

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G786	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/18/2022
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NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1570 JESSUP STREET HUNTINGTON, IN 46750
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W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00367202.</p> <p>Complaint #IN00367202: Substantiated, Federal and State deficiencies related to the allegation(s) are cited at W149, W154, W249, and W382.</p> <p>Dates of Survey: 2/1, 2/3, 2/7, 2/10, 2/16, 2/17, and 2/18/2022.</p> <p>Facility number: 012414 Provider Number: 15G786 AIMS Number: 200998980</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/7/22.</p>	W 0000		
W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, for 3 of 3 sampled clients (clients A, B, and C) and 4 additional clients (clients D, E, F, and G), the facility failed to implement its policy and procedures to protect clients A, B, C, D, E, F, and G from abuse, neglect, and/or mistreatment, to thoroughly investigate client A's hip fracture, and to ensure staff supervised and implemented client A, B, C, and E's ISPs (Individual Support Plans), BSPs (Behavior Support Plans), and Risk Plans for their identified supervision needs.</p> <p>Findings include:</p>	W 0149	<p>POC for tag number W149: Staff Treatment of Clients</p> <p>1. -Staff will ensure all individuals' personal care needs are met with staff assistance, if needed, on a person centered basis -Staff will complete training in Abuse, Neglect and Exploitation (ANE) annually as required and report any suspected incidents. - Oversight on documentation by QIDP, ADRS and/or LPN to be</p>	03/18/2022

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>1. On 2/1/2022 at 12:15pm, on 2/3/2022 at 7:00pm, on 2/7/2022 at 8:10am, and on 2/10/2022 at 1:00pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and indicated the following for clients A, B, C, D, E, F, and G:</p> <p>A 11/12/2021 BDDS report for an allegation of staff to client neglect on 11/11/2021 at 4:30pm indicated "On 11/11/21 at approximately 4:30pm, [Direct Support Professional] #1 sent an email to [name of Assistant Director of Residential Services (ADRS)] expressing concern over many incidents of potential neglect for the residents of the [name of group home]. Those concerns included: neglecting to change/toilet incontinent individuals on a regular basis, showering/bathing individuals on a regular basis and neglecting to reposition individuals in wheelchairs. It was documented in the email that the concerns had been addressed with the group home manager on several occasions, but the situations had not been resolved. Plan to resolve: Supervisor for the group home has been suspended pending investigation."</p> <p>A 11/23/2021 BDDS follow up report regarding the allegations of neglect for clients A, B, C, D, E, F, and G indicated "The investigation was found to be substantiated" regarding staff to client neglect.</p> <p>The 11/12/2021 "Investigation Summary" indicated the investigation was completed on 11/18/2021 by the investigator and indicated the investigation was determined to result as "inconclusive" regarding abuse, neglect, and mistreatment. The investigation summary</p>		<p>completed weekly.</p> <ul style="list-style-type: none"> <li>- Agency will follow ANE policies as written/trained and complete any investigations in a timely manner.</li> <li>-March 18, 2022</li> <li>2.</li> <li>-Staff will implement programs/plans as trained</li> <li>-Progress on programs will be discussed as a team to determine efficacy of plan for individual and/or others</li> <li>-Staff will document verbally re-directive methods used and their efficacy to determine when more restrictive interventions may be needed.</li> <li>-Any potentially restrictive interventions will be presented to a Human Rights Committee for approval prior to implementation</li> <li>-March 18, 2022</li> </ul>	

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	<p>indicated on 11/22/2021 the investigation was reviewed by the "ANE (Abuse, Neglect, and Exploitation) Committee" and recommended "ANE and PCT (Patient Centered Training, retraining on ISPs, BSPs, and Risk Plans), [Name of group home manager] (to complete) more management training, expectations for each staff, and group home supervisor to do random checks in the home." The investigation summary indicated on 11/22/2021 the facility's administrator reviewed the investigation, the ANE committee recommendations, and indicated "Additional recommendations and due date: Overturn-Substantiate [signed the administration/CEO (Chief Executive Officer)]."</p> <p>The 11/12/2021 investigation summary indicated the following paraphrased witness statements documented by the investigator:</p> <p>-The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 12/17/2021 at 12:09pm. The QIDP indicated she "has been working at the house this past weekend (12/17/21) about 13 hours...and sometimes she will run transport during the week and stays until 4:00pm-5:00pm. [The QIDP] said when she took over the house...In November it stank and now it doesn't. Trash wasn't getting changed so it smelled gross because lots of people wearing depends (an adult brief). Depends on the day but working at [name of group home] can be overwhelming at times with everything that goes on at times. There is tracking for toileting, BM (Bowel Movement), showers, its kept in two books and now (the books with the information) is transferred back and forth to the house and day services. [The QIDP] is unsure where these tracking sheets go at the end of the month. [The QIDP] would think the medical ones like the</p>			

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	<p>toileting one and the BM one would get brought into the nurse to look over but the shower tracking she is unsure where they go. We then talked about using the rest room and that [client E] is a process sometimes to get to the bathroom. That the other day it took a while trying to get her to the bathroom. But once you get [client E] there its not bad. [Client E] likes to plop down while trying to get her to the bathroom. Then you must wait [client E] out and once she gets back up you must direct her in the direction of the bathroom again. We talked about food being available at the house. [The QIDP] feels like it is available. [The QIDP] herself just put an order in for [name of grocery store] on Saturday because the house was out of trash bags and when she went to order pudding, she was not able to get any of the snack cups that [name of grocery store] was out of those. [The QIDP] said a staff just came to her last night 11/16/2021 and saying there was no canned veggies but when [name of the QIDP] was there on Sunday there were plenty of frozen veggies in the freezer that could be used for pureed food. You just must cook them first and then puree them. Not sure if the staff realize that you must cook them before you puree the frozen veggies. Also talked about a discussion that [QIDP] has sat in on with [name of house manager] and [a staff member]. [The QIDP] let me know that the discussion was about the [name of staff] not doing his job and he said he stopped doing his job because nobody else was doing theirs. This discussion wasn't long ago. [The QIDP] thinks maybe around October 24, (2021). [The QIDP] feels that most of the staff work well at the house while she is there. [The QIDP] also feels [name of house manager] does not sit in the office all the time. She is hands on at the house. [Name of house manager] is tired between her</p>			

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	<p>hours at the house and her school schedule by what [the QIDP] stated. [Name of house manager] is a positive person and advocates for everyone and is always working with a smile. [The QIDP] has not seen [client E] sitting in her wheelchair longer than her plan states. She has not seen anyone not being changed or sitting in depends longer than they should. [The QIDP] also has never seen anyone being put to bed in gait belts, body suits, or shoes."</p> <p>DSP #1's witness statement and email on 11/11/2021 indicated "Multiple occasions of [client E] sleeping with gait belts on (sic) and all of the individuals in the house that wear gait belts, [client E] still in bra, and bodysuit from the day before, left in the same clothing &amp; un-bathed, sometimes even the same depend. The people who do give her showers do not shave her armpits. No showers daily every other day. I have worked for example, a Monday, and then came into [name of group home] on a Thursday, and [client E] has an odor, there is no documentation of a shower, &amp; from talking to the staff she hasn't gotten a shower because she was too hard to get into the shower. They let her stay in bed all day and do not change her depend. I understand not wanting to physically get her out of bed, but it isn't like that. [Name of group home manager] doesn't try. They leave [client E] in her wheelchair all night when she gets home from day services. If it isn't all night, it is for hours until the staff comes in later that evening. Twice her private parts have been covered in gunk (sic). I don't know how else to describe it, but [DSP #2] and I have had to wash her really well in that area for it to come off. I have had an instance come up to me that a depend that [client E] was wearing was literally falling apart off of her body. It was so filled with bodily fluids and BM</p>			

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	(Bowel Movement) that it was disintegrating off of her body. [Client E] had went (sic) out the front door one time without anyone noticing and she walked around the house to the back where [DSP #3] was grilling & touched him. That means she walked around the whole house to get to him, if [DSP #3] had not been outside [client E] could and would have taken off without the staff in the house ever noticing. Other than just [client E] who is my main concern, I'm going to add all of the other things that I have noticed while working in the home with the other individuals & the lack of support from the manager/other staff who don't seem to be trained, won't listen to the people who are trained, & don't want to listen to the suggestions that are being given to help run the house better. [Name of group home manager] waits until the last minute to order groceries which leads the house unable to follow the menu provided by the dietitian, and the house runs out of food. [Client D] must have some sort of yeast infection or something going on with her because there is always an odor, when given suggestions to the manager, nothing comes from it. [Client A] fell for no apparent reason. I don't even know if a report was made, but when brought up to the manager about concussion tracking & reports I was ignored, so I went to the nurse & explained everything that happened which led to possible appointments being ran (sic) by the manager. When I brought up to the manager that appointments will have to be made & ran (sic), she complained & said that she doesn't have time to take him to the doctor when something could have been seriously wrong with him. [Name of group home manager] stays in the office all day, even if the staff are struggling with the individuals or the tasks that need to be done that night for the house to run smoothly and the individuals to not get neglected. Almost			

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	<p>everyone who has worked at [name of group home] have (sic) said to me that she will stay in the office &amp; not help with anything, and then leave. [DSP #4] has come in to [client B] still sitting in his own mess from dinner and not changed on multiple occasions as well. The meds. (medications) at the house are always a mess &amp; unorganized, making it easy to get a message error if you are not paying attention. None of the paperwork at [name of group home] is ever organized or it's missing from the binders leaving tracking not filled out, and some/most of the tracking is substantial for the individuals &amp; their health. To add, when you check the bathroom tracking on the weekends when you work a later shift or you come in at 4, usually the individuals have not been toileted. [DSP #5 and DSP #6] have suggested a shower chair for [client E] and her bathroom and [name of group home manager] brushed it off immediately. I have some pictures that [DSP #4] sent me from a while back of the mess that [name of group home manager] had left for the overnights to come in, which is ridiculous. In my two years working here I have never been at that house even with only two people working &amp; left a huge mess for the next staff to come in without even attempting to clean it up. It really is a disappointment that myself and other people have talked &amp; have agreed that it is honestly scary to work at [name of group home]. The conditions of the individuals &amp; the house make it so easy for anyone to get written up or possibly even lose our jobs."</p> <p>2. On 2/1/2022 at 12:15pm, on 2/3/2022 at 7:00pm, on 2/7/2022 at 8:10am, and on 2/10/2022 at 1:00pm, the facility's BDDS reports and investigations were reviewed and indicated the following for client A:</p>			

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	<p>-A 1/22/2022 BDDS report for a significant fall which resulted in a fractured hip on 1/21/2022 at 2:45pm indicated client A "had a fall in HAB (Habilitation area of day program) room during day services and [name of nurse] was asked to assess [client A]. Upon arrival into room, [client A] was up and sitting in a chair. [LPN (Licensed Practical Nurse) #1] was notified of incident where [client A] was sleeping in a chair that got bumped by a peer [client C], [client A] then fell out of the chair and landed on right side of body. Day services staff then assisted [client A] off the floor and into a chair. [LPN #1] attempted to have [client A] stand to assess his gait and strength of arms and legs, also to assess skin for bruising or injuries. [Client A] stood very slowly with help of [LPN #1] but would not bear weight to his right foot and leg. [LPN #1] had to physically hold [client A] up while standing due to not being able to apply pressure to right leg. [LPN #1] consulted with [name of RN (Registered Nurse)] and both agreed EMS (Emergency Medical Services) needed to be called and [client A] needed to have an evaluation at ER (Emergency Room). 9-1-1 was called per [LPN #1] and EMS arrived, helped [client A] to a stretcher and he was transported to [name of hospital]. [Client A] was admitted...after X-ray results were reviewed by ER MD (Medical Doctor). X-rays of the right hip show markedly displaced, transverse femoral neck fracture (a fracture of the leg)...Proceed with operative fixation when medically cleared...." The BDDS report did not indicate why client A was asleep upright in a chair at the day program. No investigation was available for review to determine if abuse, neglect, and/or mistreatment had occurred and if clients A and C's ISPs (Individual Support Plans) and BSPs (Behavior</p>			
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	<p>Support Plans) were implemented by the facility staff before and during the incident.</p> <p>-Client A's 1/21/2022 at 2:30pm "Incident Report", indicated "What had occurred prior to the incident? [DPS (Day Program Staff) #1] was spending time with [other client name] one table away and staff [DPS #2] was across the room moving [client B's] chair. [Client C] slammed his fist on the desk, a common signal of irritation from him. [Day Program Staff (DPS) #1] heard this and looked over to see [client C] adjust himself in his chair before scooting it back as far as he could in a quick manner knocking [client A's] chair, the jolt, sending [client A] tumbling to the floor."</p> <p>Client A's record was reviewed on 2/7/2022 at 9:15am. Client A's 6/16/2021 ISP (Individual Support Plan) and 6/11/2021 BSP (Behavior Support Plan) both indicated staff should be with client A to supervise client A. Client A's 6/2021 FAT (Functional Assessment Tool) and 6/2021 High Risk Plans indicated client A was not at risk for falls. Client A's ISP indicated client A had Dementia and needed staff to supervise him to ensure he had activities to complete, assistance/prompts to use the bathroom, and to express his wants/needs.</p> <p>Client B's record was reviewed on 2/16/2022 at 10:00am. Client B's 5/1/2021 ISP and 12/17/2021 BSP indicated client B had the targeted behavior of "PICA (eating inedible items) grabbing edible and non edible items from the floor, ground, trash, etc. and putting it in his mouth." Client B's ISP and BSP indicated client B was line of sight staff supervision. Client B's BSP indicated "Signals: PICA signal, edging his way closer to a counter, leaning over to the</p>			

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	<p>floor/ground, boredom, having another's property, sporadic...Staff will ensure all unsafe edibles and/or non edibles small enough to fit in [client B's] mouth are monitored and/or out of [client B's] reach or easy access."</p> <p>Client C's record was reviewed on 2/16/2022 at 8:00am. Client C's 9/1/2021 ISP and 8/13/2021 BSP indicated client C had the targeted behaviors of physical aggression, intimidation, and property destruction. Client C's ISP and BSP indicated client C was line of sight staff supervision. Client C's BSP indicated "Behavior Signals...starts slapping his hand, or table...Give [client C] as much individual attention as possible without limiting attention to peers...try to get [client C's] attention focused back on staff and helping staff. Let [client C] know that displayed behavior is not appropriate...Staff will direct [client C] to his bedroom or to an area away from the individual he is trying to intimidate or aggress upon while attempting to block his aggression..As a last resort, staff will use CPI (Crisis Prevention Intervention, a program to intervene to protect others from aggressive clients) techniques to guide all individuals to safety."</p> <p>Client E's record was reviewed on 2/7/2022 at 8:00am. Client E's 8/1/2021 ISP, 2/17/2021 BSP, and 2021 risk plans indicated client E needed staff supervision within the line of sight while awake. Client E's 2/17/2021 BSP indicated client E's targeted behaviors included, but were not limited to: physical aggression, dropping to the floor, and elopement (leaving the area). Client E's BSP indicated "Special Considerations: [Client E] has a strong tendency to wander off and must be watched closely at all times...[Client E] uses her wheelchair when she</p>			

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	<p>is doing activities outside of the home due to her tiring easily. [Client E's] wheelchair is also a safe place for her and used to assist her in calming when anxious. [Client E's] wheelchair is considered restrictive as there is a wheelchair belt to keep [client E] from slipping out...Due to [client E] targeting peers, there will also be a specific schedule of use residentially. Day Service Wheelchair Schedule: Transition times, defined as morning arrivals, lunch, preparing to leave for the day...When preparing to leave, [client E] will get in her chair 15 minutes prior to 3pm so others can safely get their items ready to leave...[Client E] will be asked to sit in her chair if [client E] has engaged in physical aggression twice in a 15 minute period...[Client E's] chair is available to her throughout the day. If [client E] chooses to sit in her chair, staff will make sure the belt is buckled, but will see if [client E] would like to leave her chair every 10 minutes by unbuckling her belt. If [client E] does not leave after a minute, then staff will re buckle the belt and check again in 10 minutes."</p> <p>On 2/1/2022 at 12:15pm, an interview was conducted with the Registered Nurse (RN). The RN indicated the facility followed the BDDS reporting and investigating policy and procedure and the agency's policy and procedure which indicated the facility prohibited neglect.</p> <p>On 2/7/2022 at 8:30am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility followed the BDDS reporting and investigating policy and procedure and the agency's policy and procedure which indicated the facility prohibited neglect.</p> <p>On 2/18/2022 at 2:30pm, an interview was</p>			

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	<p>conducted with the QIDP. The QIDP indicated clients A, B, C, D, E, F, and G needed staff supervision at the group home. The QIDP indicated staff should ensure the environment was clean and neat, to implement clients A, B, C, D, E, F, and G's ISPs and BSPs when opportunities existed. The QIDP stated "I was interviewed" regarding the 11/11/2021 investigation. The QIDP stated "I had worked at the home" to cover open shifts of personnel and indicated she told the investigator what she had observed. The QIDP stated "the house was a mess during that time. I just took back over this home near the same time all this was happening." The QIDP stated "some of the staff were not doing their jobs for whatever reason. [Clients A, B, C, D, E, F, and G's] ISPs and BSPs were not always implemented and should have been." The QIDP indicated clients A, C, and D needed reminders to use the bathroom and clients B, E, and G needed staff assistance to use the bathroom every two hours. The QIDP indicated clients A, B, D, E, and G would not initiate their own hygiene needs. The QIDP stated client A was not at risk for falls, however, when client C had a behavior "he slapped his hand on the table, shifted his weight in his seat, and jumped out of his chair which was on rollers and hit [client A's] chair which in turn knocked [client A] out of his chair onto the floor." The QIDP stated "I don't know how that could have been predicted." When asked why client C sat in a chair with rollers if staff knew this type of behavior had occurred previously, the QIDP stated "I don't know." When asked why client A was sleeping during day program upright in a chair, the QIDP indicated she did not know. The QIDP indicated she was not aware of a completed investigation regarding client A's fractured hip.</p>			

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W 0154 Bldg. 00	<p>On 2/1/2022 at 12:15pm, a review of the facility's records indicated the facility's undated "Handling client Abuse, Neglect, and Injuries of Unknown Origin &amp; BDDS Incident Reporting" policy which indicated "It is Pathfinder Services, Inc. policy to provide a service where clients are free from abuse, neglect, or exploitation. In the event that any of these conditions are suspected, an investigation will immediately be conducted...Any alleged, suspected, or actual abuse-physical, sexual, emotional, or domestic improper treatment, neglect-failure to provide appropriate care, environment, food, medical care, or supervision, exploitation or any other mistreatment must be immediately reported..."</p> <p>This federal tag relates to complaint #IN00367202.</p> <p>9-3-2(a)</p> <p>483.420(d)(3)</p> <p><b>STAFF TREATMENT OF CLIENTS</b></p> <p>The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, for 2 of 3 sampled clients (clients A and C), the facility failed to thoroughly investigate the circumstances of client A's hip fracture.</p> <p>Findings include:</p> <p>On 2/1/2022 at 12:15pm, on 2/3/2022 at 7:00pm, on 2/7/2022 at 8:10am, and on 2/10/2022 at 1:00pm, the facility's BDDS reports and investigations were reviewed and indicated the following for client A:</p> <p>-A 1/22/2022 BDDS report for a significant fall which resulted in a fractured hip on 1/21/2022 at</p>	W 0154	<p>POC for tag number W154: Staff Treatment of Clients</p> <ul style="list-style-type: none"> <li>-Staff will complete an investigation of circumstances surrounding critical incidents to ensure implementation of plans.</li> <li>-Staff will share findings, if any, with supervisor and follow up with retraining where necessary</li> <li>-Staff will complete retraining on individuals' plans prior to working with the individuals again to ensure implementation of plans.</li> <li>-Monitoring of implementation of plans to be completed monthly by</li> </ul>	03/18/2022

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	2:45pm indicated client A "had a fall in HAB (Habilitation area of day program) room during day services and was [name of nurse] asked to assess [client A]. Upon arrival into room, [client A] was up and sitting in a chair. [LPN (Licensed Practical Nurse) #1] was notified of incident where [client A] was sleeping in a chair that got bumped by a peer [client C], [client A] then fell out of the chair and landed on right side of body. Day services staff then assisted [client A] off the floor and into a chair. [LPN #1] attempted to have [client A] stand to assess his gait and strength of arms and legs, also to assess skin for bruising or injuries. [Client A] stood very slowly with help of [LPN #1] but would not bear weight to his right foot and leg. [LPN #1] had to physically hold [client A] up while standing due to not being able to apply pressure to right leg. [LPN #1] consulted with [name of RN (Registered Nurse)] and both agreed EMS (Emergency Medical Services) needed to be called and [client A] needed to have an evaluation at ER (Emergency Room). 9-1-1 was called per [LPN #1] and EMS arrived, helped [client A] to a stretcher and he was transported to [name of hospital]. [Client A] was admitted...after X-ray results were reviewed by ER MD (Medical Doctor). X-rays of the right hip show markedly displaced, transverse femoral neck fracture (a fracture of the leg)...Proceed with operative fixation when medically cleared...." The BDDS report did not indicate why client A was asleep upright in a chair at the day program. No investigation was available for review to determine if abuse, neglect, and/or mistreatment had occurred and if clients A and C's ISPs (Individual Support Plans) and BSPs (Behavior Support Plans) were implemented by the facility staff before and during the incident.		QIDP, ADRS and/or LPN -March 18, 2022 **Special note: The chair in which Client C was seated who backed up and bumped into Client A did not then, nor did it ever, have rollers/wheels attached to it due to this individual having a seizure condition and being a fall risk.		

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	<p>-Client A's 1/21/2022 at 2:30pm "Incident Report", indicated "What had occurred prior to the incident? [DPS (Day Program Staff) #1] was spending time with [other client name] one table away and staff [DPS #2] was across the room moving [client B's] chair. [Client C] slammed his fist on the desk, a common signal of irritation from him. [Day Program Staff (DPS) #1] heard this and looked over to see [client C] adjust himself in his chair before scooting it back as far as he could in a quick manner knocking [client A's] chair, the jolt, sending [client A] tumbling to the floor."</p> <p>On 2/7/2022 at 8:30am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility followed the BDDS investigating policy and procedure and the agency's policy and procedure which included client to client physical aggression.</p> <p>On 2/18/2022 at 2:30pm, an interview was conducted with the QIDP. The QIDP stated client A was not at risk for falls, however, when client C had a behavior "[client C] slapped his hand on the table, shifted his weight in his seat, and jumped out of his chair which was on rollers and hit [client A's] chair which in turn knocked [client A] out of his chair onto the floor." The QIDP stated "I don't know how that could have been predicted." When asked why client C sat in a chair with rollers if staff knew this type of behavior had occurred previously, the QIDP stated "I don't know." When asked why client A was sleeping during day program upright in a chair, the QIDP indicated she did not know. The QIDP indicated she was not aware of a completed investigation regarding client A's fractured hip.</p>			

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W 0249 Bldg. 00	<p>This federal tag relates to complaint #IN00367202.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) <b>PROGRAM IMPLEMENTATION</b></p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 2 of 3 sampled clients (clients B and C) and 1 additional client (client E), the facility failed to ensure staff supervised and implemented clients B, C, and E's ISPs (Individual Support Plans), BSPs (Behavior Support Plans), and Risk Plans for their identified staff support and supervision needs.</p> <p>Findings include:</p> <p>1. On 2/1/2022 from 12:45pm until 2:35pm, client C was observed at the day program. During the observation period, client C sat in a chair at a desk with DPS (Day Program Staff) #1 completing a puzzle. During the observation periods, client C slammed his hand on the desk, stood up and the chair with wheels moved against the non occupied chair at the table in the classroom. DPS #1 redirected client C to use his coping skills and client C sat back down to continue working his puzzle.</p> <p>On 2/1/2022 from 3:15pm until 4:40pm, client</p>	W 0249	<p>POC for tag number W249: Program Implementation</p> <p>1.</p> <ul style="list-style-type: none"> <li>-Staff will implement programs/plans as trained</li> <li>-Progress on programs will be discussed as a team to determine efficacy of plan for individual and/or others</li> <li>-Staff will document verbally re-directive methods used and their efficacy to determine when more restrictive interventions may be needed.</li> <li>-Any potentially restrictive interventions will be presented to a Human Rights Committee for approval prior to implementation and staff training</li> <li>-March 18, 2022</li> </ul> <p>2.</p> <ul style="list-style-type: none"> <li>-Staff will be retrained on programs/plans of individuals</li> <li>-Implementation of plan/program</li> </ul>	04/01/2022

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	<p>C was observed at the group home. At 3:15pm, client C entered the group home from the facility van with DSP (Direct Support Professional) #7 and DSP #8. During the observation period, client C approached client B multiple times, client C redirected client B who was sweeping a broom on the floor to gather items closer to him, and client B yelled multiple times. DSP #7 redirected client C to help staff with to unload the dish washer. At 4:15pm, client C approached client B who sat quietly at the dining room table, slapped client B with an open hand eight times on [client B's] left side, and DSP #9 verbally asked client C to stop. DSP #9 positioned herself physically between clients B and C. Client C began to yell, attempted to reach around DSP #9 to grab client B by his head, and DSP #9 and DSP #10 escorted client C holding his hands and arms to walk from the dining room area to client C's bedroom. Client C was not offered a choice of activities before and during the incident by the facility staff.</p> <p>Client C's record was reviewed on 2/16/2022 at 8:00am. Client C's 9/1/2021 ISP and 8/13/2021 BSP indicated client C had the targeted behaviors of physical aggression, intimidation, and property destruction. Client C's ISP and BSP indicated client C was line of sight staff supervision. Client C's BSP indicated "Behavior Signals...starts slapping his hand, or table...Give [client C] as much individual attention as possible without limiting attention to peers...try to get [client C's] attention focused back on staff and helping staff. Let [client C] know that displayed behavior is not appropriate...Staff will direct [client C] to his bedroom or to an area away from the individual he is trying to intimidate or aggress upon while attempting to block his aggression..As a last resort, staff will</p>		<p>will be discussed as a team to determine efficacy of plan and potential lateral use with other individuals</p> <ul style="list-style-type: none"> <li>- Staff will document Client E's activities/routines/concerns so modification of her plan can take place if needed</li> <li>- Programs will be monitored to ensure individuals' plans are being implemented accurately</li> </ul> <p>-April 1, 2022</p> <p>3.</p> <ul style="list-style-type: none"> <li>-Staff will be retrained on programs/plans of individuals</li> <li>-Implementation of plan/program will be discussed as a team to determine efficacy of plan and potential lateral use with other individuals</li> <li>-Staff will ensure the environment is free of debris and routinely cleaned</li> <li>-Staff will follow cleaning checklist procedures in place and monitor environment for issues needing addressed</li> </ul> <p>-March 18, 2022</p>	

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	<p>use CPI (Crisis Prevention Intervention, a program to intervene to protect others from aggressive clients) techniques to guide all individuals to safety."</p> <p>2. On 2/1/2022 from 12:45pm until 2:35pm, client E was observed at the day program. During the observation period, client E sat in a wheelchair with the seat belt attached in place. At 2:20pm, DPS #3 stated client E sat in a wheelchair with the seat belt attached in place because client E "would wander and [client E] gets in other client's personal space." DPS #3 indicated client E had been physically aggressive with other clients and stated "It's HRC (Human Rights Committee) approved to have her use the wheelchair during day program." During the observation period, client E was not offered the opportunity to leave her wheelchair.</p> <p>On 2/1/2022 from 3:15pm until 4:40pm, client E was observed at the group home. At 3:15pm, client E was assisted by DSP #7 and DSP #8 to enter the group home sitting in her wheelchair. At 3:40pm, DSP #7 assisted client E to press the button to release her seat belt and client E stood up independently from the wheelchair. At 3:40pm, DSP #7 stated client E used a "wheelchair only for transport to and from the day program." DSP #7 stated client E was to be seated in her wheelchair "about 15-20 minutes before and after transport to and from the day program daily." DSP #7 indicated client E could walk independently and had behaviors which required staff supervision. From 3:40pm until 4:40pm, DSP #7 and DSP #8 redirected client E from tearing up staff papers and tracking sheets for other clients which sat on the center island in the kitchen, from repeated pinching of clients B and G, from opening the front door, from taking</p>			

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	<p>clients A and B's snack items, and from sitting on top of client G in the living room.</p> <p>Client E's record was reviewed on 2/7/2022 at 8:00am. Client E's 8/1/2021 ISP, 2/17/2021 BSP, and 2021 risk plans indicated client E needed staff supervision within the line of sight while awake. Client E's 2/17/2021 BSP indicated client E's targeted behaviors included, but were not limited to: physical aggression, dropping to the floor, and elopement (leaving the area). Client E's BSP indicated "Special Considerations: [Client E] has a strong tendency to wander off and must be watched closely at all times...[Client E] uses her wheelchair when she is doing activities outside of the home due to her tiring easily. [Client E's] wheelchair is also a safe place for her and used to assist her in calming when anxious. [Client E's] wheelchair is considered restrictive as there is a wheelchair belt to keep [client E] from slipping out...Due to [client E] targeting peers, there will also be a specific schedule of use residentially. Day Service Wheelchair Schedule: Transition times, defined as morning arrivals, lunch, preparing to leave for the day...When preparing to leave, [client E] will get in her chair 15 minutes prior to 3pm so others can safely get their items ready to leave...[Client E] will be asked to sit in her chair if [client E] has engaged in physical aggression twice in a 15 minute period...[Client E's] chair is available to her throughout the day. If [client E] chooses to sit in her chair, staff will make sure the belt is buckled, but will see if [client E] would like to leave her chair every 10 minutes by unbuckling her belt. If [client E] does not leave after a minute, then staff will re buckle the belt and check again in 10 minutes."</p> <p>3. On 2/1/2022 from 3:15pm until 4:40pm,</p>			

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	<p>client B was observed at the group home. At 3:15pm, client B entered the group home from the facility van with DSP #7 and DSP #8. At 3:15pm, dried foods from breakfast, bits of paper, bits of clear plastic wrap, and a dried white substance were on the floor around and under the dining room table. During the observation period, client B sat in a chair at the dining room table and bent over repeatedly to pick items up from the floor with his right and left hands and placed the objects into his mouth without redirection from the facility staff. At 3:40pm, DSP #7 handed client B a broom. Client B sat at the dining room table, used the broom to sweep items on the floor around the dining room table closer to his seat at the table. No redirection was encouraged by the facility staff. From 4:00pm until 4:40pm, client B sat at the dining room table, bent at the waist repeatedly, picked with his finger nails dried foods and items on the floor. From 4:00pm until 4:40pm, client B picked up bits of paper and the dropped dried food on the floor from breakfast and placed the items into his mouth without redirection from the facility staff.</p> <p>Client B's record was reviewed on 2/16/2022 at 10:00am. Client B's 5/1/2021 ISP and 12/17/2021 BSP indicated client B had the targeted behavior of "PICA (eating inedible items) grabbing edible and non edible items from the floor, ground, trash, etc. and putting it in his mouth." Client B's ISP and BSP indicated client B was line of sight staff supervision. Client B's BSP indicated "Signals: PICA signal, edging his way closer to a counter, leaning over to the floor/ground, boredom, having another's property, sporadic...Staff will ensure all unsafe edibles and/or non edibles small enough to fit in [client B's] mouth are monitored and/or out of</p>			

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W 0382 Bldg. 00	<p>[client B's] reach or easy access."</p> <p>On 2/18/2022 at 2:30pm, an interview was conducted with the QIDP. The QIDP indicated the staff should have ensured the environment was clean before the clients had left for day program on 2/1/2022 and the evening staff should have checked the environment when the clients arrived home to ensure no food or inedible items were on the floor around client B. The QIDP stated client C had displayed physically aggressive behaviors toward his housemates in the past and the staff should have ensured client C was offered activities and tasks "like helping the staff cook or clean to keep him busy." The QIDP indicated client E had a schedule for her wheelchair at the day program and client E should have been offered and encouraged to get up from her wheelchair every 10 minutes. The QIDP indicated the facility staff did not implement clients B, C, and E's ISPs and BSPs when opportunities existed.</p> <p>This federal tag relates to complaint #IN00367202.</p> <p>9-3-4(a)</p> <p>483.460(l)(2) <b>DRUG STORAGE AND RECORDKEEPING</b> The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 3 of 3 sampled clients (clients A, B, and C) and 4 additional clients (clients D, E, F, and G), the facility failed to keep medications locked when medications were not being administered.</p>	W 0382	<p>POC for tag number W382: Drug Storage and Recordkeeping -Staff will be retrained to ensure medications are locked properly when not in use -Staff at all group homes will verify receipt of training on maintaining</p>	03/18/2022

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NAME OF PROVIDER OR SUPPLIER  PATHFINDER SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1570 JESSUP STREET HUNTINGTON, IN 46750
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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
	<p>Findings include:</p> <p>During observations on 2/1/2022 from 3:15pm until 4:40pm, clients A, B, C, D, E, F, and G were at the group home. From 3:15pm until 3:50pm, the medication cabinet was unlocked and stored clients A, B, C, D, E, F, and G's medications inside the cabinet. From 3:15pm until 3:50pm, clients C, E, and F walked into and out of the medication room independently without staff present. At 3:50pm, (Direct Support Professional) #7 and #8 locked the medication cabinet. At 3:50pm, DSP #7 stated "Yes, the cabinet (to the medications) was unlocked." DSP #7 stated the unlocked medication cabinet should have been kept locked and stated "It must have been left unlocked by the morning staff." DSP #7 indicated the facility staff followed Core A/Core B medication administration training which indicated all medications should be kept locked unless being administered.</p> <p>On 2/1/2022 at 12:15pm, an interview was conducted with the Registered Nurse (RN). The RN indicated the facility followed Core A/Core B medication administration training when administering medications.</p> <p>On 2/7/2022 at 8:30am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the facility followed Core A/Core B medication administration training when administering medications.</p> <p>On 2/18/2022 at 2:30pm, an interview was conducted with the QIDP. The QIDP indicated the facility followed Core A/Core B medication administration training when administering medications and indicated the agency nurse was</p>		<p>medications not in use in a secure locked area</p> <p>-Shift checks will be implemented to ensure employees are following Core A/B guidelines</p> <p>-Staff found to not be following Core A/B guidelines will have disciplinary action taken of all staff working the checked shift</p> <p>-March 18, 2022</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G786		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/18/2022	
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	<p>not available for further interview. The QIDP indicated the medication cabinet should have been kept locked when medications were not being administered.</p> <p>On 2/18/2022 at 2:30pm, the agency's 6/25/17 policy and procedure for "Medication Administration Handbook" indicated the agency followed the Core A/Core B medication training. The policy and procedure indicated medications should be locked when not being administered.</p> <p>On 2/18/2022 at 2:30pm, a review of the 2004 "Living in the Community" medication administration training manual, "Core Lesson : Principles of Administering Medications" indicated medications should be kept secured/locked when not being administered.</p> <p>This federal tag relates to complaint #IN00367202.</p> <p>9-3-6(a)</p>						