

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G716		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2012	
NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 8521 CROWN POINT RD INDIANAPOLIS, IN 46278			
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May 9, 10, 11, and 14, 2012</p> <p>Facility number: 0004061 Provider number: 15G716 AIM number: 200483530</p> <p>Surveyor: Brenda Nunan, RN, Public Health Nurse Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 5/23/12 by Tim Shebel, Medical Surveyor III.</p>			W0000			

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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W0149	<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.</p> <p>Based on record review and interview, the facility failed to implement its policy and procedures in regard to reporting all allegations of abuse/neglect immediately to the administrator for 1 of 2 clients (client #1). The facility neglected to implement its policy and procedures to prevent 1 of 2 clients (client #4) from self injurious behaviors.</p> <p>Findings include:</p> <p>The facility's policy and procedures were reviewed on 05/09/2012 at 11:10 a.m. The facility's October 2011 policy, titled, "Incident Reporting & Management," indicated, "...Incidents to be reported to BQIS (Bureau of Quality and Improvement Services) include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to...Alleged, suspected or actual neglect...failure to provide appropriate supervision, care or training...A fall resulting in injury, regardless of the severity of the injury...."</p> <p>The facility's policy, titled "Suspected</p>	W0149	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Policy and procedure were reviewed and remain current. Staff were retrained on policy implementation for falls, unknown injuries and other reportable incidents, including who and when to contact. Reportable incident guidelines were posted in the home.</p> <p>Behavior services has reviewed the Behavior Support Plans and updated as needed. The plans were reviewed with all staff.</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 notes were reviewed for this individual and the other individuals in the home. There were no further missed reportable incidents. Behavior Consultant continues to monitor staff interaction, behavior data and implementation at routine visits to home.</p> <p>QDDP and Team also continue to monitor by onsite visits which occur daily for TL and at minimum weekly for QDDP.</p>	06/13/2012			

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	<p>Abuse," date 09/2011, was reviewed on 05/09/2012 at 11:10 a.m. The policy indicated, "...Neglect is a practice that denies an individual any of the following without a physician's order: the repeated failure of a caregiver to provide supervision, training, appropriate care and the basic necessities of life...."</p> <p>1. The facility failed to ensure facility staff immediately reported an injury of unknown origin for for 1 of 9 allegations of abuse, neglect and/or injuries of unknown origin to the administrator and Bureau of Developmental Disabilities, in accordance with state law regarding client #1. Please see W153.</p> <p>2. The facility neglected to ensure facility staff provided appropriate interventions to prevent client #4 from repeatedly and forcefully hitting herself in the head and hitting the back of her hand against a wall. Please see W249.</p> <p>9-3-2(a)</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 and Manager will review documentation weekly, initialing on the data sheets to improve oversight to appropriate interventions and monitoring of reportable situations. Further failure to call to report by staff will be addressed with disciplinary action as appropriate. Reportable incident guidelines posted at the home for continued reference and review.</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>QDDP will continue to complete routine oversight of Team Leader steps, at minimum weekly. Director will continue monthly nursing and program chart and site reviews.</p>		

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview, the facility failed to report an allegation of neglect for 1 of 9 allegations of abuse/neglect reviewed to the administrator and /or to the Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services as required by state law (client #1).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 05/10/2012 at 12:48 p.m. A progress note, dated 04/19/2012 at 1:30 p.m., indicated, "...[Client #1] had a good morning except for a miner (sic) knee bump when she fell from getting up from her brown chair...."</p> <p>A "Body Check Sheet," dated 04/19/2012, indicated, "...Cause of injury: She got up from the chair, staff was doing another client's Blood Sugar at the time...scrap (sic) on the knee, small as the tip of a pinky finger on the left knee...."</p>	W0153	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Staff were retrained policy implementation for falls, unknown injuries and other reportable incidents, including who and when to contact. Reportable incident guidelines were posted in the home.</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 notes were reviewed for this individual and the other individuals in the home. There were no further missed reportable incidents.</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 has increased oversight by reviewing the progress notes at minimum weekly to ensure that no further incidents go unreported. Reportable incident guidelines posted at the home for continued reference and review.</p>	06/13/2012

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	<p>During an interview on 05/10/2012 at 2:40 p.m. the Qualified Developmental Disabilities Professional (QDDP) indicated he was not aware of the fall with injury and did not report the injury to the administrator or Indiana Division of Disability and Rehabilitative Services/ Bureau of Developmental Disabilities Services as required by state law.</p> <p>9-3-2(a)</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>QDDP will continue to complete routine oversight of Team Leader steps, at minimum weekly. Director will continue monthly nursing and program chart and site reviews.</p>		

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</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 to ensure fall prevention guidelines and/or behavior reducing strategies were implemented as written in the Individual Support Plan (ISP) for 1 of 2 sampled clients and 1 additional client (clients #1 and #4).</p> <p>Findings include:</p> <p>1. During observations on 05/09/2012 at 3:10 p.m., client #1 had a gait belt around her waist. She used a rolling walker and walked without staff assistance from her bedroom to the living room.</p> <p>During observations on 05/09/2012 at 3:15 p.m., client #1 ambulated using her walker from the living room, through the front door and onto the from porch. Direct Support Professional (DSP) #5 walked behind client #1 without holding onto the gait belt.</p> <p>During observations on 05/09/2012 at 3:20 p.m., DSP #5 held onto client #1's</p>	W0249	<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 IDT reviewed adaptive equipment issue for Client #1. All staff were retrained on proper use of gait belt. Fall plan was updated as appropriate and is in home for staff training and reference. Behavior services has reviewed the Behavior Support Plans and updated as needed. The plans were reviewed with all staff.</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 other resident records were reviewed. All other identified adaptive equipment needs are addressed as used correctly, implemented and integrated into the Individual Support Plan.</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>Monthly IDT review of progress on</p>	06/13/2012			

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	<p>gait belt with the fingertips of her right hand as client #1 climbed into the van.</p> <p>During observations on 05/09/2012 at 5 p.m., DSP #5 held client #1's hand as she ambulated with her rolling walker from the living room to the kitchen table. DSP #5 did not use the gait belt that was around client #1's waist.</p> <p>During observations on 05/09/2012 at 5:18 p.m., client #1 used her rolling walker to independently ambulate from her bedroom to a recliner in the living room. DSP #1 was assisting another client in her bed room.. DSP #5 was in the laundry room passing medication to another consumer. The Team Leader was assisting another client with meal preparations in the kitchen.</p> <p>During observations on 05/10/2012 at 7:50 a.m., client #1 used her walker to ambulate from her bedroom to the bathroom. She was dressed in pajamas and was not wearing a gait belt around her waist. DSP #2 walked behind client #1 and carried her clothing and gait belt to the bathroom.</p> <p>During observations on 05/10/2012 at 8:00 a.m., the Qualified Developmental Disabilities Professional (QDDP) used an overhand grip with 2 fingers to hold client</p>		<p>this and all other support needs for each individual in the home.</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>Team Leader, Nurse Consultant and/or QDDP will monitor use of gait belt on site to assure continued appropriate use. Documentation of onsite observation will be included on the treatment record to occur at minimum weekly.</p> <p>Behavior Consultant continues to participate in monthly meetings as well as routine visits to home to meet with individuals and monitor progress and data.</p>		

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	<p>#1's gait belt while she ambulated using her rolling walker in the living room.</p> <p>During observations on 05/10/2012 at 8:20 a.m., client #1 ambulated independently with her walker from her recliner to a a cabinet in the living room. The QDDP asked client #1 if she needed assistance. Client #1 replied, "No" and retrieved a book from the cabinet. She then used her walker to ambulate to the kitchen. The QDDP did not use the gait belt to assist client #1 when she ambulated. DSP #2 and DSP#5 were seated at the table and did not take hold of client #1's gait belt while she stood next to the table.</p> <p>The facility's reportable incidents dated, 11/01/2011-05/09/2012, were reviewed on 05/09/2012 at 11:20 a.m. The incident reports indicated client #1 fell on 01/18/2012, 01/23/2012, 02/09/2012, 02/22/2012, 02/23/2012 (two falls), and 03/10/2012.</p> <p>Client #1's record was reviewed on 05/10/2012 at 12:48 p.m. A fall was documented in a progress note, dated 04/19/2012. The record did not indicate client #1 had mammography screening during the past year.</p> <p>A Risk Plan, dated 02/20/2012, indicated</p>						

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	<p>client #1 was at risk for falls. The plan indicated, "...Client ambulates with gaitbelt (sic) and rolling walker. Client also has wheelchair with anti-tippers for traveling long distances..."</p> <p>An Interdisciplinary Team (IDT) Note, dated 03/12/2012, indicated, "...Fall Prevention Plan: (1) use wheel-chair (sic) @ (at) home for all ambulation. (2) Has to have gait belt @ all times..."</p> <p>During an interview on 05/10/2012 at 8:55 a.m., Direct Support Professional (DSP) #2 stated, "I was trained during the past year to use a gait belt." She indicated she would use an overhand grip to hold the gait belt.</p> <p>During an interview on 05/10/2012 at 2:40 p.m. the RN Consultant indicated staff should have held the gait belt with an underhand grip every time client #1 ambulated. She indicated client #1 no longer needed a wheel chair for mobility in the group home.</p> <p>During an interview on 05/10/2012 at 2:40 p.m., the QDDP stated, "Staff, including myself, should have followed the fall intervention plan."</p> <p>2. During observations on 05/10/2012 between 6:15 a.m. and 8:55 a.m., client</p>			

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	<p>#4 repeatedly hit her head with an open palm. The force and frequency of the hits increased as the morning progressed.</p> <p>During observations on 05/10/2012 at 6:20 a.m., client #4 was seated in her wheel chair in the living room. She hit the right side of her head with an open palm 25 times. DSP #2 was in the living room and did not redirect client #1 from the behavior.</p> <p>During observations on 05/10/2012 from 6:45 a.m. to 6:55 a.m., client #4 had her blood sugar checked and received medications in the laundry room. Client #4 forcefully hit the right side of her head multiple times (more than 35 times). She hit the wall with the back of her right hand 8 times. At 6:55 a.m., DSP #2 stated, "You are going to have to stop doing that to yourself." Client #4 continued to hit herself in the head and hit the wall.</p> <p>During observations on 05/10/2012 at 7:10 a.m., client #4's blood sugar was re-checked in the laundry room. She alternated between hitting herself in the right side of her head and hitting the wall with the back her right hand for 5 minutes. DSP #2 was present in the laundry room and did not redirect client #4 from the behavior.</p>						

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	<p>During observations on 05/10/2012 at 7:50 a.m., client #4 was seated in her wheel chair at the kitchen table. She alternated between hitting herself in the upper right chest and the right side of her head. The hitting occurred continuously for 5 minutes. DSP #6 was present in the kitchen and did not redirect client #4 from the behavior.</p> <p>During observations on 05/10/2912 at 8:15 a.m., DSP #6 assisted client #4 with breakfast. Client #4 hit the right side of her head between each bite of food. DSP #6 did not redirect the client from the behavioral .</p> <p>During observations on 05/10/2012 at 8:40 a.m., client #4 was seated in her wheel chair in the living room. She hit herself in the forehead and on the right side of her head. DSP #2 was seated at the kitchen table and did not redirect client #4 from hitting herself.</p> <p>During observations on 05/10/2012 at 8:44 a.m., client #4 forcefully hit the right side of her head 5 times. Client #4 wore tennis shoes and kicked the foot pedal of her wheelchair with her right foot. DSP #2 and the Team Leader entered the room. The Team Leader sat next to client #4 and rubbed her back. Client #4 hit herself on</p>			

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	<p>the forehead 5 more times. The Team Leader stated, "You don't want to do that to yourself." Client #4 hit herself 3 more times. Client #4 left for Day Services at 8:55 a.m.</p> <p>Client #4's record was reviewed on 05/10/2012 at 11:53 a.m. A Functional Assessment Plan," dated 04/25/2012, indicated, "...When [client #4] has self injury or physically aggressive behaviors she will be able to self calm with staff intervention of moving her to quiet place, repositioning her, listening to music or putting her mitten on he hand...."</p> <p>During an interview on 05/10/2012 at 8:55 a.m., DSP #2 stated, "I think she has a behavior plan." She looked at client #4's record and read aloud the interventions listed in the previous paragraph. She indicated she had client #4 listen to music prior to 6:15 a.m. She indicated she did not follow the guidelines in the Functional Assessment for reducing client #4's self injurious behaviors during the survey observation period.</p> <p>During an interview on 05/10/2012 at 8:55 a.m., the Team Leader indicated DSP #6 should have read and followed the guidelines in the Functional Assessment for reducing client #4's self</p>						

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure nursing services revised health risk plans when needed and failed to ensure facility staff were trained to meet the health needs for 1 of 2 sampled clients and 1 additional client (clients #1 and #4). The facility failed to ensure nursing services ensured annual mammography screenings for 1 of 2 sampled clients (client #1).</p> <p>Findings include:</p> <p>1. During observations on 05/09/2012 at 3:10 p.m., client #1 had a gait belt around her waist. She used a rolling walker and walked without staff assistance from her bedroom to the living room.</p> <p>During observations on 05/09/2012 at 3:15 p.m., client #1 ambulated using her walker from the living room, through the front door and onto the front porch. Direct Support Professional (DSP) #5 walked behind client #1 without holding onto the gait belt.</p> <p>During observations on 05/09/2012 at 3:20 p.m., DSP #5 held onto client #1's gait belt with the fingertips of her right</p>	W0331	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i> Insulin protocols were reviewed with all staff. Protocol was enhanced to include a time period in which meal should occur after insulin (20 min). <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>Time frame for meals and insulin accuracy will continue to be monitored by the nurse consultant. Nurse Consultant is implementing a document to record insulin time and meal time. <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> Nurse Consultant, TL and Manager will continue routine med observations to observe on site the continued accuracy with insulin administration and meal preparation times. <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> Nurse Consultant will continue to conduct on site medication observations, monitor insulin and meal time documentation. IDT will review</p>	06/13/2012			

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	<p>hand as client #1 climbed into the van.</p> <p>During observations on 05/09/2012 at 5 p.m., DSP #5 held client #1's hand as she ambulated with her rolling walker from the living room to the kitchen table. DSP #5 did not use the gait belt that was around client #1's waist.</p> <p>During observations on 05/09/2012 at 5:18 p.m., client #1 used her rolling walker to independently ambulate from her bedroom to a recliner in the living room. DSP #1 was assisting another client in her bed room.. DSP #5 was in the laundry room passing medication to another consumer. The Team Leader was assisting another client with meal preparations in the kitchen.</p> <p>During observations on 05/10/2012 at 7:50 a.m., client #1 used her walker to ambulate from her bedroom to the bathroom. She was dressed in pajamas and was not wearing a gait belt around her waist. DSP #2 walked behind client #1 and carried her clothing and gait belt to the bathroom.</p> <p>During observations on 05/10/2012 at 8:00 a.m., the Qualified Developmental Disabilities Professional (QDDP) used an overhand grip with 2 fingers to hold client #1's gait belt while she ambulated using</p>		<p>all client status monthly or as needed to address any changes in insulin orders. Nurse consultant will continue to train and monitor staff performance of diabetes management skills.</p>		

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	<p>her rolling walker in the living room.</p> <p>During observations on 05/10/2012 at 8:20 a.m., client #1 ambulated independently with her walker from her recliner to a a cabinet in the living room. The QDDP asked client #1 if she needed assistance. Client #1 replied, "No" and retrieved a book from the cabinet. She then used her walker to ambulate to the kitchen. The QDDP did not use the gait belt to assist client #1 when she ambulated. DSP #2 and DSP#5 were seated at the table and did not take hold of client #1's gait belt while she stood next to the table.</p> <p>The facility's reportable incidents dated, 11/01/2011-05/09/2012, were reviewed on 05/09/2012 at 11:20 a.m. The incident reports indicated client #1 fell on 01/18/2012, 01/23/2012, 02/09/2012, 02/22/2012, 02/23/2012 (two falls), and 03/10/2012.</p> <p>Client #1's record was reviewed on 05/10/2012 at 12:48 p.m. A fall was documented in a progress note, dated 04/19/2012. The record did not indicate client #1 had mammography screening during the past year.</p> <p>A Risk Plan, dated 02/20/2012, indicated client #1 was at risk for falls. The plan</p>			
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	<p>indicated, "...Client ambulates with gaitbelt (sic) and rolling walker. Client also has wheelchair with anti-tippers for traveling long distances...."</p> <p>An Interdisciplinary Team (IDT) Note, dated 03/12/2012, indicated, "...Fall Prevention Plan: (1) use wheel-chair (sic) @ (at) home for all ambulation. (2) Has to have gait belt @ all times...."</p> <p>During an interview on 05/10/2012 at 8:55 a.m., Direct Support Professional (DSP) #2 stated, "I was trained during the past year to use a gait belt." She indicated she would use an overhand grip to hold the gait belt.</p> <p>During an interview on 05/10/2012 at 2:40 p.m. the RN Consultant indicated staff should have held the gait belt with an underhand grip every time client #1 ambulated. She indicated client #1 no longer needed a wheel chair for mobility in the group home. The RN Consultant indicated client #1 had a manual breast exam during her annual physical. She indicated a mammogram had not been completed during the past year.</p> <p>During an interview on 05/10/2012 at 2:40 p.m., the QDDP indicated the Fall Prevention Plan had not been updated after client #1's gait/balance improved. He</p>				

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	<p>indicated the wheel chair was implemented during a time when client #1's gait was less steady. He indicated the plan should have been revised to reflect the current level of assistance client #1 required.</p> <p>2. During observations on 05/10/2012 at 6:45 a.m., client #4's blood sugar was 67. She received 3 units of Novolog insulin along with 4 ounces of orange juice. Her blood sugar was rechecked at 7:10 a.m. and was 70. Client #4 received breakfast at 7:55 a.m.</p> <p>Client #4's record was reviewed on 05/10/2012 at 11:53 a.m. A Risk Plan, dated 02/20/2012, indicated client #4 had a health risk of diabetes. The plan lacked instructions for staff in regard to the allowable amount of time from insulin administration to meal consumption.</p> <p>During an interview on 05/10/2012 at 8:55 a.m., DSP #2 indicated client #4 should have eaten within 20 minutes after receiving insulin. She stated, "[DSP #6] should have given client #4 her breakfast right after she got her meds (medications)."</p> <p>During an interview on 05/10/2012 at 8:55 a.m., the Team Leader indicated DSP #6 was not regularly scheduled to</p>			

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	<p>work in client #4's group home. She indicated DSP #6 should have read the client records to review diabetes protocols.</p> <p>During an interview on 05/10/2012 at 2:40 p.m., the RN Consultant indicated the meal should have been consumed within 30 minutes of administering the insulin. She indicated the risk plan should have included instructions for maximum allowable time between insulin administration and meal consumption.</p> <p>9-3-6(a)</p>			

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W0336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview, the facility failed to ensure quarterly nursing assessments for 2 of 2 sampled clients (clients #1 and #2).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 05/10/2012 at 12:48 p.m. Documentation indicated quarterly nursing evaluations were completed on 04/30/2011, 09/16/2011, 01/20/2012, and 04/26/2012. There was no documentation to indicate a quarterly nursing evaluation was completed between 04/30/2011 and 09/16/2011 and there were 4 months between the nursing evaluations on 09/16/2011 and 01/20/2012.</p> <p>2. Client #2's record was reviewed on 05/10/2012 at 1:50 p.m. Documentation indicated quarterly nursing evaluations were completed on 04/30/2011, 09/16/2011, 01/20/2012, and 04/26/2012. There was no documentation to indicate a quarterly nursing evaluation was completed between 04/30/2011 and 09/16/2011 and there were 4 months</p>	W0336	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>6/2011 quarterly physical assessments are not present in the chart. There is no way to create the document. This deficiency was discovered upon a change in the personnel for this caseload.</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 were affected by this practice.</p> <p>All quarterly nursing physical assessments are completed at the same time for all residents in the home to better coordinate completion.</p> <p>Upon discovery of incomplete assessments, facility nurse implemented a plan to complete and reorganize the timelines. All quarterly physical assessments and nursing notes have been completed since this corrective action occurred.</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>	06/13/2012			

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	<p>between the nursing evaluations on 09/16/2011 and 01/20/2012.</p> <p>During an interview on 05/10/2012 at 2:40 p.m., the RN Consultant indicated she was aware the previous nurse did not complete nursing quarterlies in June 2011.</p> <p>9-3-6(a)</p>		<p>All quarterly nursing physical assessments are submitted to the GH Director by the 5 th of the following month and then forwarded to the home chart.</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 receive monthly nursing notes and quarterly assessments from nurse consultants. Any untimely or inaccurate documentation will be addressed with the nursing team immediately.</p>		

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W0352	<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 to ensure an annual dental exam was completed for 1 of 2 sampled clients (client #2).</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 05/10/2012 at 1:50 p.m. There was no documentation to indicate a dental cleaning had been completed.</p> <p>During an interview on 05/10/2012 at 2:40 p.m., the RN Coordinator and Qualified Developmental Disabilities Professional indicated they were not aware a dental exam had not been completed.</p> <p>9-3-6(a)</p>	W0352	<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 dental exam for client #2 was completed 5/19/12.</p> <p>Mammogram for client #4 is under review for authorization due to hospice status. When authorized, it will be scheduled and completed at next available appointment.</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. All resident records were reviewed and no other outstanding appointments or consultations were noted.</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>Nurse consultant will send appointment list to TL at the end of each month listing the next month's appointments due. The TL will schedule the appointments, document the appointment list and send it back to the nurse consultant. At the end of each month the TL and nurse consultant</p>	06/13/2012	

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			<p>will reconcile the appointment list to ensure all appointments and follow up was completed as scheduled.</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>QDDP will continue to complete routine oversight of Team Leader steps, at minimum weekly.</p> <p>Director will continue monthly nursing and program chart and site reviews.</p>		

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W0362	<p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>Based on record review and interview, the facility failed to ensure a pharmacist reviewed 1 of 2 sampled client's drug regimen at least quarterly (clients #2).</p> <p>Findings include:</p> <p>Client #2's pharmacy recommendations were reviewed on 05/10/2012 at 3:20 p.m.</p> <p>The pharmacist reviewed drug regimens on 06/10/2011, 12/19/2011, and 03/27/2012. There was no documentation to indicate a review was completed in September 2011.</p> <p>During an interview on 05/10/2012 at 2:40 p.m., the RN Consultant indicated a review was not completed in September 2011.</p> <p>9-3-6(a)</p>	W0362	<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 pharmacy review for this time period was not available at the time of survy. It has since been recovered and was done timely.</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. All resident records were reviewed and no other outstanding pharmacy reviews were noted.</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>Director will recieve quarterly pharmacy reviews via email from consultant pharmacist and maintain a record of those reviews.</p> <p>Nurse consultant will also recieve a copy and address any recommendations with physician.</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 audit for present and addressed pharmacy reviews in</p>	06/13/2012	

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			nursing medical charts routinely with random chart audit. Director will continue monthly nursing and program chart and site reviews.	