

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G487	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4822 ALAMEDA ST INDIANAPOLIS, IN46208
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W0000	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: October 3, 4, 5, 7, 2011</p> <p>Provider Number: 15G487 Aims Number: 100245000 Facility Number: 001001</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/18/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0130	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed for 2 of 4 sampled clients (#2, #3) and one non-sample client #7 to ensure the clients privacy during dressing and bathing/toileting.</p> <p>Findings include:</p> <p>An observation was done on 10/3/11 from 4:58p.m. to 7:09p.m. at the group home.</p>	W0130	<p>Facility placed window film over the glass of the door to ensure privacy for that exit door. Staff were retrained on maintaining privacy in all areas of the home. Particularly paying attention to open doors which make it visible to others, knocking before entering and modeling this behavior for the clients. QDDP will conduct monthly home audit to monitor home environment and privacy issues.</p>	11/06/2011

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>At 6:34p.m., client #7 showed the surveyor his bedroom that he shared with client #3. There was an exit door to the back/side porch located in their bedroom. The exit door did not have a window covering on the door and you could see into client #3 and #7's bedroom from the porch. At 6:34p.m. client #7 indicated there used to be a curtain on the door. Interview of staff #2 on 10/3/11 at 6:50p.m. indicated there was usually something on the exit door window. An observation was done on 10/4/11 from 6:29a.m. to 9:14a.m. At 6:29a.m. staff #5 was assisting client #7 to get dressed. The bedroom door was open. Client #7's bedroom was visible from the dining room table where clients #1, #3, #6 and #8 were seated. At 6:41a.m. client #2 was in the bathroom with the door closed. At 6:41a.m., staff #6 went into the bathroom to assist client #2 without knocking before entering the bathroom. At 6:55a.m. staff #6 went back into the bathroom to assist client #2 without knocking before entering.</p> <p>Interview of staff #1 on 10/5/11 at 4:25p.m. indicated the bedroom door should be be shut when staff are assisting clients with the changing of clothes. Staff #1 indicated staff should knock before entering a bathroom to assist a client. Staff indicated a window covering was</p>				

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W0137	<p>needed to ensure privacy in clients #3 and #7's bedroom. 9-3-2(a)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview, for 1 of 4 sampled clients (#3), the facility failed to ensure the rights of all clients, by ensuring client #3 had proper fitting clothing.</p> <p>Findings include:</p> <p>An observation was done at the group home on 10/3/11 from 4:58p.m. to 7:09p.m. The following client clothing issue was identified: (1) at 6:04p.m., client #3 came out of the bathroom with his pants down below his adult depends (buttocks), staff had him pull his pants back up. (2) At 6:07p.m., client #3's sweat pants had slid back down below his buttocks and staff pulled them back up for him. (3) At 6:14p.m., while client #3 was in the kitchen, his sweat pants slid down below his buttocks and staff had him pull them up. (4) At 6:18p.m., client #3's sweat pants slid down below his buttocks while he assisted with laundry and staff had him pull his pants up. Client #3</p>	W0137	Client #3's clothing was sorted, and new clothing was purchased to ensure he had proper fitting pants. Staff were trained on monitoring the clothing of all individuals to ensure they present a dignified and clean appearance. Program goal for Client #3 to arrange his pants appropriately as needed. QDDP and Team Leader will monitor dressing goal and clothing status during weekly observations.	11/06/2011	

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W0159	<p>walked from the laundry room with one hand holding his pants up as he walked.</p> <p>Staff #2 was interviewed on 10/5/11 at 4:25p.m. Staff #2 indicated client #3's sweat pants on 10/3/11 were too big and didn't have a drawstring in them. Staff #2 indicated group home staff should have assisted client #3 to change into a pair of pants that fit him. 9-3-2(a)</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#2) to ensure client #2's active treatment program was coordinated and monitored by the facility's qualified mental retardation professional (QMRP), The QMRP failed to have documentation client #2's individual support plan (ISP) had been reviewed upon client #2's readmission to the facility on 9/12/11.</p> <p>Findings include:</p> <p>Record review for client #2 was done on 10/5/11 at 11:48a.m. Client #2's QMRP program reviews indicated client #2 had an ISP dated 7/24/11. The ISP indicated</p>	W0159	<p>ISP for Client #2 was updated to be current with admission status. All other individuals' ISPs were current and remain current.QDDP will review at monthly casemanagement review.Staff will be retrained on standardized approach to readmissions from the team.</p>	11/06/2011

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W0249	<p>client #2 had been discharged from the group home for medical issues on 7/19/11. Client #2 had a physician's order on 9/13/11 which indicated client #2 had been readmitted to the group home. There were no documented QMRP program reviews of the appropriateness of client #2's programs upon his readmission to the group home.</p> <p>Staff #1 (QMRP) was interviewed on 10/5/11 at 4:25p.m.. Staff #1 indicated client #2 had been readmitted to the group home on 9/12/11. Staff #1 indicated there was no documentation the facility had reviewed client #2's programs upon his readmission. 9-3-3(a)</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, the facility failed for 3 of 4 sampled clients (#1, #2, #4) to ensure the clients' dining (#1, #2) and ambulation (#4) training programs were implemented when opportunities were present.</p>	W0249	Client #4 ambulation status is under review with PCP and pending PT re-evaluation. His abilities have developed and the current stand by assistance may not be necessary at this point. PT evaluation is scheduled for Monday, Oct 31. IDT will review	11/06/2011

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	<p>Findings include:</p> <p>An observation at the group home was done on 10/3/11 from 4:58p.m. to 7:09p.m. At 5:30p.m. staff #8 poured client #1 a glass of Crystal Light drink and stirred it before giving it to client #1. Staff #8 custodially prepared pork chops and potatoes while client #2 was available to assist.</p> <p>Client #4 was observed during the observations at the group home on 10/3/11 from 4:58p.m. to 7:09p.m., on 10/4/11 from 6:29a.m. to 9:14a.m. and at the facility day program on 10/4/11 from 1:04p.m. to 2:05p.m. Client #4 wore a gait belt during all observations. During all observations client #4 was observed to ambulate independently with no staff around him and at other times to ambulate with a staff person behind him holding his gait belt.</p> <p>The record of client #1 was reviewed on 10/5/11 at 12:48p.m. Client #1's 8/25/11 individual support plan (ISP) indicated client #1's dining training program was to mix Crystal Light for mealtimes.</p> <p>The record of client #2 was reviewed on 10/5/11 at 11:48a.m. Client #2's 7/24/11 ISP indicated client #2 had a dining training program to get out pots and pans</p>		<p>and implement those recommendations. Until then, ambulation supports will be implemented as currently written. Dining plans for all individuals were reviewed and updated as needed. A specific seating and staff assignment for client support was designed for the home. Each staff will be aware of their responsibility for the shift during the meal. This will facilitate specific responsibilities for cueing and eating goals. Staff were trained on Family Style dining principles. Staff were also retrained on the meal prep and dining goals for each client. Team Leader will observe a meal weekly to ensure that staff are developing progress and consistently providing meal time active treatment and appropriate support.</p>		

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W0252	<p>needed for meals.</p> <p>The record of client #4 was reviewed on 10/5/11 at 1:53p.m. Client #4's 5/11/11 ISP indicated client #4 was to ambulate with a staff next to him.</p> <p>Staff #1 was interviewed on 10/5/11 at 4:25p.m. Staff #1 indicated clients #1 and #2's dining training programs and client #4's ambulation program should have been implemented at all opportunities. 9-3-4(a)</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview, the facility failed for 2 of 4 sampled clients (#3, #4) to document training data for client #3's money training and client #4's money and medication training program.</p> <p>Findings include:</p> <p>Record review of client #3 was done on 10/5/11 at 2:38p.m. Client #3's 5/4/11 individual support plan (ISP) indicated client #3 had a money training program. Review of the 8/11 and 9/11 monthly documented data for this training program indicated the money training program had not been in the current data collection</p>	W0252	<p>Medication and money goals were implemented for both clients in sample. All other individuals were reviewed to have current and appropriate goals implemented and documented on ISP. Team Leader will review program book weekly to ensure that proper implemenatation and documentation is occurring. QDDP will review ISP and programs monthly at case review to ensure proper documentation and implementation is occurring. Staff were retrained on goals, documentation expectations.</p>	11/06/2011	

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W0331	<p>book and there was no documented data for 8/11 and 9/11.</p> <p>Record review of client #4 was done on 10/5/11 at 1:53p.m. Client #4's 5/11/11 ISP indicated client #4 had a money training program and medication training program. Review of the 8/11 and 9/11 monthly documented data for this training program indicated the medication and money training programs had not been in the current data collection book and there was no documented data for 8/11 and 9/11.</p> <p>Interview on 10/5/11 at 4:25p.m. of staff #1 (QMRP) indicated the facility did not have 8/11 and 9/11 documented data for client #3's money training program and client #4's money and medication training programs. Staff indicated training data sheets for these programs had not been included in the group home data collection books for clients #3 and #4. 9-3-4(a)</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#4) to ensure client #4 received nursing services as indicated in regards to his blood sugar monitoring.</p>	W0331	<p>Nurse will train all staff on Diabetes Management Protocol. Nurse will ensure staff are trained and observed to be competent with protocols according to the St. Vincent New Hope Nursing Procedure for Diabetes</p>	11/06/2011

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	<p>Findings include:</p> <p>An observation was done on 10/4/11 at the group home from 6:29a.m. to 9:14a.m. At 7:55a.m. client #4 was assisted to the medication room for a.m. medication. Staff #7 informed client #4 they would take his blood sugar after breakfast. Client #4 ate breakfast at 8:07a.m. At 8:34a.m. staff #7 took client #4's blood sugar. Record review of client #4's 10/11 medication administration record (MAR) indicated client #4 was to have his blood sugar checked before each meal. Interview of staff #7 on 10/4/11 at 8:45a.m. indicated the doctor had changed the order to check blood sugar after each meal.</p> <p>Record review for client #4 was done on 10/5/11 at 1:53p.m. Client #4 had a physician's order on 8/26/11 to check client #4's blood sugar before each meal and to follow protocol. There were no documented changes to this 8/26/11 physician's order in client #4's record.</p> <p>Staff #3 (nurse) was interviewed on 10/5/11 at 4:25p.m. Staff #3 indicated client #4 was to have his blood sugar checked before each meal as indicated in the 8/26/11 physician's order.</p> <p>9-3-6(a)</p>		<p>Management. Training is scheduled for Tues., November 1, 2011. Protocol will be maintained in the home and staff will be trained on the specific needs for both diabetic clients.</p>				

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W0436	<p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 3 sampled clients (#4) with adaptive equipment, to provide client #4 with training for the refusal to wear his hearing aid.</p> <p>Findings include:</p> <p>An observation was done at the group home on 10/3/11 from 4:58p.m. to 7:09p.m. and on 10/4/11 from 6:29a.m. to 9:14a.m. Client #4 did not wear nor was he observed to be prompted to wear hearing aids.</p> <p>Record review of client #4 was done on 10/5/11 at 1:53p.m. Client #4's 3/16/11 audiological note indicated client #4 had fitted hearing aids. Client #4 had a 5/11/11 individual support plan (ISP) that indicated client #4 refuses hearing aids. Client #4's ISP did not have documentation of a training program in place to address his refusal to wear his hearing aids.</p> <p>Interview on 10/5/11 at 4:25p.m. of staff #1, indicated client #4 had hearing aids but did not have a training program in place to address his</p>	W0436	Team Leader will implement a goal for Client #4 to wear his hearing aid as ordered. QDDP and Team Leader will monitor progress on goal during monthly case management reviews. All other individuals in the home were reviewed to have current adaptive equipment and supports in place.	11/06/2011

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W0488	<p>refusal of wearing his hearing aids. 9-3-7(a)</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3, #4) and 3 additional clients (#6, #7, #8), the facility failed to encourage clients to participate in meal preparation and family style dining to the extent they were capable.</p> <p>Findings include:</p> <p>During the 10/3/11 observation period between 4:58p.m. and 7:09p.m. at the group home, facility staff did not encourage clients, who were available to assist (#1, #2, #3, #4, #6, #7 and #8), to participate in all aspects of the meal preparation and family style dining. From 4:58p.m. through 5:37p.m. the following was observed during supper preparation and client dining: Staff #8 custodially put prepared food into serving bowls and prepared each client's plate of food at the kitchen counter while clients #1, #2, #3, #4, #6, #7 and #8 were at home and available to assist; staff cut</p>	W0488	<p>Dining plans for all individuals were reviewed and updated as needed. A specific seating and staff assignment for client support was designed for the home. Each staff will be aware of their responsibility for the shift during the meal. This will facilitate specific responsibilities for cueing and eating goals. Staff were trained on Family Style dining principles. Staff were also retrained on the meal prep and dining goals for each client. Team Leader will observe a meal weekly to ensure that staff are developing progress and consistently providing meal time active treatment and appropriate support.</p>	11/06/2011	

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	<p>up the pork chops; staff took the prepared plates of food to the dining room table; client # had food on his face with no verbal prompt to use his napkin, at the end of his meal staff custodially wiped off his face; client #2 had food on his face during his meal with no verbal prompts from staff to use a napkin; staff #8 poured client #1's drink and stirred it for him. During the observation on 10/4/11 from 6:29a.m. to 9:14a.m. the following was observed: staff custodially made scrambled eggs; custodially put jelly on client #6's toast; custodially prepared client #4's entire breakfast plate of eggs, toast, cereal and put it in the microwave for him; staff custodially wiped off client #3's mouth.</p> <p>Interview of staff #1 on 10/5/11 at 4:25p.m. indicated all the clients were capable of assisting with the preparation of supper and serving themselves with some staff assistance. Staff #1 indicated the clients should have been more involved with supper preparation and using napkins.</p> <p>9-3-8(a)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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