

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G490	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2015
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NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1667 PIKE ST WABASH, IN 46992
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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 recertification and state licensure survey.</p> <p>Dates of Survey: 6/17, 6/18, and 6/19/2015.</p> <p>Facility Number: 001004 Provider Number: 15G490 AIMS Number: 100245030</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0382  Bldg. 00	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation, record review and interview, the facility failed to keep medications locked/secured when not administered for 3 of 3 sampled clients (#1, #2, and #3) and three additional clients (clients #4, #5, and #6) who resided in the home.</p> <p>Findings include:</p>	W 0382	<p><b>- What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice;</b> The Manager will provide re-training to staff regarding the medication policy, focusing on drug storage. <b>- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All other</p>	07/29/2015

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>On 6/17/15 from 5:40am until 7:45am, observation and interview were completed for clients #1, #2, #3, #4, #5, and #6. During the observation period, clients #1, #2, #3, #4, #5, and #6 independently accessed the areas inside the group home. From 5:40am until 6:00am, the medication/office area door was open and inside the room the medication cabinet doors were unlocked and ajar. At 6:00am, client #3 was prompted to walk into the medication/office room by GHS (Group Home Staff) #1. At 6:15am, GHS #1 left the medication room with client #3, left the medication cabinet unlocked and the doors open, and walked with client #3 from the unsecured medication/office area, through the living room, down a hallway, and into client #3's bedroom. From 6:15am until 6:25am, clients #1, #2, #4, #5, and #6 independently accessed the areas inside the group home and the medication/office area door was open and the medication cabinet was open without facility staff present. At 6:25am, GHS #1 stated "the medication cabinet should be locked at all times" and GHS #1 locked the medication cabinet and the medication/office door. GHS #1 indicated clients #1, #2, #3, #4, #5, and #6's medications were kept inside the medication cabinet.</p>		<p>clients in the home could be affected by the same deficient practice as all clients take medications. The Manager will provide re-training to staff focusing on proper drug storage. There will be a review of medication policies regarding to drug storage (focusing on locking up the medication whenever leaving the medication area.) This will prevent the deficient practice from affecting other clients. - <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur;</b> Staff will ensure anytime they leave the medication area they lock the medication cabinet. Staff will sign the inservice sheet showing that they are aware of the medication policy that they must lock the cabinet when leaving the medication area. - <b>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;</b> The Manager will observe a medication pass every week in the home to ensure staff are properly following the medication policy.</p>	

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9-3-6(a)	<p>On 6/18/15 at 11:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated medications should be kept locked when not administered.</p> <p>On 6/18/15 at 9:00am, a record review was conducted of the facility's policy and procedures, 5/8/2015 "Medication Administration Handbook" which indicated "...all medications should be in a locked container" and secured when not being administered.</p> <p>On 6/18/15 at 12:00noon, an interview with the agency nurse was conducted. The agency nurse indicated medications should be kept locked/secured when medications were not administered. The agency nurse indicated the facility followed "Living in the Community" training for medication administration.</p> <p>On 6/18/15 at 9:00am, a record review of the facility's 2004 "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medication should be kept secure when not administered.</p>			

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W 0383 Bldg. 00	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients #1, #2, and #3) and 3 additional clients (clients #4, #5, and #6), the facility staff failed to ensure the medication keys were kept secured and to ensure clients #1, #2, #3, #4, #5, and #6 did not have access to the medication keys.</p> <p>Findings include:</p> <p>On 6/17/15 from 5:40am until 7:45am, observation and interview were completed for clients #1, #2, #3, #4, #5, and #6. During the observation period, clients #1, #2, #3, #4, #5 and #6 independently accessed the areas inside the group home. From 5:40am until 6:00am, the medication/office area door was open, inside the room the medication cabinet doors were unlocked and open. The medication cabinet keys were sitting unsecured on the desk. At 6:00am, client #3 was prompted to walk into the medication/office room by GHS (Group Home Staff) #1. At 6:15am, GHS #1 left</p>	W 0383	<p>- <b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice;</b> The Manager will provide re-training to staff regarding the medication policy, focusing on keeping medication keys secured. - <b>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> All other clients in the home could be affected by the same deficient practice as all clients take medications. The Manager will provide re-training to staff focusing on properly securing medication keys. There will be a review of medication policies related to securing the medication keys(focusing on locking up the medication keys whenever leaving the medication area.) This will prevent the deficient practice from affecting other clients. - <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur;</b> Staff will ensure anytime they leave the medication area</p>	07/29/2015

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	<p>sight of the medication/office area after administering client #3's medications, left the medication cabinet open, and left the medication keys unsecured on the desk. GHS #1 walked with client #3 from the unsecured medication/office area, through the living room, down a hallway, and into client #3's bedroom. From 6:15am until 6:25am, clients #1, #2, #4, #5, and #6 independently accessed the areas inside the group home and the medication/office area door was open and the medication keys were unsecured on the desk, without facility staff present. At 6:25am, GHS #1 stated the medication cabinet keys should be secured "at all times." GHS #1 indicated clients #1, #2, #3, #4, #5, and #6's medications were kept inside the medication cabinet.</p> <p>On 6/18/15 at 11:55am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP stated the medication cabinet keys should be kept secured at "all times."</p> <p>On 6/18/15 at 9:00am, a record review was conducted of the facility's policy and procedures, 5/8/2015 "Medication Administration Handbook" which indicated the medication cabinet keys should be kept secured by the facility</p>		<p>they either have the key on their person or they lock the keys up, so clients cannot access them. Staff will sign the inservice sheet showing that they are aware of the medication policy that they must lock up the medication keys when leaving the medication area. - <b>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;</b></p> <p>The Manager will observe a medication pass every week in the home to ensure staff are properly following the medication policy.</p>	

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	<p>staff.</p> <p>On 6/18/15 at 12:00noon, an interview with the agency nurse was conducted. The agency nurse indicated medication cabinet keys should be kept secured when medications were not administered. The agency nurse indicated the facility followed the "Living in the Community" training for medication administration.</p> <p>On 6/18/15 at 9:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications keys should be kept secured.</p> <p>9-3-6(a)</p>				