

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G522		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/01/2013	
NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 10264 N COLLEGE INDIANAPOLIS, IN 46280			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: February 26, 27, 28 and March 1, 2013.</p> <p>Facility Number: 001036 Provider Number: 15G522 AIMS Number: 100245250</p> <p>Surveyor: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/11/13 by Ruth Shackelford, Medical Surveyor III.</p>			W000000			

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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W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4) by not obtaining a legally sanctioned representative to assist the client in making informed health or financial decisions.</p> <p>Findings include:</p> <p>Client #4's records were reviewed on 02/28/13 at 11:00 AM. Client #4's Individual Support Plan (ISP) dated 11/21/12 indicated she had a guardian, but he died 11/01/12 and the client currently did not have a legally sanctioned representative. Client #4's diagnoses included, but were not limited to: Mental Retardation, Seizure Disorder, Cerebral Palsy, Traumatic Brain Injury, Shaken Baby Syndrome, Spine with Scoliosis/Rod in place and Spastic Quadriplegia. Client #4's Comprehensive Functional Assessment (CFA) dated 11/07/12 indicated client #4 required 24 hour supervision and was not able to independently manage her own finances. The CFA indicated client #4 required</p>	W000125	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>St. Vincent New Hope proceeded with guardianship application for Client #4. Application for a state appointed guardian to represent Client #4 has been completed, approved by physician and submitted for court approval.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>All other individuals in the home have the potential to be affected. All individuals were reviewed and have appropriate active representation.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Admission and annual ISP processes review the representation status of each person. This process will continue.</p> <p><i>How the corrective action will be monitored to ensure the deficient</i></p>	03/31/2013			

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	<p>assistance with maintaining personal skills of daily living, making health care decisions and needed physical assistance to identify money values, to have awareness of the value of money, and to make small purchases. The CFA indicated client #4 was unable to manage her financial needs independently.</p> <p>On 02/28/13 at 2:30 PM an interview with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated client #4 did not have a legal representative and was not able to fully make informed decisions on her own regarding her health needs or finances.</p> <p>9-3-2(a)</p>		<p><i>practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director maintains a current spreadsheet of all clients, representatives, guardians and "at risk" individuals. Those individuals who are deemed at risk have ISP discussion with family and others involved about making plans should the representation change.</p>		

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W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to maintain an accurate accounting system for each client's personal fund account.</p> <p>Findings include:</p> <p>On 02/27/13 at 11:38 AM a petty cash count was conducted with the TL (Team Leader) for clients #1, #2, #3 and #4 along with a review of their monthly Cash Ledgers and receipts for petty cash funds from September 2012 to February 26, 2013. The review of receipts indicated the following:</p> <p>Client #1: October 2012: 10/27/12 - Missing receipt for manicure at nail salon - \$20.00 was missing from account. December 2012: 12/17/12 - Missing receipt for [store] bath products - \$57.34 missing from account. January 2013: 12/30/12 - Missing receipt for [store] - \$77.86. Total of missing funds without receipts: \$155.20.</p> <p>Client #2: November 2012: 11/21/12 - Missing receipt from [restaurant] - \$2.54</p>	W000140	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>The in home system for accounting of finances was modified to ensure a more secure holding of petty cash prior to outings and a receipt returned after outings. In these instances, there was no indication that the articles, items were not purchased. The overlying issue was a particular staff person who was not diligent about bringing back receipts. The Team Leader will ensure that money and arrangements are made for outings and expenditures. The person responsible for the outing will conduct it as directed and return any change and receipt to a locked mailbox in the home. Weekly or sooner if needed, the Team Leader will review all expenditures for appropriate documentation. Any missing documentation will be addressed within that week of purchase. Investigations will occur if missing documentation is not supplemented with a reasonable explanation or if a pattern develops.</p> <p><i>How will other residents be identified as having the potential to</i></p>	03/31/2013
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	<p>was missing from account. December 2012: 12/17/12 - Missing receipt for [store] gift card - \$20.00 missing from account. 12/18/12 - Missing receipt for [store] - \$43.42. Total of missing funds without receipts: \$65.96.</p> <p>Client #3: December 2012: 12/18/12 - Missing receipt for [store] - \$43.28 missing from account. January 2013: 01/30/13 - Missing receipt for [store] - \$49.98. Total of missing funds without receipts: \$93.26.</p> <p>Client #4: October 2012: 10/15/12 - Missing receipt for pumpkin - \$1.50 missing from account. December 2012: 12/31/12 - Missing receipts for cash out - \$30.71 missing from account. Total of missing funds without receipts: \$32.21.</p> <p>Total value of missing receipts/items: \$346.63.</p> <p>Client #1's records were reviewed on 02/27/13 at 12:50 PM. Client #1's ISP (Individual Support Plan) dated 11/17/12 indicated client #1 was not able to independently handle her money and required assistance.</p> <p>Client #2's records were reviewed on 02/27/13 at 2:00 PM. Client #2's ISP dated 11/14/12 indicated client #2 was not</p>		<p><i>be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents have the potential to be affected by this deficient practice. The system change will apply to all facility client finances. All staff were trained on new system for expenses and the expectations for documentation and accounting of funds.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Team Leader will review the finances and documentation on a weekly basis and take corrective action. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope continues to have a more comprehensive policy and procedure for client finances. All facilities must account for all expenses and balance all transactions monthly. The Team Leader completes the initial accounting of funds. It is then submitted to the Manager/Q for review. This financial documentation is then submitted to Quality Assurance monthly by a due date. Any discrepancies, questions or errors are returned to the manager for corrective action. Director receives a monthly report</p>				

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	<p>able to independently handle her money and required assistance.</p> <p>Client #3's records were reviewed on 02/28/13 at 10:30 AM. Client #3's ISP dated 11/14/12 indicated client #3 was not able to independently handle her money and required assistance.</p> <p>Client #4's records were reviewed on 02/28/13 at 11:30 AM. Client #4's ISP dated 11/21/12 indicated client #4 was not able to independently handle her money and required assistance.</p> <p>On 02/28/13 at 2:25 PM an interview with the Director, QMRP (Qualified Mental Retardation Professional) and TL (Team Leader) was conducted. The Director indicated the agency was responsible for assisting clients #1, #2, #3 and #4 with their funds as they were not independent with their money and required assistance. The Director, QMRP and TL indicated they were aware of the receipts missing and there were items that had been purchased for clients #1, #2, #3 and #4. However there was no way without the receipts to accurately account for all of the items or to indicate exactly how much each of the purchased items cost. The Director indicated due to the missing information the accounts were not accurate. She further indicated the</p>		<p>on financial tracking specific to late submissions, inaccuracies. Through this system the Director, Manager and Team Leader were aware of the missing receipts and addressing via performance/disciplinary action.</p>				

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	<p>agency failed to investigate and write a cumulative report of the amount of money which had missing receipts. She indicated she had no idea what the total amount of money involved was. The TL indicated the missing receipts involved two staff members who had been terminated, however the missing receipts for clients #1, #2, #3 and #4 had occurred on more than one occasion and over several months time. She indicated she did not know the exact dates of some of the missing money.</p> <p>9-3-2(a)</p>						

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W000149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS 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 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility neglected to implement the facility's policy and procedure to ensure proper use of client funds to prevent financial exploitation.</p> <p>Findings include:</p> <p>On 02/26/13 at 1:55 PM the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 03/01/12 through 02/26/13. Review of the BDDS reports failed to include a BDDS report regarding the following:</p> <p>On 02/27/13 at 11:38 AM a petty cash count was conducted with the TL (Team Leader) for clients #1, #2, #3 and #4 along with a review of their monthly Cash Ledgers and receipts for petty cash funds from September 2012 to February 26, 2013. The review of receipts indicated the following:</p> <p>Client #1: October 2012: 10/27/12 - Missing receipt for manicure at nail salon - \$20.00 was missing from account. December 2012: 12/17/12 - Missing</p>	W000149	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. See W140 for specific corrective action taken to address failure to protect from financial abuse or exploitation. Items identified for those individuals to have been purchased but no receipt were confirmed as appropriately spent finances. There was no indication that the clients were exploited or money was stolen. St. Vincent New Hope has a comprehensive system to address and protect client finances. The facility also developed specific home procedures for day to day handling of client finances to better protect and document expenditures. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. An investigation will occur for any future financial deviations that lack receipts or a reasonable explanation. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur St. Vincent New Hope will continue to follow its policy on Client Finances as outlined in</i></p>	03/31/2013			

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	<p>receipt for [store] bath products - \$57.34 missing from account. January 2013: 12/30/12 - Missing receipt for [store] - \$77.86. Total of missing funds without receipts: \$155.20.</p> <p>Client #2: November 2012: 11/21/12 - Missing receipt from [restaurant] - \$2.54 was missing from account. December 2012: 12/17/12 - Missing receipt for [store] gift card - \$20.00 missing from account. 12/18/12 - Missing receipt for [store] - \$43.42. Total of missing funds without receipts: \$65.96.</p> <p>Client #3: December 2012: 12/18/12 - Missing receipt for [store] - \$43.28 missing from account. January 2013: 01/30/13 - Missing receipt for [store] - \$49.98. Total of missing funds without receipts: \$93.26.</p> <p>Client #4: October 2012: 10/15/12 - Missing receipt for pumpkin - \$1.50 missing from account. December 2012: 12/31/12 - Missing receipts for cash out - \$30.71 missing from account. Total of missing funds without receipts: \$32.21.</p> <p>Total value of missing receipts/items: \$346.63.</p> <p>Client #1's records were reviewed on 02/27/13 at 12:50 PM. Client #1's ISP</p>		<p>W140 and attached. Specific facility procedures were outlined to more securely maintain money and receipts as outlined in W140 and attached guidelines. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Director will continue to review the monthly client finance spreadsheet for any pattern of untimeliness, inaccuracies or missing documentation.</p>		

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	<p>(Individual Support Plan) dated 11/17/12 indicated client #1 was not able to independently handle her money and required assistance.</p> <p>Client #2's records were reviewed on 02/27/13 at 2:00 PM. Client #2's ISP dated 11/14/12 indicated client #2 was not able to independently handle her money and required assistance.</p> <p>Client #3's records were reviewed on 02/28/13 at 10:30 AM. Client #3's ISP dated 11/14/12 indicated client #3 was not able to independently handle her money and required assistance.</p> <p>Client #4's records were reviewed on 02/28/13 at 11:30 AM. Client #4's ISP dated 11/21/12 indicated client #4 was not able to independently handle her money and required assistance.</p> <p>On 02/26/13 at 2:00 PM, a review of the facility's 07/2012 Policy on Suspected Abuse indicated, "St Vincent New Hope (SVNH) will not condone abuse or violation of individual rights by anyone...SVNH will comply with all applicable laws, statutes, and/or regulations with respect to reporting to authorities, investigation and warranted follow-up action to assure resolution...Indiana public law protects</p>						

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	<p>endangered adults...from abuse, battery, neglect and exploitation or mistreatment. An endangered adult is any individual who is 18 years of age or older who: is incapable of managing his property or caring for himself or both by reason of insanity, mental illness, mental retardation...of either managing his property or caring for himself or both; is harmed or threatened with harm as a result of neglect, battery, or exploitation of the individual's personal services or property...Exploitation is unauthorized use of individual's personally services, property or identity. These practices are prohibited and reporting to local authorities and specific agencies of such battery, neglect or exploitation is also mandated by law...."</p> <p>On 02/28/13 at 2:25 PM an interview with the Director, QMRP (Qualified Mental Retardation Professional) and TL (Team Leader) was conducted. The Director indicated the agency was responsible for assisting clients #1, #2, #3 and #4 with their funds as they were not independent with their money and required assistance. The Director, QMRP and TL indicated they were aware of the receipts missing and there were items that had been purchased for clients #1, #2, #3 and #4. However there was no way without the receipts to accurately account</p>			

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	<p>for all of the items or to indicate exactly how much each of the purchased items cost. The Director indicated due to the missing information the accounts were not accurate. She further indicated the agency failed to investigate and write a cumulative report of the amount of money which had missing receipts. She indicated she had no idea what the total amount of money involved was. The TL indicated the missing receipts involved two staff members who had been terminated, however the missing receipts for clients #1, #2, #3 and #4 had occurred on more than one occasion and over several months time. She indicated she did not know the exact dates of some of the missing money.</p> <p>9-3-2(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to conduct thorough investigations in regards to client funds (missing receipts) to prevent financial exploitation.</p> <p>Findings include:</p> <p>On 02/26/13 at 1:55 PM the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 03/01/12 through 02/26/13. Review of the BDDS reports failed to include a BDDS report regarding the following:</p> <p>On 02/27/13 at 11:38 AM a petty cash count was conducted with the TL (Team Leader) for clients #1, #2, #3 and #4 along with a review of their monthly Cash Ledgers and receipts for petty cash funds from September 2012 to February 26, 2013. The review of receipts indicated the following:</p> <p>Client #1: October 2012: 10/27/12 - Missing receipt for manicure at nail salon - \$20.00 was missing from account. December 2012: 12/17/12 - Missing</p>	W000154	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>See W140 for specific corrective action taken to address failure to protect from financial abuse or exploitation.</p> <p>Items identified for those individuals to have been purchased but no receipt were confirmed as appropriately spent finances. There was no indication that the clients were exploited or money was stolen.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>An investigation will occur for any future financial deviations that lack receipts or a reasonable explanation.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>St. Vincent New Hope will continue to follow its policy on Client Finances as outlined in W140 and attached. Specific facility procedures were outlined to more securely maintain money and receipts as outlined in W140 and attached guidelines.</p>	03/31/2013			

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	<p>receipt for [store] bath products - \$57.34 missing from account. January 2013: 12/30/12 - Missing receipt for [store] - \$77.86. Total of missing funds without receipts: \$155.20.</p> <p>Client #2: November 2012: 11/21/12 - Missing receipt from [restaurant] - \$2.54 was missing from account. December 2012: 12/17/12 - Missing receipt for [store] gift card - \$20.00 missing from account. 12/18/12 - Missing receipt for [store] - \$43.42. Total of missing funds without receipts: \$65.96.</p> <p>Client #3: December 2012: 12/18/12 - Missing receipt for [store] - \$43.28 missing from account. January 2013: 01/30/13 - Missing receipt for [store] - \$49.98. Total of missing funds without receipts: \$93.26.</p> <p>Client #4: October 2012: 10/15/12 - Missing receipt for pumpkin - \$1.50 missing from account. December 2012: 12/31/12 - Missing receipts for cash out - \$30.71 missing from account. Total of missing funds without receipts: \$32.21.</p> <p>Total value of missing receipts/items: \$346.63.</p> <p>Client #1's records were reviewed on 02/27/13 at 12:50 PM. Client #1's ISP</p>		<p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director will continue to review the monthly client finance spreadsheet for any pattern of untimeliness, inaccuracies or missing documentation.</p>		

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	<p>(Individual Support Plan) dated 11/17/12 indicated client #1 was not able to independently handle her money and required assistance.</p> <p>Client #2's records were reviewed on 02/27/13 at 2:00 PM. Client #2's ISP dated 11/14/12 indicated client #2 was not able to independently handle her money and required assistance.</p> <p>Client #3's records were reviewed on 02/28/13 at 10:30 AM. Client #3's ISP dated 11/14/12 indicated client #3 was not able to independently handle her money and required assistance.</p> <p>Client #4's records were reviewed on 02/28/13 at 11:30 AM. Client #4's ISP dated 11/21/12 indicated client #4 was not able to independently handle her money and required assistance.</p> <p>On 02/28/13 at 2:25 PM an interview with the Director, QMRP (Qualified Mental Retardation Professional) and TL (Team Leader) was conducted. The Director indicated the agency was responsible for assisting clients #1, #2, #2 and #4 with their funds as they were not independent with their money and required assistance. The Director, QMRP and TL indicated they were aware of the receipts missing and there were items that</p>						

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	<p>had been purchased for clients #1, #2, #3 and #4. However there was no way without the receipts to accurately account for all of the items or to indicate exactly how much each of the purchased items cost. The Director indicated due to the missing information the accounts were not accurate. She further indicated the agency failed to investigate and write a cumulative report of the amount of money which had missing receipts. She indicated she had no idea what the total amount of money involved was. The TL indicated the missing receipts involved two staff members who had been terminated, however the missing receipts for clients #1, #2, #3 and #4 had occurred on more than one occasion and over several months time. She indicated she did not know the exact dates of some of the missing money.</p> <p>9-3-2(a)</p>			

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to initiate and document effective corrective action to prevent further incidents of missing client funds to prevent financial exploitation.</p> <p>Findings include:</p> <p>On 02/26/13 at 1:55 PM the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed from 03/01/12 through 02/26/13. Review of the BDDS reports failed to include a BDDS report regarding the following:</p> <p>On 02/27/13 at 11:38 AM a petty cash count was conducted with the TL (Team Leader) for clients #1, #2, #3 and #4 along with a review of their monthly Cash Ledgers and receipts for petty cash funds from September 2012 to February 26, 2013. The review of receipts indicated the following:</p> <p>Client #1: October 2012: 10/27/12 - Missing receipt for manicure at nail salon - \$20.00 was missing from account. December 2012: 12/17/12 - Missing</p>	W000157	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>The in home system for accounting of finances was modified to ensure a more secure holding of petty cash prior to outings and a receipt returned after outings. In these instances, there was no indication that the articles, items were not purchased. The overlying issue was a particular staff person who was not diligent about bringing back receipts. The Team Leader will ensure that money and arrangements are made for outings and expenditures. The person responsible for the outing will conduct it as directed and return any change and receipt to a locked mailbox in the home. Weekly or sooner if needed, the Team Leader will review all expenditures for appropriate documentation. Any missing documentation will be addressed within that week of purchase. Investigations will occur if missing documentation is not supplemented with a reasonable explanation or if a pattern develops.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action</i></p>	03/31/2013			

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	<p>receipt for [store] bath products - \$57.34 missing from account. January 2013: 12/30/12 - Missing receipt for [store] - \$77.86. Total of missing funds without receipts: \$155.20.</p> <p>Client #2: November 2012: 11/21/12 - Missing receipt from [restaurant] - \$2.54 was missing from account. December 2012: 12/17/12 - Missing receipt for [store] gift card - \$20.00 missing from account. 12/18/12 - Missing receipt for [store] - \$43.42. Total of missing funds without receipts: \$65.96.</p> <p>Client #3: December 2012: 12/18/12 - Missing receipt for [store] - \$43.28 missing from account. January 2013: 01/30/13 - Missing receipt for [store] - \$49.98. Total of missing funds without receipts: \$93.26.</p> <p>Client #4: October 2012: 10/15/12 - Missing receipt for pumpkin - \$1.50 missing from account. December 2012: 12/31/12 - Missing receipts for cash out - \$30.71 missing from account. Total of missing funds without receipts: \$32.21.</p> <p>Total value of missing receipts/items: \$346.63.</p> <p>Client #1's records were reviewed on 02/27/13 at 12:50 PM. Client #1's ISP</p>		<p><i>will be taken.</i></p> <p>All residents have the potential to be affected by this deficient practice. The system change will apply to all facility client finances. All staff were trained on new system for expenses and the expectations for documentation and accounting of funds.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Team Leader will review the finances and documentation on a weekly basis and take corrective action.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope continues to have a more comprehensive policy and procedure for client finances. All facilities must account for all expenses and balance all transactions monthly. The Team Leader completes the initial accounting of funds. It is then submitted to the Manager/Q for review. This financial documentation is then submitted to Quality Assurance monthly by a due date. Any discrepancies, questions or errors are returned to the manager for corrective action. Director receives a monthly report on financial tracking specific to late submissions, inaccuracies. Through</p>		

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	<p>(Individual Support Plan) dated 11/17/12 indicated client #1 was not able to independently handle her money and required assistance.</p> <p>Client #2's records were reviewed on 02/27/13 at 2:00 PM. Client #2's ISP dated 11/14/12 indicated client #2 was not able to independently handle her money and required assistance.</p> <p>Client #3's records were reviewed on 02/28/13 at 10:30 AM. Client #3's ISP dated 11/14/12 indicated client #3 was not able to independently handle her money and required assistance.</p> <p>Client #4's records were reviewed on 02/28/13 at 11:30 AM. Client #4's ISP dated 11/21/12 indicated client #4 was not able to independently handle her money and required assistance.</p> <p>On 02/28/13 at 2:25 PM an interview with the Director, QMRP (Qualified Mental Retardation Professional) and TL (Team Leader) was conducted. The Director indicated the agency was responsible for assisting clients #1, #2, #3 and #4 with their funds as they were not independent with their money and required assistance. The Director, QMRP and TL indicated they were aware of the receipts missing, sometimes within a</p>		<p>this system the Director, Manager and Team Leader were aware of the missing receipts and addressing via performance/disciplinary action.</p>				

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	<p>couple of days of the outing to the store and sometimes not until the end of the month when she balanced the ledger. The TL indicated she had asked the staff involved for the receipts and they did not produce them for the items that had been purchased for clients #1, #2, #3 and #4. She further indicated there was no way without the receipts to accurately account for all of the items or to indicate exactly how much each of the purchased items cost. The Director indicated due to the missing information the accounts were not accurate. She further indicated the agency failed to investigate and write a cumulative report of the amount of money which had missing receipts. She indicated she had no idea what the total amount of money involved was. The TL indicated the missing receipts involved two staff members who had been terminated, however the missing receipts for clients #1, #2, #3 and #4 had occurred on more than one occasion and over several months time. She indicated she did not know the exact dates of some of the missing money.</p> <p>9-3-2(a)</p>				

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W000218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (clients #1 and #2) with sensorimotor deficits to have a sensorimotor assessment.</p> <p>Findings include:</p> <p>1. Observations were conducted in the facility on 02/26/13 from 3:35 PM until 5:46 PM and on 02/27/13 from 6:35 AM until 9:15 AM. During the observation times client #1 was observed to be nonambulatory and used a wheelchair for mobility.</p> <p>Client #1's record was reviewed on 02/27/13 at 12:50 PM. Client #1's record did not contain a Physical Therapy Evaluation (PT).</p> <p>On 02/28/13 at 2:30 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated due to client #1's medical condition she should have yearly updated evaluations. She indicated she was recently rehired by the agency and did not know what evaluations the previous nurse had obtained, but no PT evaluations were in</p>	W000218	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Clients #1 and 2 have obtained an order for OT/PT evaluation and appointments have been scheduled. Client #1 4/5/13, Client #2 4/19/13 Upon receipt of evaluation, IDT will review all recommendations and integrate them accordingly into treatment plan. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All individuals have the potential to be affected by this practice. All other individuals were reviewed and all appropriate assessments are present and treatment plan is identified on ISP. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Director and IDT review chart q 6 months to monitor compliance.</i></p>	03/31/2013			

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	<p>the chart.</p> <p>2. Observations were conducted in the facility on 02/26/13 from 3:35 PM until 5:46 PM and on 02/27/13 from 6:35 AM until 9:15 AM. During the observation times client #2 was observed to be nonambulatory and used a wheelchair for mobility. Client #2's hands were observed to shake when she tried to feed herself and staff was observed to feed her on 02/27/13 at 8:06 AM. Staff #3 indicated it was difficult for client #2 to feed herself due to her hands shaking and she also had difficulty holding utensils.</p> <p>Client #2's record was reviewed on 02/27/13 at 2:00 PM. Client #2's record did not contain an Occupational Therapy (OT) Evaluation or a Physical Therapy Evaluation.</p> <p>On 02/28/13 at 2:30 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated due to client #2's medical condition she should have yearly updated evaluations. She indicated she was recently rehired by the agency and did not know what evaluations the previous nurse had obtained, but no evaluations were in the chart.</p> <p>9-3-4(a)</p>						

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.</p> <p>Based on record review and interview, the facility's Human Rights Committee (HRC) failed for 3 of 3 sampled clients with behavior plans (clients #1, #2 and #3) to review, approve, and monitor restrictive practices, (psychotropic medications) in the clients' BSPs (Behavioral Support Plans).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 02/27/13 at 12:50 PM. Client #1's BSP dated 11/01/12 indicated client #1 was on behavioral medications which included: Effexor and Mirtazapine for the following behaviors: physical aggression, verbal aggression and non-compliance. The BSP signature page was dated 11/01/12. Client #1's record did not indicate HRC (Human Rights Committee) review/approval of client #1's BSP.</p> <p>On 02/28/13 at 2:35 PM an interview with the Director was conducted. The Director indicated client #1's current BSP</p>	W000262	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Behavior Consultant reviewed all plans with Human Rights Committee on 3/6/13, obtaining verbal approval. Monthly HRC meeting will occur on 3/27 at which time written confirmation of verbal approval will be documented.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents have the potential to be affected by this practice. All other plans were reviewed and have appropriate reviews and approvals. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Behavior Consultant was retrained and requirements of plan approvals were reviewed by her manager. QMRP and Director will complete</p>	03/31/2013	

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	<p>did not indicate HRC approval.</p> <p>2. Client #2's record was reviewed on 02/27/13 at 2:00 PM. Client #2's BSP dated 11/01/12 indicated client #2 was on behavioral medications which included: Effexor for the following behaviors: irritability. The BSP signature page was dated 11/01/12. Client #2's record did not indicate HRC (Human Rights Committee) review/approval of client #2's BSP.</p> <p>On 02/28/13 at 2:35 PM an interview with the Director was conducted. The Director indicated client #2's current BSP did not indicate HRC approval.</p> <p>3. Client #3's record was reviewed on 02/28/13 at 10:30 AM. Client #3's BSP dated 11/01/12 indicated client #3 was on behavioral medications which included: Risperdal for the following behaviors: personal boundaries, physical aggression and verbal aggression. The BSP signature page was dated 11/01/12. Client #3's record did not indicate HRC (Human Rights Committee) review/approval of client #3's BSP.</p> <p>On 02/28/13 at 2:35 PM an interview with the Director was conducted. The Director indicated client #3's current BSP did not indicate HRC approval.</p>		<p>audits of behavior plan documents on a routine basis as they are initiated or revised. Group Home Managers/Q and Team Leaders will be retrained on the requirements of behavior plans and to monitor that appropriate approvals are in place when plans are entered into the home documentation charts.</p>		

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W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (clients #1, #2 and #3), and 1 additional client (client #6), by not ensuring clients received nursing services according to their medical needs: by not obtaining updated Physical Therapy Evaluations for clients #1 and #2 who are non-ambulatory and use wheelchairs for mobility, by not obtaining an updated Occupational Therapy Evaluation for client #2 who was not able to easily feed herself, by not ensuring medication information in the neurologists report was accurate for client #2, by not ensuring information regarding client #2's seizure activity was recorded fully and accurately prior to sharing said information with the neurologist who prescribed seizure medications, by not ensuring an annual dental evaluation was obtained (client #4), by not ensuring the policy for G-tube medication administration takes into account what to do if medication particles are still in the medication cup after administering the crushed medication (client #4) and by not ensuring staff obtained adequate amounts of client (client #4) prescribed medication so they don't run out of medications.</p>	W000331	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. See W218 regarding specific OT/PT evaluations corrections.</i></p> <p>Neurology report was corrected on 3/1/13 by neurology office and submitted to nurse consultant. Nurse Consultant retrained staff on recording seizure report for all seizures, including ones that are addressed with Emergency Medical Services. Client #2 seizure log will accurately reflect all seizure activity. Neurologist for Client #2 was consulted for each ER visit by the attending physicians in the Emergency Room. Neurologist conducts rounds at St. Vincent New Hope monthly and was well aware of all present seizure activity and accurate medications. GTube protocol for Client #2 was revised to include the specific guidelines for staff to address any particles of medication that may remain in the medication cup. All staff were trained on protocols. The Group Home Team Leader assigned designee to monitor the medication supply in the home ensuring a 7 day supply was present. Dental appointments for Client #4 are provided. The care that dental recommends will be scheduled but is pending the</p>	03/31/2013			

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	<p>Findings include:</p> <p>1. Observations were conducted in the facility on 02/26/13 from 3:35 PM until 5:46 PM and on 02/27/13 from 6:35 AM until 9:15 AM. During the observation times clients #1 and #2 were observed to be nonambulatory and used wheelchairs for mobility. Client #2's hands were observed to shake when she tried to feed herself and staff was observed to feed her on 02/27/13 at 8:06 AM. Staff #3 indicated it was difficult for client #2 to feed herself due to her hands shaking and she also had difficulty holding utensils.</p> <p>Client #1's record was reviewed on 02/27/13 at 12:50 PM. Client #1's record did not contain a Physical Therapy Evaluation (PT).</p> <p>Client #2's record was reviewed on 02/27/13 at 2:00 PM. Client #2's record did not contain an Occupational Therapy (OT) Evaluation or a Physical Therapy Evaluation.</p> <p>On 02/28/13 at 2:30 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated due to client #1's and #2's medical conditions they should have yearly updated evaluations. She indicated she was recently rehired by the agency and did not</p>		<p>approval of pending guardian. <i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i> Reviewed all other seizure logs for accuracy and thorough documentation. All dental and other appointments and care will be scheduled as recommended. All individuals were reviewed and no other appointments were missing. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Nurse Consultant (initially and monthly) will conduct medication observations to ensure proper techniques are used. Team Leader will complement these observations with weekly completion. Team Leader will review med supply checks weekly to ensure they are completed and accurate. Director continues monthly nurse chart audits. Nurse Consultant will continue to monitor monthly appointments and compliance issues. Guardianship will be instituted pending court appointment. Director will follow up on this issue weekly until complete.</p>				

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	<p>know what evaluations the previous nurse had obtained, but no evaluations were in the chart.</p> <p>2. Client #2's record was reviewed on 02/27/13 at 2:00 PM. Client #2's record contained a letter dated 01/15/13 from her Neurologist to her PCP (Primary Care Physician). The letter indicated client #2's current medications included but were not limited to: Lamictal (seizures) 200 mg (milligram) b.i.d. (twice daily) 200 mg every p.m. (evening) for a total daily dose of 600 mg and Vimpat 100 b.i.d. for a total daily dose of 200 mg. Client #2's February 2013 MAR (Medication Administration Record) indicated client #2 was on Lamictal 200 mg bid for a total of 400 mg and Vimpat 200 bid for a total of 400 mg. A Seizure Flow Sheet starting date 02/03/11 indicated client #4 had seizures on the following dates: 03/24/12, 04/22/12, 05/12/12, 09/23/12, 11/03/12 x 2, 11/15/12, 11/27/12, 12/05/12, 12/12/12 and 01/12/13. The Seizure Flow Sheet failed to list seizures on the following dates: 06/07/12, 07/17/12, 08/09/12, 09/13/12, 10/02/12 and 12/30/12 for a total of 6 seizures. Five of the six seizures which were not listed were significant enough to result in a trip to the ER (Emergency Room).</p>			

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	<p>On 02/28/13 at 2:30 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated the medication information in the letter was incorrect and it was important for the information going from the neurologist to the PCP to be correct. The LPN further indicated the Seizure Flow Sheet was the information used to provide the neurologist with client #2's seizure activity. She indicated the flow sheet needed to be accurate to provide the neurologist with an accurate picture of the client's condition. She indicated if all of the seizures were not listed then the flow sheet was not accurate and the neurologist would not get the correct information.</p> <p>3. Client #4's records were reviewed on 02/28/13 at 11:00 AM. Client #4's records indicated client #4 had been to the dentist office and was uncooperative on 02/07/12, 08/22/12 and 02/13/13. At each visit the dentist indicated he recommended client #4 go to the OR (operating room) to do x-rays and general cleaning which he could not provide.</p> <p>On 02/28/13 at 2:12 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #4 had not yet had her annual dental examination completed as recommended.</p>						

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	<p>4. Client #4's records were reviewed on 02/28/13 at 11:00 AM. Client #4's February 2013 MAR (Medication Administration Record) indicated client #4 had not received the following prescribed medication doses:</p> <p>Baclofen (for spasticity) - 02/03/13 - 3 PM; 02/03/13 - 9 PM; 02/04/13 - 9 AM; 02/04/13 - 3 PM; 02/04/13 - 9 PM; 02/05/13 - 9 AM; 02/05/13 - 3 PM; 02/05/13 - 9 PM and 02/06/13 - 9 AM for a total of 9 missed doses.</p> <p>Calcium - (supplement) - 02/03/13 - 9 PM; 02/04/13 - 9 AM; 02/04/13 - 9 PM; 02/05/13 - 9 AM; 02/05/13 - 9 PM and 02/06/13 - 9 AM for a total of 6 missed doses.</p> <p>D-Vi-Sol - (supplement) - 02/06/13 - 7 AM and 02/27/13 - 7 AM for a total of 2 missed doses.</p> <p>Client #4's MAR indicated she had missed a total of 17 medication doses due to the medications not being available.</p> <p>An interview with the LPN (Licensed Practical Nurse) on 02/28/13 at 2:30 PM was conducted. The LPN indicated medications that are not given as prescribed are considered medication errors as staff are not following the</p>			

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	<p>physician's orders. She further indicated medications should be ordered timely so staff do not run out of medications for the clients.</p> <p>5. On 02/27/13 from 6:35 AM until 9:15 AM observations were conducted at the group home. At 8:33 AM, staff #3 poured each liquid medication in an individual medication cup, and crushed one pill with a spoon in approximately 5 ml (milliliters) of water and administered client #4's medications via her G-tube (Gastrostomy tube). Staff #3 administered the medications one after the other and did not add additional water to the medication cups. The cup with the pill pieces was administered and pill pieces remained in the cup when staff #3 threw all the medication cups into the trash. At 8:40 AM an interview with staff #3 was conducted and she indicated the pill did not dissolve all the way and some particles of the pill remained in the cup which was thrown in the trash.</p> <p>An interview with the LPN (Licensed Practical Nurse) on 02/28/13 at 2:30 PM was conducted. The LPN indicated there should not be pill pieces in the bottom of the medication cup and the policy failed to indicate what to do if all the medication was not out of the cup.</p>						

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	9-3-6(a)			

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W000352	<p>483.460(f)(2) COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4) to provide annual dental examinations.</p> <p>Findings include:</p> <p>Client #4's records were reviewed on 02/28/13 at 11:00 AM. Client #4's records indicated client #4 had been to the dentist office and was uncooperative on 02/07/12, 08/22/12 and 02/13/13. At each visit the dentist indicated he recommended client #4 go to the OR (operating room) to do x-rays and general cleaning which he could not provide.</p> <p>On 02/28/13 at 2:12 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated client #4 had not yet had her annual dental examination completed as recommended.</p> <p>9-3-6(a)</p>	W000352	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Dental appointments for Client #4 are provided. The extensive care that dental recommends to complete cleanings will be scheduled but is pending the approval of pending guardian.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All dental and other appointments and care will be scheduled as recommended. All individuals were reviewed and no other appointments were missing.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director continues monthly nurse chart audits.</p> <p>Nurse Consultant will continue to monitor monthly appointments and compliance issues.</p> <p>Guardianship will be instituted</p>	03/31/2013	

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			pending court appointment. Director will follow up on this issue weekly until complete.	

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #4) who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>Client #4's records were reviewed on 02/28/13 at 11:00 AM. Client #4's February 2013 MAR (Medication Administration Record) indicated client #4 had not received the following prescribed medication doses:</p> <p>Baclofen (for spasticity) - 02/03/13 - 3 PM; 02/03/13 - 9 PM; 02/04/13 - 9 AM; 02/04/13 - 3 PM; 02/04/13 - 9 PM; 02/05/13 - 9 AM; 02/05/13 - 3 PM; 02/05/13 - 9 PM and 02/06/13 - 9 AM for a total of 9 missed doses.</p> <p>Calcium - (supplement) - 02/03/13 - 9 PM; 02/04/13 - 9 AM; 02/04/13 - 9 PM; 02/05/13 - 9 AM; 02/05/13 - 9 PM and 02/06/13 - 9 AM for a total of 6 missed doses.</p> <p>D-Vi-Sol - (supplement) - 02/06/13 - 7</p>	W000368	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The Group Home Team Leader assigned designee to monitor the medication supply in the home ensuring a 7 day supply was present. These errors were specific to a medication in which the pharmacy constitutes into a liquid as it is not manufactured in liquid form. The home will reorder as bottle is half way used. All staff were retrained on monitoring the medication supply and how to address using the last pill in a particular package. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected and the system will address all client medication supplies What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Team Leader will review med supply checks weekly to ensure they are completed and</i></p>	03/31/2013			

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	<p>AM and 02/27/13 - 7 AM for a total of 2 missed doses.</p> <p>Client #4's MAR indicated she had missed a total of 17 medication doses due to the medications not being available.</p> <p>An interview with the LPN (Licensed Practical Nurse) on 02/28/13 at 2:30 PM was conducted. The LPN indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. She further indicated medications should be ordered timely so staff do not run out of medications for the clients.</p> <p>9-3-6(a)</p>		<p>accurate.Nurse Consultant will review med supply issues with the Team Leader at her weekly checks.</p>		

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W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 9 medication doses administered at the 9:00 AM medication administration, the facility failed to ensure staff administered client medication (client #4), as ordered without error.</p> <p>Findings include:</p> <p>On 02/27/13 from 6:35 AM until 9:15 AM observations were conducted at the group home. At 8:33 AM, staff #3 prepared and administered client #4's medications. Staff #3 indicated she was not able to administer client #4's D-Vi-Sol - (supplement) because they were out of it.</p> <p>An interview with the LPN (Licensed Practical Nurse) on 02/28/13 at 2:30 PM was conducted. The LPN indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. She further indicated medications should be ordered timely so staff do not run out of medications for the</p>	W000369	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The Group Home Team Leader assigned designee to monitor the medication supply in the home ensuring a 7 day supply was present. These errors were specific to a medication in which the pharmacy constitutes into a liquid as it is not manufactured in liquid form. The home will reorder when bottle is half way used. All staff were retrained on monitoring the medication supply and how to address using the last pill in a particular package. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected and the system will address all client medication supplies What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Team Leader will review med</i></p>	03/31/2013
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	clients. 9-3-6(a)		supply checks weekly to ensure they are completed and accurate.Nurse Consultant will review med supply issues with the Team Leader at her weekly checks.				

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W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview, the facility failed to maintain proper medication security for 1 of 1 sampled client (client #4) whose medications included a medication which required refrigeration.</p> <p>Findings include:</p> <p>On 02/27/13 from 6:35 AM until 9:15 AM observations were conducted at the group home. At 8:33 AM, staff #3 brought a bottle of liquid medication (Baclofen) (spasticity) into the medication room indicating she had obtained the bottle out of the refrigerator for client #4. Staff #3 administered the Baclofen to client #4 and indicated she was going to put it away. Staff #3 then went to a small refrigerator in the open pantry off the kitchen and put the Baclofen bottle into the small refrigerator. Staff #3 indicated the refrigerator was not locked.</p> <p>On 02/28/13 at 2:12 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated all medications should be locked when unattended by staff including refrigerator</p>	W000382	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>A new locked refrigerator was obtained to secure the liquid medication.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>Staff were retrained that all medications for all individuals must remain secured/locked.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Team Leader will conduct weekly medication observations. Nurse consultant will conduct minimum monthly observations.</p>	03/31/2013	

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10264 N COLLEGE INDIANAPOLIS, IN 46280
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	medications. 9-3-6(a)			

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W000383	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area.</p> <p>Based on observation, record review, and interview, the facility failed to secure the medication cabinet keys for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, and #8) who resided in the home.</p> <p>Findings include:</p> <p>During observations on 02/26/13 from 3:35 PM until 5:46 PM, at the group home, clients #1, #2, #3, #4, #5, #6, #7, and #8 accessed the area inside the medication office room. During the observation period the medication closet key hung on a hook over the copy/fax machine across the room from the medication closet. On 02/27/13 from 6:35 AM until 9:15 AM clients #1, #2, #3, #4, #5, #6, #7 and #8 accessed the area inside the medication office room. During the observation period the medication closet key hung over the locked padlock to the medication closet.</p> <p>On 02/28/13 at 2:12 PM an interview with the LPN (Licensed Practical Nurse) was conducted. The LPN indicated staff were to comply with the teaching of Core A/B which indicated the medication cabinet keys should be secured when</p>	W000383	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>The medication door key location was moved to a non visible area inside the closet in which client charts are kept. It is maintained in this area out of sight and reach of all individuals.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents have the potential to be affected and the system will remain consistent for all residents.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>All staff were trained on securing the keys.</p> <p>Team Leader will review med supply checks weekly to ensure they are completed and accurate.</p> <p>Nurse Consultant will review med supply issues with the Team Leader at her weekly checks.</p>	03/31/2013			

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	<p>medications are not being administered and when the keys hung on the hook or over the padlock, the keys were not secure.</p> <p>9-3-6(a)</p>			

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W000448	<p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills, including accidents.</p> <p>Based on interview and record review, the facility failed for 8 of 8 clients (clients #1, #2, #3, #4, #5, #6, #7 and #8) who resided in the group home by not investigating total evacuation times on the evening and night shifts.</p> <p>Findings include:</p> <p>On 02/26/13 at 2:15 PM, record reviews were completed of the facility's evacuation drills for the period of 03/13/12 through 02/25/13 for clients #1, #2, #3, #4, #5, #6, #7 and #8. There were 4 evening shift drills conducted during that time period. On 05/18/12 an evening drill was conducted at 7:00 PM and the total evacuation time was recorded as 13 minutes. On 11/14/12 an evening drill was conducted and the total evacuation time was recorded as 11 minutes. There were 4 night shift drills conducted during the time period. On 03/17/12 a night drill was conducted at 2:30 AM and the total evacuation time was recorded as 5 minutes. On 06/09/12 a night drill was conducted at 11:00 PM and the total evacuation time was recorded as 10 minutes.</p>	W000448	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Drills for each shift were repeated for accurate assessment. Team Leader retrained all staff on evacuation plan and proper execution of evacuation as well as accurate completion of forms. Fire Drill form was revised to require an analysis of each drill for appropriateness or improvement needed. Home evacuation scores are consistent with Life Safety code compliance. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected and the system will remain consistent for all residents. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Manager and Director will review drills that exceed expected evacuation time and address needs as indicated. Any future changes to evacuation plan will</i></p>	03/31/2013			

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	<p>On 02/28/13 at 2:30 PM an interview with the Qualified Mental Retardation Professional (QMRP) was conducted. The QMRP indicated there were no further documented drills for review and there were no investigations into the amount of time it took for the clients to evacuate.</p> <p>9-3-7(a)</p>		<p>be implemented and staff will be retrained accordingly.</p>	

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W000449	<p>483.470(i)(2)(iv) EVACUATION DRILLS The facility must investigate all problems with evacuation drills and take corrective action.</p> <p>Based on record review and interview for 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to initiate and document effective corrective action to address extended evacuation drill times on the evening and night shifts.</p> <p>Findings include:</p> <p>On 02/26/13 at 2:15 PM, record reviews were completed of the facility's evacuation drills for the period of 03/13/12 through 02/25/13 for clients #1, #2, #3, #4, #5, #6, #7 and #8. There were 4 evening shift drills conducted during that time period. On 05/18/12 an evening drill was conducted at 7:00 PM and the total evacuation time was recorded as 13 minutes. On 11/14/12 an evening drill was conducted and the total evacuation time was recorded as 11 minutes. There were 4 night shift drills conducted during the time period. On 03/17/12 a night drill was conducted at 2:30 AM and the total evacuation time was recorded as 5 minutes. On 06/09/12 a night drill was conducted at 11:00 PM and the total evacuation time was recorded as 10 minutes.</p>	W000449	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Fire Drill form was revised to require an analysis of each drill for appropriateness or improvement needed. Home evacuation scores and safety code are in compliance. How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected and the system will remain consistent for all residents. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Manager and Director will review drills that exceed expected evacuation time and address needs as indicated. Any future changes to evacuation plan will be implemented and staff will be retrained accordingly.</i></p>	03/31/2013	

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	<p>On 02/28/13 at 2:30 PM an interview with the Qualified Mental Retardation Professional (QMRP) was conducted. The QMRP indicated there were no further documented drills for review. The QMRP further indicated they recently had decided to meet about the drill procedure and develop further guidelines when running a drill and further policies.</p> <p>9-3-7(a)</p>			