STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G532	A. BUILDING 00 B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PATHFINDER SERVICES INC	107 BINKLEY KNOX, IN 46534

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00394439. Complaint #IN00394439: Substantiated, Federal and State deficiency related to the allegation(s) is cited at W0192. Dates of Survey: 12/8, 12/9, and 12/14/2022. Provider Number: 15G532 AIM Number: 100245310 Facility Number: 001046 This federal deficiency also reflects a state finding in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/22/22.	W 0000		
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review, and interview for 2 of 3 sampled clients (clients A and C) plus 1 additional client (client H), the facility failed to ensure the facility staff demonstrated competency of applying, assessing, and maintaining clients A, C, and H's side bedrails securely to their beds and in good working order. Findings include: On 12/8/2022 from 1:55pm until 4:25pm, client A was observed at the group home. On 12/8/2022 from 4:00pm until 4:25pm, clients A, C, and H were observed at the group home. During the	W 0192	What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice; Facility admits that all individuals could have been potentially affected by deficient practice. Facility has provided retraining on proper usage of bedrails and bedrail checks of bedrails to staff. An Inservice documentation sheet has been uploaded for review. · How you will identify other residents having the potential to	01/07/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Taylor Minix	Qualified Intellectual Disabilities Professional	01/06/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	observation periods, clients A and C were assisted by the facility staff to walk from room to room inside the group home. From 4:00pm until 4:25pm, client H used a wheelchair to move himself throughout the group home. On 12/8/2022 at 2:10pm, the RM (Residential Manager) indicated clients A, C, and H used side bedrails on their beds for safety for years to prevent the clients from falling from their beds and to encourage the clients to grab the side bedrails to move themselves while lying down in the beds. The RM indicated client A had fallen between her side bedrail on her bed and her mattress the first week of November, 2022 when she became tangled and wrapped in the blanket on her bed. The RM stated, "The staff actually heard her crying when the staff had gone to the rest room and then went to check on [client A]. The staff found [client A] wrapped in her blanket, pinned between the side bedrail and the mattress, hanging there. It had been about 15 minutes since the staff had last checked on [client A]." The RM stated, "[Client A] was trapped." The RM stated, "The staff had taken the rails off of [client A's] bed when she went to camp back in June, 2022. The staff took the side bedrails to camp for [client A] to use there. [Client A] returned home from camp and the staff reapplied the side bedrails to her bed" in June, 2022. The RM indicated client A's side bedrails were not checked to ensure the rails were securely applied to her bed since June, 2022. The RM stated, "Apparently the staff did not get the rails locked into place when the side bedrails were reapplied to [client A's] bed and the side bedrail over time worked its way free and had disconnected from the security bar which had not been reapplied to lock the side bedrail in place securely when she returned from camp."		be affected by the same deficient practice and what corrective action will be taken; All individuals will be assessed on an annual basis through their functional assessments. If a falling out of bed risk is identified, it will be added to the individual's high-risk plans. Training of staff will occur annually or if any changes occur. · What measures will be put into place or what systemic changes you will make to ensure that the deficient practices does not recur; A daily inspection of bedrails has been added to the Medication Administration Record. Staff are to document inspection of the bedrails for safety and proper installation. Medication Administration Record documentation has been uploaded for review. · 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; and A daily inspection of bedrails has been added to the Medication Administration Record. Staff are to document inspection of the bedrails for safety and proper installation. High Risk Plans are reviewed and updated annually or on a per needed basis. Staff are given High Risk Plans training annually or on a per needed basis. Inservice signature sheets are	

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	The RM indicated clients C and H also used side bedrails. At 2:10pm, clients A, C, and H's side bedrails were observed on their beds inside their bedrooms at the group home and secured to their beds. The RM stated, "The staff were trained on how to apply and monitor clients [A, C, and H's] side bedrails to ensure the side bedrails were securely in place after 11/7/2022." The RM provided client A's 12/2022 MAR (Medication Administration Record) which indicated "Check Bedrails, Every Sunday Evening." The RM indicated clients C and H's side bedrails were not listed on their 12/2022 MARs. The RM indicated the staff were to check clients C and H's side bedrails weekly, but there was no documentation available for review to show staff had completed checks on clients C and H's side bedrails. The RM stated, "No documentation was available" for review to show that clients A, C, and H's side bedrails were checked and monitored to ensure the side bedrails were securely in place on their beds before client A's incident on 11/5/2022. When asked if the staff had been trained to remove and apply the side bedrails on clients A, C, and H's beds, the RM stated, "Yes the staff was trained but we don't know when because it was not written down as a formal training. It was verbal." When asked who completed the training with the staff, the RM stated, "I'm not sure." The RM showed the surveyor how the metal tube on the side bedrail extended under the mattress on the bed and the metal tube fitted into another metal tube which connected the opposite side bedrail together. The connected metal tube portions of the side bedrail were inserted together until they clicked into place, a metal button popped through the connection tube to secure the metal frame portion of the side bedrails together, and the mattress was placed on top of		collected as documentation of training received. · What is the date by which the systemic changes will be completed. 1.7.23	

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	the side bedrail frame. The RM stated, "The metal tubes were not connected until the metal button had popped through the connection hole which indicated the side bedrail frame was securely together." On 12/14/2022 at 8:00am, the facility's reportable incident reports and investigations were reviewed and indicated the following for client A: The 11/5/2022 BDDS (Bureau of Developmental Disabilities Services) report for client A's fall on 11/5/2022 at 7:30am and the 11/5/2022 at 7:30am "Incident Report" indicated "The staff found [client A] on the floor in her bedroom at 7:30am. The Staff helped [client A] up off the floor and observed her for any injuries. Staff concluded adding the checking of tightening of the bedrail on Sunday nights, once a week on MAR. Injuries: Bruise on her right arm 3/4" (inches) wide by 1" long. Bruise on right arm 1 1/2" wide by 2" long. Bruise on left elbow 3 1/2" wide by 4" long. Bruise on left elbow 1 1/4" wide by 1" long." Client A's 11/5/2022 "Fall Investigation" indicated "[Client A] was in her bed this morning sleeping, with both bed rails up, per [client A's] high risk plan for fall prevention." The investigation indicated the staff checked on client A at 7:15am. The investigation indicated the staff "heard [client A] moaning and when she entered [client A's] bedroom, she discovered [client A] had fallen from her bed onto the floor, wrapped in her comforter." The investigation indicated client A "had fallen between the bed and the railing, hitting her arms and elbows causing bruising. Staff made the bed railings shorter to help prevent falling along with rearranging her room. Later it was discovered the bedrail screws were not completely tightened."			

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	Client A's record was reviewed on 12/8/2022 at 2:45pm. Client A's 11/1/2022 ISP (Individual Support Plan), 11/2022 high risk plan, and 12/1/2022 physician's order indicated client A used side bedrails on her bed at the group home for her safety. Client A's 12/1/2022 physician's order indicated "Check Bedrails, every Sunday evening, Staff will check [client A's] bedrails every Sunday night prior to putting her to bed to ensure they are tightened." Client C's record was reviewed on 12/14/2022 at 6:00am. Client C's 3/7/2022 ISP, 3/2022 high risk plans, and 12/1/2022 physician's order indicated client C used side bedrails for her safety at the group home. Client C's 9/12/2022 "Quarterly Medical Examination" completed by the nurse indicated client C had a history of falls, seizure disorder, and "severe Osteopenia (reduced bone mass) in her left femoral neck." Client C's 12/2022 MAR did not include the use of side bedrails. Client H's record was reviewed on 12/14/2022 at 9:00am. Client H's 11/23/2022 ISP, 11/2022 high risk plans, and 12/1/2022 physician's order indicated client H used side bedrails for his safety at the group home. Client H's 9/12/2022 "Quarterly Medical Examination" completed by the nurse indicated client H had a history of falls, seizure disorder, and Bilateral extremity weakness. Uses a wheelchair." Client H's 12/2022 MAR did not include the use of side bedrails. On 12/14/2022 at 8:45am, the facility's 11/8/2022 "Meeting and Inservice Attendance Roster" indicated the staff were provided training presented by the LPN on "Sit to Stand Lift, Adaptive Equipment, and Bedrail/Siderails."			

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	On 12/14/2022 at 10:15am, an interview was conducted with the LPN and the QIDP (Qualified Intellectual Disabilities Professional). The LPN and the QIDP were asked if client A was pinned between the side bedrail and the mattress on 11/5/2022 or if client A was found on the floor in her bedroom after the fall. The LPN stated, "She was pinned between the side bedrail and the mattress." The LPN indicated initially it was reported client A fell; then the staff who discovered client A indicated client A was pinned, and the staff were trying to get her out of the side bedrail then client A fell to the floor. The LPN indicated the staff at the home had been long term staff and she did not know when and by whom they were trained regarding applying and monitoring clients A, C, and H's side bedrails. The LPN indicated the staff should check clients A, C, and H's side bedrails each time they use the rails when assisting the clients while the clients were in bed. The LPN indicated staff should check clients A, C, and H's side bedrails "at least weekly" on their beds and lift up the mattress to ensure the side bedrails were securely connected. When asked if the facility staff demonstrated competency when applying and monitoring clients A, C, and H's side bedrails, the LPN stated, "We don't have documents to show they were competent," and client A's side bedrails had come apart because they were not securely in place. This federal tag relates to complaint #IN00394439. 9-3-3(a)			