client #2's restrictive program, the QIDP stated "HRC approval should be in the HRC book". The QIDP was unable to provide HRC approval for the restrictive program for review.</p>			

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W 0289  Bldg. 00	<p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR 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 record review and interview for 1 of 4 sampled clients (#2), the facility failed to incorporate specific restraint techniques into the BSP (Behavior Support Plan) which could be utilized with the client when she demonstrated physical aggression.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/18/16 at 12:13pm. Client #2's 10/19/15 Behavior Support Plan (BSP) indicated client #2 displayed "Impulsivity, hyperactivity, lack of focus, agitation (yelling at or about others), Anger (throwing objects, breaking items, kicking, biting, hitting, throwing objects at others, hitting self usually on the head), Mood swings, and PICA (putting inedible things in his mouth)". Client #2's BSP indicated the facility staff could utilize CPI (restraint techniques) if "[client #2]</p>	W 0289	Client #2's behavior support plan has been updated to include a new plan for monitoring PICA behavior, emergency removal of personal belongings that client #2 is using for PICA behavior and earning back personal items that have been removed due to PICA behavior. The QDDP will collect behavior data daily via staff completing behavior reports, keeping track of how often it is occurring, what inedibles are being eaten and if there are any precursors to the behavior. Staff in the home will complete behavior reports whenever the PICA behavior occurs. Reports will also report what interventions the staff used to assist the client to stop the behavior. Compliance will be observed through QDDP observations in the home. There were no other clients affected by this deficiency. When new behavior trends occur for any client the QDDP will add the information to their behavior plan and/or risk plans	04/01/2016			

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	<p>starts to become physically aggressive to others and will not calm down after staff attempt redirection one time to another area". Client #2's BSP did not specifically define what CPI techniques could be used with client #2.</p> <p>An interview with the QIDP (Qualified Intellectual Disability Professional) was conducted on 2/18/16 at 2:28pm. When asked which specific CPI restraints could be used with Client #2, the QIDP stated "The CPI is not specifically defined".</p> <p>9-3-5(a)</p>		immediately.		