

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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		
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: November 7, 8, 9, 13, 14, 15, and 16, 2012.</p> <p>Surveyor: Susan Eakright, Medical Surveyor III/QMRP</p> <p>Provider Number: 15G534 AIM Number: 100245410 Facility Number: 001048</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/28/12 by Ruth Shackelford, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
(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	
W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, record review, and interview for 4 of 4 sampled clients (clients #1, #2, #3, and #4), the QMRP (Qualified Mental Retardation Professional) failed to monitor the clients' programs by not conducting quarterly reviews of the clients' progress.</p> <p>Findings include:</p> <p>1. On 11/8/12 at 11:18am, client #1's record was reviewed. Client #1's 7/30/12 ISP (Individual Support Plan) indicated goals/objectives to participate in group activity 75% of the time, to participate in community activities twice per month, will write her name on check, will push talk button, will measure own cereal, will fold one load of towels, will name reasons for Celebrex medication, will wash hands after bathroom, will complete physical therapy exercises daily, will wipe off table while sitting, will participate in activities, and will clean own glasses daily. There were no quarterly reviews of client #1's goal data available in the record.</p> <p>2. On 11/9/12 at 8:20am, client #2's</p>	W0159	W 159 does not require quarterly reviews. Evidence was provide but not noted that the program was reviewed monthly by the QMRP. In addition progress towards goals is further reviewed and entered into a database with recommendations each month by the QMRP. To assure that the program is monitored adequately, the QMRP will continue with monthly reviews of the program. Person Responsible: QMRP	12/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
(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	
	<p>record was reviewed. Client #2's 9/12/12 ISP indicated goals/objectives to deliver a meals on wheels in the community twice per month, to take turns on Wii game system, will begin job task with two verbal prompts, will attend three different community groups per month, will wait turn for staff instructions before beginning a pre vocational task, will put toothpaste on toothbrush twice daily, will correctly state the shape of Seroquel medication and its color, will participate in light exercises for 15 minutes, will pull start button on wash machine weekly, will make own bed daily, will correctly print his name using model three times per week, will correctly identify quarter three days per week, will wear glasses for one minute daily, will wear glasses daily, will give glasses to staff when he takes them off, and will exercise thirty minutes daily. Client #2's 10/27/11 Behavior Management Plan (BMP) indicated he had targeted behaviors of non-compliance, elopement, talking to self, pacing/rocking, obsessing on sensory items (cause/effect items such as a Wii game system), and poor eating habits. There were no quarterly reviews of client #2's goal data/behavioral data available in the record.</p> <p>3. On 11/8/12 at 1:30pm, client #3's record was reviewed. Client #3's 5/22/12</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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			
	<p>ISP indicated goals/objectives to work for two fifteen minute periods and stay on task, to participate in volunteer activity, to increase independence to make his own bed, to sort his laundry, to clean out dryer vent, to sit in chair properly for safety, to choose community outing, to sort colored objects, to participate in light stretching exercise fifteen minutes, to participate in home activity thirty minutes, to identify penny coin, to wash under arms during shower, to sit down in vehicle seat, to complete physical therapy exercises daily, and to slow his rate while eating. There were no quarterly reviews of client #3's goal data available in the record.</p> <p>4. On 11/9/12 at 9:05am, client #4's record was reviewed. Client #4's 9/11/12 ISP indicated goals/objectives to count bills up to fifteen, to stay on task for game, to participate in physical activity in community, to put her activity away fifteen minutes prior to meal, to wash off face, to wash hands before medication administration, to spit out toothpaste, to take own Blood Pressure, to exercise thirty minutes daily, to deep breathe exercise three times a week, to ambulate safely, to wash arms during shower, and to participate in activity. There were no quarterly reviews of client #4's goal data available in the record.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
(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	
	<p>On 11/09/12 at 10:15am, an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated there were no QMRP quarterly reviews of the ISP goals/objectives for clients #1, #2, #3, and #4.</p> <p>9-3-3(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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			
W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview and record review for 1 of 4 sampled clients (client #1) and one additional client (client #6), the facility failed to initiate programming in client #1 and #6's Individual Support Plans (ISP) regarding their civil rights/voting skills.</p> <p>Findings include:</p> <p>1. On 11/8/12 at 11:18am, client #1's record was reviewed. Client #1's 7/30/12 ISP (Individual Support Plan) indicated client #1 was an emancipated adult and did not indicate if she was a registered voter. Client #1's record contained a 7/2012 FAT (Functional Assessment Tool) which did not indicate if client #1 was a registered voter. Client #1's 8/9/11 "Decision Making Critical Skills" assessment indicated client #1 "can self advocate for personal preferences (and did not) understand representative government" and no additional information to define "representative government" was available for review. Client #1's record and ISP did not indicate</p>	W0227	Objectives have been implemented for #1 and #6 to participate in training to improve knowledge civil, voting and client rights. To assure that such training in included as appropriate the topic will be added to a checklist of things to be include in programming development Person Responsible: QMRP	12/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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			
	<p>the facility had encouraged and/or taught the client her civil rights in regard to voting.</p> <p>On 11/7/12 at 4:25pm, client #1 stated "I wanted to vote. I like (O)bama." Client #1 indicated she was not registered to vote.</p> <p>An interview with the QMRP (Qualified Mental Retardation Professional) was conducted on 11/9/12 at 10:15am. The QMRP stated she was "unaware" if client #1 was a registered voter. The QMRP indicated client #1 had been called for jury duty in the past. The QMRP indicated the clients should be taught their civil rights in regard to voting and should be allowed to vote if they chose to.</p> <p>2. On 11/8/12 at 12noon, client #6's record was reviewed. Client #6's 3/6/12 ISP (Individual Support Plan) indicated client #6 had a guardian and did not indicate if she was a registered voter. Client #6's record contained a 1/28/2012 "Decision Making Critical Skills" assessment which indicated client #6 "can self advocate for personal preferences (and did not) understand representative government" and no additional information to define "representative government" was available for review. Client #6's record and ISP did not indicate</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
-------------------------------------------------------------	-----------------------------------------------------------------------------

(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
	<p>the facility had encouraged and/or taught the client her civil rights in regard to voting.</p> <p>On 11/7/12 at 4:25pm, client #6 stated "I want to vote. I want a new president, I want to vote." Client #6 indicated she was not registered to vote.</p> <p>An interview with the QMRP (Qualified Mental Retardation Professional) was conducted on 11/9/12 at 10:15am. The QMRP stated client #6 was not a registered voter "because she had a guardian." The QMRP indicated clients should be taught their civil rights in regard to voting and should be allowed to vote if they chose to.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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			
W0312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview, the facility failed for 1 of 1 sampled client on behavior medication (client #2) by not having a plan to address the reason for the medication and failed to ensure a plan of reduction was in place.</p> <p>Findings include:</p> <p>On 11/9/12 at 8:20am, client #2's record was reviewed. Client #2's 11/2012 MAR (Medication Administration Record) indicated client #2 was taking "Risperdal 1mg (milligram) at HS (bedtime)." A "Psychiatric Review" on 6/28/12 indicated client #2 was started on Risperdal 1mg at HS for behaviors. Client #2's 9/12/12 ISP (Individual Support Plan) and 10/27/11 Behavior Management Plan (BMP) indicated he had targeted behaviors of non-compliance, elopement, talking to self, pacing/rocking, obsessing over sensory items (such as cause/effect items and gaming systems), and poor eating habits. Client #2's 10/27/11 BMP and 10/2011 medication reduction plans did not include the use of Risperdal.</p> <p>Interview on 11/9/12 at 10:15 AM with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated client #2 was on Risperdal for behaviors and stated "there was no plan in place to address the use of the Risperdal." The QMRP indicated client #2's BMP had not been updated to include the use of the Risperdal</p>	W0312	A medication reduction plan for Risperdal has been implemented. A checklist for new medications will be used to determine if a reductions plan is required and to assure that one is developed. Person Responsible: QMRP	12/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
(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	
	and there was no medication reduction plan available for review.  9-3-5(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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			
W0371	<p><b>483.460(k)(4) DRUG ADMINISTRATION</b></p> <p>The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.</p> <p>Based on observation, record review, and interview for 2 of 4 sampled clients (clients #3 and #4), the facility failed to develop medication objectives to provide medication training.</p> <p>Findings include:</p> <p>On 11/8/12 at 7:35am, the facility medication administration was observed. Facility Staff (FS) #1 and FS #2 indicated clients #3 and #4 did not have medication objectives.</p> <p>On 11/8/12 at 1:30pm, client #3's record was reviewed. Client #3's 5/22/12 ISP (Individual Support Plan) indicated he was not independent with medication administration and did not indicate a medication objective. Client #3's 9/1/12 "Physician Orders" included the use of Bag Balm for dry skin.</p> <p>On 11/9/12 at 9:05am, client #4's record was reviewed. Client #4's 9/11/12 ISP indicated she was not independent with medication administration and did not indicate a medication objective. Client #4's 9/1/12 "Physician Orders" included Aspirin for blood pressure daily.</p> <p>On 11/09/12 at 10:15am, an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated no medication objectives for clients #3 and #4 were available for review.</p>	W0371	<p>Medication objectives have been implemented for Client 3 and 4. To assure that such training in included as appropriate the topic will be added to a checklist of things to be include in programming development. Person Responsible: QMRP Addendum</p> <p>According to 2567 report the standard was not met "Based on ... the facility failed to develop medication objectives to provide medication training."</p> <p>The citation for W371 was for not developing objective for client 3 and 4.</p> <ol style="list-style-type: none"> <li>1. That has been corrected by developing and implementing medication objective for client 3 and 4.</li> <li>2. All other client already had medication objectives.</li> <li>3. As originally noted "a checklist of things to be include in programming development" will be used to assure that self medication goals are include as</li> </ol>	12/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
(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	
	9-3-6(a)		<p>part of the programming. That checklist will identify self medication goal as and item that must be included in the programming. A copy of that checklist was previously submitted with the POC.</p> <p>4. To monitor that self medications goals are included in the programming, the QMRP will review the check list following program development and confirm that the self medication goal has been included. Further, the QMRP will review the objectives monthly to assure that a self medication objectives are still include in the programming.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
(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	
W0386	<p>483.460(l)(4) DRUG STORAGE AND RECORDKEEPING The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #1), the facility failed to implement their facility policy to maintain an accurate accounting of client #1's controlled medication.</p> <p>Findings include:</p> <p>On 11/7/12 at 1:55pm, the facility's BDDS (Bureau of Developmental Disability Services) reports from 11/2011 through 11/2012 were reviewed and indicated the following:</p> <p>-On 4/16/12 a report for an incident on 4/15/12 at 1:45pm, indicated client #1's medication count for "Hydrocodone" was missing 16 doses of medication and the local police had been notified.</p> <p>On 11/9/12 at 10:15am, the facility's investigation notes were reviewed with the Site Director (SD) for the 4/15/12 missing medication incident. The SD provided a confidential investigation which indicated the facility staff on duty</p>	W0386	<p>The policy for accounting for controlled medications will be followed. Staff have been retrained in the proper procedure. In addition the facility manager will monitor the any controlled medication count record at least monthly to assure that the procedure is being followed. If the procedure is not followed staff will be retrained and monitoring of the count record will be done more frequently. Person Responsible: Residential Manager</p>	12/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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			
	<p>from 4/13/12 Friday at 8am until 4/15/12 Sunday at 1:45pm were interviewed and each staff's whereabouts was documented. The investigation indicated client #1's controlled medication administration sheet was not counted from 4/13/12 at 8am until 4/15/12 at 1:45pm by the facility staff.</p> <p>On 11/9/12 at 10:15am, client #1's "Medical Sheet Count" for "Hydrocodone (for pain)" was reviewed. Client #1's count sheet indicated a count of nineteen (19) tablets of Hydrocodone controlled medication on 3/17/12 at 8am and 8pm, on 3/18/12 at 8am, on 3/19/12 at 8am, on 3/20/12 at 8am, on 3/23/12 at 7am, on 3/24/12 at 8pm, on 3/25/12 at 8am, on 3/26/12 at 8am, on 3/28/12 at 8am, on 4/2/12 at 9:30am, on 4/3/12 at 8am, on 4/4/12 at 8am, on 4/6/12 at 8am and 8pm, on 4/7/12 at 8pm, on 4/8/12 at 8pm, on 4/11/12 at 8am, on 4/12/12 at 8am, and on 4/13/12 at 8am. Client #1's count sheet indicated on 4/15/12 at 1:45pm, 3 tablets were left.</p> <p>On 11/9/12 at 10:15am, the facility's 4/19/12 "Controlled Substance Record Count - Update/Reminder" indicated "The medication is to be counted each time it is given by the staff administering the medication. Staff sign the Controlled Substance Record when they do this</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/16/2012
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511
-------------------------------------------------------------	-----------------------------------------------------------------------------

(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
	<p>count. The medication is then placed back under double lock and key. The medication is then documented on the PRN (as needed) medication record. The medication is also to be counted once every 24 hours by 2 staff doing the count together and signing together on the controlled substance record...."</p> <p>On 11/9/12 at 10:15am, an interview with the agency Registered Nurse (RN) was completed. The RN indicated staff should have counted the controlled medication after each medication administration pass in the group home and recorded the number of pills left in the box for client #1. The RN indicated the facility staff did not follow the policy and procedure and client #1's missing medications were not discovered until 4/15/12.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012	
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511			
(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			
W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review, and interview for 1 of 2 sampled clients (client #2) who had prescribed eye glasses, the facility failed to to teach and encourage client #2 to wear his prescribed eye glasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 11/7/12 from 3:30pm until 5:55pm and on 11/8/12 from 6:25am until 9am. During both observation periods, client #2 did not wear his prescribed eye glasses and was not prompted to use them.</p> <p>Client #2's record was reviewed on 11/9/12 at 8:20am. Client #2's 10/25/11 vision assessment indicated client #2 had prescribed eye glasses and a recommendation to wear them during waking hours. Client #2's 9/12/12 ISP (Individual Support Plan) indicated objectives for client #2 to wear his eye glasses 1 minute daily, to wear eye</p>	W0436	<p>Client #2 did wear his glasses on the morning of 11/7/12 with staff encouragement and according to the goal. Staff did encourage #2 to wear his glasses on the morning or 11/8/12 according to the goal and #2 refused. The surveyor's morning observation on 11/8/12 did not take place at the location in the home of the encouragement. The manager will at least weekly will review the implementation of the goal to assure that it continues to be done. Person Responsible: Residential Manager Addendum 1. Staff were trained on the importance of encouraging the use of adaptive equipment at the staff meeting on 12/19/12. Additional tracking was added for the evening; previously it was only being tracked in the morning. Staff will encourage Client #2 by saying " You look very handsome in your glasses" " Your glasses will help you with enjoying your movies you like to watch" 2. All other clients are independent in the use of assistive devices. 3. Goals will be set in place to ensure that clients use adaptive equipment. The</p>	12/16/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G534	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  11/16/2012
NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 605 ACADEMY RD CULVER, IN 46511		
(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	
	<p>glasses daily, and to give glasses to staff when he takes off his glasses.</p> <p>On 11/9/12 at 10:15am, an interview was conducted with the QDP (Qualified Developmental Professional) and the Agency Registered Nurse (RN). The QDP and RN both indicated client #2 had prescribed eye glasses. The QDP indicated client #2 had broken and lost his glasses in the past. The QDP indicated she did not know where client #2's glasses were. The QDP stated client #2 had a formal goal to wear his eye glasses since he had not had them for "a while." The QDP indicated client #2 should have been taught and encouraged to wear his prescribed eye glasses.</p> <p>9-3-7(a)</p>		<p>encouragement of staff and response of the clients is tracked. 4. The manager will at least weekly will review the implementation of the goal to assure that it continues to be done.</p>		