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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G032 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/13/2012 |
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| NAME OF PROVIDER OR SUPPLIER PATHFINDER SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 404 W CANAL ST WABASH, IN 46992 |
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| W0000 | <p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: March 5, 6, 7, 8, 9, 12, and 13, 2012.</p> <p>Provider Number: 15G032 Facility Number: 000592 AIM Number: 100233360</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 3/16/12 by Tim Shebel, Medical Surveyor III.</p> | W0000 | | |

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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| W0137 | <p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation, record review, and interview for 1 of 4 sampled clients (client #4) who lived in the group home, the facility failed to encourage and teach client #4 to wear a clean shirt daily.</p> <p>Findings include:</p> <p>On 3/5/12 from 3:15pm until 5:37pm, at the group home, on 3/6/12 from 6:25am until 8:12am, at the group home, and on 3/7/12 from 8:50am until 9:30am, at the workshop, client #4 wore the same green tee shirt with his barber shop logo. On 3/6/12 at 7:45am, client #4 stated "yes" he wore the same green shirt with his barber shop logo on it and "I like green." At 7:45am, GHT (Group Home Trainer) #1 indicated she did not work on 3/5/12 and GHT #2 stated "I'm not sure" whether client #4 wore the same shirt both days. On 3/6/12 at 8:12am, client #4 left in the facility van with GHT #2 for workshop with the same green shirt with his barber shop logo.</p> <p>Client #4's record was reviewed on 3/8/12</p> | W0137 | <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; A dressing goal has been put in place for client #4. The goal states: Client will wear a clean outfit daily with 3 vps or less for a 4th quarter average of 90%.</p> <p>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; Clients who like to wear the same shirt, pants, or other clothing could be affected. The Residential Manager will train the group home staff on informal training opportunities and how to ensure all clients are given training in the area of dressing skills when needed. (specifically to ensure staff are encouraging clients to change into clean clothes if they have worn an outfit once and haven't washed it.)</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient</p> | 04/12/2012 |

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| | <p>at 10am Client #4's 8/9/11 ISP (Individual Support Plan) did not indicate an identified dressing objective. Client #4's 8/9/11 FAT (Functional Assessment Tool) did not indicate if client #4 had the skill to change his clothing or to wear clean clothing.</p> <p>On 3/12/12 at 8:45am, an interview with the PD/QMRP (Program Director/Qualified Mental Retardation Professional) was completed. The PD/QMRP indicated client #4 did not have a dressing objective. The PD/QMRP indicated no objective was available for review. The PD/QMRP indicated client #4 should have been prompted to change his shirt daily and was to put on clean clothing after showering.</p> <p>9-3-4(a)</p> | | <p>practices does not recur; Client #4 has a training goal in place (dressing goal) and Res. Mgr. will train staff on informal training opportunities.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; Client #4's goal will be reviewed monthly by the Res. Mgr. and QDDP to ensure proper training is being given to the client to prevent the deficiency from happening again.</p> | | |

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| W0331 | <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review, for 1 of 1 client (client #2) with an identified medical need, the facility's nursing services failed to ensure client #2's open areas were identified, assessed, and treated.</p> <p>Findings include:</p> <p>On 3/5/12 from 3:15pm until 5:37pm, client #2 was observed with two fifty-cent circular sized open areas on top of his head where his hair was receding.</p> <p>On 3/6/12 at 6:30am, client #2 was in the medication administration area with GHT (Group Home Trainer) #1. At 6:30am, GHT #1 asked client #2 "How did that happen?" and pointed to client #2's head. Client #2 held out his hand and wiggled his fingers. At 6:30am, GHT #1 indicated there were three (3) open areas on top of client #2's head in his receding hair. GHT #1 measured and stated the following areas: one area was half an inch (1/2") and "open," one area was one fourth inch (1/4") and "scabbed," and one was one half inch (1/2") and "open." GHT #1 applied Neosporin antibiotic ointment to</p> | W0331 | <p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice;Staff to be in serviced on A/I reports and skin alterations sheets. High risk plan in place for picking and skin integrity for this client.How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;Staff to be in serviced on A/I reports and skin alterations sheets. What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur;Staff to monitor skin for all clients on shower days. Informal tracking sheet.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;Nurse will monitor quarterly with quarterly reviews.</p> | 04/12/2012 | |

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| | <p>each of the areas on top of client #2's head. At 6:45am, GHT #1 stated client #2's open areas "should have been recorded on the MAR (Medication Administration Record) and no record of [client #2's] open areas were recorded before 3/6/12."</p> <p>On 3/8/12 at 9:20am, client #2's record was reviewed. Client #2's 2/23/12 and 4/14/11 ISP (Individual Support Plan) did not indicate client #2 had open areas. Client #2's 2/20/12 Nursing Quarterly assessment indicated client #2 was a diabetic and did not indicate he had open areas. The facility provided a 3/6/12 incident report which indicated client #2 had scratched his head open "because it itched." Client #2's 4/14/11 ISP and "Diabetic Protocol" indicated staff where to check client #2's skin nightly after he bathed for changes in client #2's skin integrity.</p> <p>On 3/12/12 at 8:45am, an interview with the Program Director/Qualified Mental Retardation Professional (PD/QMRP) and the agency nurse was completed. The PD/QMRP and the agency nurse both indicated staff should have checked client #2 after showering for problems with his skin. The agency nurse indicated client #2's skin was not being monitored by the staff and should have been.</p> | | | | | | |

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| | 9-3-6(a) | | | |