

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G545	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/08/2013
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN 46260
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: March 5, 6, 7 and 8, 2013.</p> <p>Facility Number: 001059 Provider Number: 15G545 AIMS Number: 100245370</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.</p> <p>Quality review completed March 19, 2013 by Dotty Walton, 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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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 7 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility neglected to implement the facility's policy and procedure and neglected to provide appropriate supervision to 2 of 4 sample clients (clients #3 and #4) and 1 additional client (client #6).</p> <p>Findings include:</p> <p>On 03/05/13 at 1:50 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following:</p> <p>1. A BDDS report dated 08/21/12 indicated: "[Client #4] transferred to the group home on 08/20/12. QDDP (Qualified Developmental Disabilities Professional) was at the group home on 08/27/12 at 08:00 am. Q (QDDP) went to [client #4's] room to say hello. Her door was open so writer knocked on the door and looked inside. [Client #4] was half-dressed, she had not yet put on her pants. Writer noticed a small, quarter-sized bruise on [client #4's] left hip. Writer asked associate [staff #6]</p>	W000149	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The facility has reviewed its prevention of abuse and neglect policy and find it appropriate. The staff who had failed to report this bruise was retrained and coached at the time of the event (8/21/12). The incident was reviewed again after the survey findings along with all other incidents for the facility. After reporting, the investigation was completed thoroughly and there was appropriate follow up action. No other incidents have been reported untimely by this staff or any other. The facility also reviewed the incident for Client #3 in which staff neglect was substantiated and staff was discharged. St. Vincent New Hope confirms the investigation to be accurate and complete as indicated. Client #6 was reviewed by IDT again. All Fall Plans, transfer methods and other adaptive equipment needs were ensured to be present on this ISP and treatment plan documents. 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</i></p>	03/29/2013
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	<p>about the bruise. [Staff #6] stated that when she helped [client #4] on the morning of 08/21/12 she saw the bruise. [Staff #6] stated she did not notify QDDP or nurse because she felt the bruise had occurred at her previous group home and that the other group home must have reported the bruise. QDDP informed [staff #6] that she should have followed protocol and completed an OOPS (unidentified name) form, body check sheet, notified her TL (Team Leader) and the Nurse."</p> <p>2. A BDDS report dated 10/22/12 indicated: "Associate [staff #14] completed an OOPS (Occurrence Outside Practice Standards)/Incident report stating that [client #3] had fallen, trying to get himself out of bed. [Staff #14] stated that [client #3] was calling to get out of bed, but she was assisting another individual and told [client #3] to wait. [Staff #14] stated that [client #3] never tried to get himself out of bed before and did not believe he would try himself and fall. [Client #3] stated he layed (sic) on the floor for several minutes. [Staff #14] had denied this stating he was only on the floor briefly. [Staff #14] has been suspended pending an investigation into allegation of neglect...."</p> <p>The 10/27/12 Investigation Summary</p>		<p>affected. All staff were retrained on 3/21/13 regarding reporting criteria, procedures. All staff are trained upon hire and annually, at minimum on the responsibilities of reporting potential abuse, neglect as well as the expectations of their duties in responding to client needs. All other fall risk plans, transfer methods and ISPs were reviewed for the other residents of the facility. All were revised as needed. All staff were retrained on the revisions and the safe transfer methods for all individuals. <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> Reportable incidents are tracked by St. Vincent New Hope Quality Assurance. The date of incident and the date of reporting are included in this tracking. Director receives a weekly copy of this spreadsheet for oversight purposes. Any trends or deficiency is reviewed and Director is aware that appropriate follow up occurs (retraining/discipline as appropriate). Quality Assurance also tracks any investigations of abuse, neglect and Director receives this as well. This report is useful in identifying any trends</p>				

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	contained statements from staff. Staff #14's statement indicated, "On Monday morning of October 22, 2012. Perhaps, It (sic) was around 4:30 AM when [client #3] started calling me for help with arm reposition and to go up in bed then he call (sic) again and again approximately 5 to 10 minute (sic) apart stating to reposition his legs like put them apart, then ask me (sic) it time to get up. Staff (staff #14) told him, remember you get up by morning shift, it (sic) not time and [client #3] was okey (sic). Staff (staff #14) get up (sic) neighbor to shower room, and [client #3] call (sic) again, staff (staff #14) told him same thing, and he get (sic) angry staring: now ? (sic) I want to get up now! and (sic) staff told him, okey (sic) but let me finish with your roommate then I will help you. [Client #3] was very angry, (sic) Earlier staff put a green long pillow in front of his legs to prevent legs lide (sic) over. While staff giving (sic) his neighbor shower, staff heard a noise, rushed in [client #3's] room found him on the floor, fitted sheet hanging down and green long pillow on the floor and [client #3] was very angry still try to get to chair (sic), I check (sic) [client #3's] arm legs, head (sic) according to [client #3] he was not in pain except minor scratch in legs perhaps arm. I put pillow under his head and told him hold done (sic) since he was find. (sic) I went and rush his neighbor		or instances where improvement can occur. This report will continue to be utilized by the facility team. IDT will continue to conduct full investigation into any falls. QDDP and Director will review that all steps identified in fall investigation are completed timely. IDT will review each person's transfer status regularly at the standing meetings in order to identify from staff any potential problem areas.	

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	<p>out in the shower room. I went back to him and [client #3] still angry and on his belly still try (sic) to get to chair. I wanted to wait for day shift who came at 6 a.m., because I did not want to drop him on the floor or injury (sic) my back. (sic) but his condom that attached (sic) to catheter was detach (sic) when he was trying to crolling (sic) to the chair (sic) [client #3] was soak (sic) with pie (sic), that's why I did not wait for morning shift who came at 6a.m (sic) to help me get him up. But I tried and tried (sic) get him back to bed. Even though I felt it on my back but, (sic) [client #3] was back to bed instead of cold wet floor. [Client #3] apologized (sic) for not waiting on staff and want (sic) to go back to sleep. When morning staff came around 6a.m (sic) I ask (sic) her if anyone give (sic) [client #3] any habit of getting up early morning (sic) and I told her what happened (sic) and I did incident report left (sic) for team leader. Staff (staff #14) did not (sic) aware of get out behavior, [client #3] never tried that before. Yes he can get very angry but not to the point to get himself down, Also (sic) if staff (staff #14) was aware that he will get himself down, staff would rushed (sic) him to chair. At the time he want to get up he was not in pain, perhaps he thought, it was time to get up for doctor appointment. I don't know."</p>			

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	<p>Staff to Staff Communication log indicated the following written by staff #7:</p> <p>10/20/12: "[Client #3] has developed an (sic) habit of getting out of the (sic) by himself without calling staffs attention. And he did tried me (sic) yesterday (evening shift), so staffs (sic) should take note of this and pay more close attention when [client #3] is alone."</p> <p>10/20/12: Entry written by staff #14 indicated: "Staff, be aware that [client #3] try (sic) to get out of bed especially at night, if he ask (sic) to get up and staff don't get him up immediately, he will crolled (sic) himself down to the chair."</p> <p>10/27/12 Investigation Summary indicated, "Findings: Based on all of the information reviewed for this incident investigation, I have determined that incident number...is: Substantiated, the findings support the event as described/allegation. Determination has been found that: Rights have been violated, Services were not provided, Agency polices/procedure were not followed. Associate [staff #14] was terminated on 10/24/12."</p> <p>3. A BDDS report for an incident dated 12/11/12 indicated: "[Client #6] was</p>						

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	<p>being assisted with his AM shower. There were two associates assisting him, [staff #3 and staff #5], is being precepted (sic). After completing his shower as [client #6] was pivoting to get on the toilet he slipped and fell. [Client #6] suffered a laceration under his chin. Staff assisted [client #6] up and applied pressure to stop the bleeding. Staff paged the nurse and team leader. Nurse sent [client #6] to ER (Emergency Room) for treatment. [Client #6's] guardians/parents were notified and met [client #6] in the ER. [Client #6] required three stitches to close the cut. [Client #6] had no further injuries and was discharged back to the group home at 1 pm on 12/11/2012. [Client #6] is doing well this am and is attending Day Services today." Plan to Resolve: "Staff will be trained to use Rolling Shower Chair with seatbelt when showering [client #6]. Staff will be trained to wheel shower chair over the toilet while [client #6] is sitting on the shower chair. Maintenance will also assess the tile floor for possible grip strips on the floor."</p> <p>An OOPS report dated 12/11/12 filled out by staff #3 indicated: "[Client #6] was been (sic) assisted in taking his bath this morning...He wanted to use the toilet when he (making) a turn around while holding the bar in the bathroom when he</p>				

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	<p>lost his balance and fell...."</p> <p>The Fall Investigation dated 12/14/12 for the 12/11/12 incident indicated: "[Client #6] was taking a shower assisted by 2 direct support specialist. [Client #6] was pivoting to get on the toilet when he slipped and fell, striking his chin on the floor...."</p> <p>Client #6's records were reviewed on 03/06/13 at 3:15 PM. Client #6's ISP (Individual Support Plan) dated 02/20/12 indicated he "uses walker for stability due to falls, used a helmet for safety due to falls and a rolling shower chair with seatbelt, daily for shower/toileting."</p> <p>4. A BDDS report for an incident dated 12/14/12 indicated: [Client #6] had come in from Day Program and went in to use the bathroom and fell. When [client #6] fell he hit is nose. Nose turned red and started to swell. Staff notified the Nurse of the incident, nurse instructed the staff to take [client #6] to the ER. [Client #6] was checked out by ER Dr (doctor), who stated that nose would just be bruised, but was not broken...TL (Team Leader) instructed staff to assist [client #6] when needing to toilet."</p> <p>The Fall Investigation dated 12/18/12 for the 12/14/12 incident indicated: "Activity</p>						

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	<p>at time of fall: In the bathroom, turning to sit onto the commode...Bathroom had been re-tiled. The new tile were larger and did not have good traction. Maintenance has now painted the tile with an adhesive substance...."</p> <p>On 03/05/13 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 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</p>			

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	<p>authorities and specific agencies of such battery, neglect or exploitation is also mandated by law...."</p> <p>On 03/07/13 at 2:30 PM an interview with the QDDP was conducted. He indicated staff failed to follow the facility policy and procedure on abuse and neglect. The QDDP indicated staff failed to report client #4's bruise on 08/20/12 to the Administrator.</p> <p>The QDDP indicated client #3 fell out of bed when staff #14 neglected to care for his needs. He indicated she was terminated after the incident. The QDDP also indicated on the 12/11/12 incident client #6 was standing after his shower and turned around to sit on the toilet when he fell. Client #6 was not using the shower chair at the time which his ISP indicated he should have been.</p> <p>9-3-2(a)</p>						

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W000153	<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. Based on record review and interview for 1 of 7 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection (client #4), the facility neglected to report the alleged client neglect timely to the Administrator.</p> <p>Findings include:</p> <p>On 03/05/13 at 1:50 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following incident:</p> <p>08/21/12: "[Client #4] transferred to the group home on 08/20/12. QDDP (Qualified Developmental Disability Professional) was at the group home on 08/27/12 at 08:00 am. Q (QDDP) went to [client #4's] room to say hello. Her door was open so writer knocked on the door and looked inside. [Client #4] was half-dressed, she had not yet put on her pants. Writer noticed a small, quarter-sized bruise on [client #4's] left hip. Writer asked associate [staff #6]</p>	W000153	<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 facility has reviewed its prevention of abuse and neglect policy and find it appropriate. The staff who had failed to report this bruise was retrained and coached at the time of the event (8/21/12). The incident was reviewed again after the survey findings along with all other incidents for the facility. After reporting, the investigation was completed thoroughly and there was appropriate follow up action. No other incidents have been reported untimely by this staff or any other.</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 staff were retrained on 3/21/13 regarding reporting criteria, procedures.</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</i></p>	03/29/2013
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	<p>about the bruise. [Staff #6] stated that when she helped [client #4] on the morning of 08/21/12 she saw the bruise. [Staff #6] stated she did not notify QDDP or nurse because she felt the bruise had occurred at her previous group home and that the other group home must have reported the bruise. QDDP informed [staff #6] that she should have followed protocol and completed an OOPS (Occurrence Outside Practice Standards) form, body check sheet, notified her TL (Team Leader) and the Nurse."</p> <p>On 03/07/13 at 2:30 PM an interview with the QDDP was conducted. The QDDP indicated staff failed to report the 08/20/12 incident timely to the Administrator.</p> <p>9-3-2(a)</p>		<p><i>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 is copied and notified on all incidents within 24 hours. At that time, it is notable whether incident is late. Reportable incidents are tracked by St. Vincent New Hope Quality Assurance. The date of incident and the date of reporting are included in this tracking. Director receives a weekly copy of this spreadsheet for oversight purposes. Any trends or deficiency is reviewed and Director is aware that appropriate follow up occurs (retraining/discipline as appropriate).</p>		

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #3) and 1 additional client (client #6), by not ensuring clients received nursing services according to their medical needs.</p> <p>Findings include:</p> <p>On 03/05/13 at 1:50 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following:</p> <p>1. A BDDS report for an incident dated 08/27/12 indicated client #3 had a small abrasion to his left big toe due to new shoes "about three weeks ago" and the area did not improve. He was taken to the Emergency Room on 08/27/12 for the infected toe and admitted for treatment. A BDDS follow-up dated 09/04/12 indicated client #3 was discharged from the hospital on 08/31/12.</p> <p>Client #3's records were reviewed on 03/06/12 and contained the following dated documents:</p> <p>Undated: Instructions for wearing New Pedorthic Devices: "A break in period is</p>	W000331	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Client #3 foot is fully healed. Daily body checks were implemented to note any specific skin issue that may arise in the future. These are documented on the individual's medication administration record daily.</p> <p>Client #6 was reviewed by IDT again. All Fall Plans, transfer methods and other adaptive equipment needs were ensured to be present on this ISP and treatment plan documents.</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 staff were retrained on the skin integrity concerns for all individuals and the proactive measures to monitor (High Risk Plans). In addition staff were trained on skin pressure points and potential breakdown areas. Staff also received review of when to call the nurse. This facility nurse takes call for her homes full time, so she is the constant primary contact for her homes unless she is off work. At that time, there continues to be 24 hr on-call support provided by the other nurse consultants.</p>	03/29/2013			

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	<p>necessary. Wear pedorthic device(s) 1 hour the first day and increase your time by 1 hour every day...At least 3-4 times per day, remove your pedorthic device(s) and examine your feet and your footwear. Check for anything that looks out of the ordinary that may result in cuts, scratches, blister, etc. Look for swelling, redness, or rise in skin temperature...If you find anything out of the ordinary, discontinue use immediately and call and make an appointment for an adjustment...."</p> <p>08/01/12: Nurses notes indicated, "[Client #3] has been complaining of L (left) foot pain. Writer (nurse) advised TL (Team Leader) to make appointment at [name] store for a custom shoe....."</p> <p>08/03/12: Nurses notes indicated, "Saw [client #3] at Day Services per him he is doing much better...Client denies needs at this time."</p> <p>08/09/12: Nurses notes indicated, "Saw [client #3] at Day Services today, he had just returned from camp. He denies complaints."</p> <p>08/20/12 - 9:15 AM: Nurse's notes indicated, "Received phone call from [staff #15] from [unidentified staff]. [Client #3's] big toe, Left foot - oozing puss and green drainage and bleeding.</p>		<p>All other fall risk plans, transfer methods and ISPs were reviewed for the other residents of the facility. All were revised as needed. All staff were retrained on the revisions and the safe transfer methods for all individuals. <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> Group Home Team Leader reviews the med administration log and skin checks weekly. Nurse consultant does thorough physical assessment monthly. IDT will continue to conduct full investigation into any falls. QDDP and Director will review that all steps identified in fall investigation are completed timely. IDT will review each person's transfer status regularly at the standing meetings in order to identify from staff any potential problem areas.</p>				

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	<p>Called Dr [name] office left message with nurse in regards to appt (appointment) needed or script (prescription) for something - awaiting return phone call."</p> <p>08/20/12 - 10:30 AM: Nurse's notes indicated, "Once [client #3] arrived at day services, I (nurse) cleansed left great toe with NS (normal saline) and patted dry then applied bacitracin ointment and covered with bandaids. Recovered with sock."</p> <p>08/21/12 - 9:00 AM: Nurse's notes indicated, "Received phone call from [Drs (doctor's) office staff name] at Dr [name] office. Received new orders for Septra DS (antibiotic) tablet #20 (20 tablets). PO (by mouth) BID (twice daily) x (times) 10 days and Bacitracin ointment apply to L (left) great toe till (until) healed. Call to [staff #16] and let her know about new orders."</p> <p>08/23/12 - 9:00 AM: Nurses notes indicated, "[Staff #15] from home called stating [client #3's] toe looks worse so made appt at Dr [name] office and was seen at 11:30 AM. Received order to D/C (discontinue) Septra and start Augmentin (antibiotic) 875 PO BID for cellulitis."</p> <p>08/27/12 - 9:00 AM: Nurses notes indicated, "[Staff #15] called taking</p>			

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	<p>[client #3] per [QDDP] to the ER for toe worsening symptoms on foot."</p> <p>08/27/12 - 3:00 PM: Nurses notes indicated, "[Client #3] was taken to [name] ER and was admitted (to hospital). Admitting diagnosis was cellulitis. Dr. stated he was not responding to previous ATB (antibiotic) treatment."</p> <p>Client #3's record contained a Risk Plan indicating client #3 was at risk for impaired skin integrity. The risk plan dated 12/28/12 indicated, "staff will monitor client daily and complete body check sheets if any notes changes. Staff will monitor client for open areas or breaks in the skin, tears, cracks, bruises, boils, warm, swollen and or reddened areas, changes in mole size, shape, or color." The record did not contain documentation of daily monitoring.</p> <p>Client #3's record did not contain documentation of instructed foot checks for client #3 after he received the new therapeutic shoes.</p> <p>2. A BDDS report for an incident dated 12/11/12 indicated: "[Client #6] was being assisted with his AM shower. There were two associates assisting him, [staff #3 and staff #5], is being precepted</p>			

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	<p>(sic). After completing his shower as [client #6] was pivoting to get on the toilet he slipped and fell. [Client #6] suffered a laceration under his chin. Staff assisted [client #6] up and applied pressure to stop the bleeding. Staff paged the nurse and team leader. Nurse sent [client #6] to ER (Emergency Room) for treatment. [Client #6's] guardians/parents were notified and met [client #6] in the ER. [Client #6] required three stitches to close the cut. [Client #6] had no further injuries and was discharged back to the group home at 1 pm on 12/11/2012. [Client #6] is doing well this am and is attending Day Services today."</p> <p>Plan to Resolve: "Staff will be trained to use Rolling Shower Chair with seatbelt when showering [client #6]. Staff will be trained to wheel shower chair over the toilet while [client #6] is sitting on the shower chair. Maintenance will also assess the tile floor for possible grip strips on the floor."</p> <p>An OOPS report dated 12/11/12 filled out by staff #3 indicated: "[Client #6] was been (sic) assisted in taking his bath this morning...He wanted to use the toilet when he (making) (sic) a turn around while holding the bar in the bathroom when he lost his balance and fell...."</p> <p>Client #6's records were reviewed on</p>						

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	<p>03/06/13 at 3:15 PM. Client #6's ISP (Individual Support Plan) dated 02/20/12 indicated he "uses walker for stability due to falls, uses a helmet for safety due to falls and a rolling shower chair with seatbelt, daily for shower/toileting." Client #6's record did not contain a Fall Risk Plan prior to one dated 12/28/2012. The Fall Risk Plan of 12/28/12 indicated client #6 "requires stand by assist x 1 with transfers from sitting/walking." This risk plan did not indicate how client #6 was to be toileted. The risk plan failed to indicate client #6 was to use a shower chair and specifically how and when the shower chair should be utilized.</p> <p>An interview with the RN (Registered Nurse) on 03/07/13 at 2:00 PM was conducted. The RN indicated there was no documentation for the daily skin checks. She indicated client #3's toe was very infected by the time he saw the doctor. She indicated the risk plan for client #3 failed to indicated staff should document skin checks daily. She also indicated client #6's fall risk plan failed to indicate how/when staff were to use the shower chair for shower/toileting and how to toilet staff #6 when not showering.</p> <p>9-3-6(a)</p>						

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W000368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 1 of 4 sampled clients (clients #1, #2 and #3) and 2 additional clients (clients #5 and #8) who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 03/05/13 at 1:50 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following medication errors:</p> <p>03/25/12: "Upon TL's (Team Leader) review of med (medication) book on 3/26/12, it was found that [client #2's] antibiotic had not been passed over the weekend properly. He missed two doses on the 24th and all three doses on the 25th. The order times had not been written in correctly by the staff who received the medication and no one called anyone to clarify the order. The staff who should've (sic) passed the meds were give medication errors for not passing the meds at 5 and 9 as written in the med book. Nurse was notified, administrator and guardians."</p>	W000368	<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 Group Home Team Leader has an assigned designee to monitor the medication supply in the home ensuring a 7 day supply is present. This incident (5/7/12) was implemented following prior issues of maintaining supply in the facility. There have been no other errors related to supply since this implementation. All staff were required to attend a mandatory training session on 3/21/13 with the TL, Q and Nurse consultant. At that time all staff completed a med administration check off with the nurse consultant. <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 staff were required to attend a mandatory training session on 3/21/13 with the TL, Q and Nurse consultant. At that time all staff completed a med administration check off with the nurse consultant. <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</i></p>	03/29/2013
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	<p>05/07/12: "[Staff #6] failed to pass [client #5's] 7 am dose of Levetiraceta 500 mg (milligram) for seizures. No ill effects were suffered due to this missed doses. No seizures. Next dose this evening. Nurse and doctor notified of error."</p> <p>07/06/12: "[Client #3] was not given his 7 pm dose of Natural Fiber Powder (constipation). [Staff #13] was responsible for passing 7 pm meds. At 9 pm, staff noticed [client #3] had not been given his Natural Fiber Powder. Nurse on call paged and Nurse [name] stated to hold the Powder."</p> <p>10/21/12: "[Client #3's] medication Oxybutynin ER 5 mg 1x (time)/daily (urinary frequency) was discontinued on 10/18/12. [Staff #6], gave [client #3] the Oxybutynin from 10/21/12 through 10/25/12. Another associate noticed the error this morning. [Client #3] is doing well and has shown no adverse effects from this error."</p> <p>01/15/13: "Team Leader and QDDP (Qualified Developmental Disabilities Professional) were conducting an IDT (Inter-disciplinary Team) meeting at the group home. Staff member [staff #6] approached QDDP and informed QDDP that she had discovered a medication</p>		<p><i>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 continue to review med supply checks weekly to ensure they are completed and accurate. Team Leaders will continue to observe staff medication pass monthly.</p> <p>Nurse consultant will also continue to observe staff medication pass monthly. Nurse consultant retrains staff after any medication error. St. Vincent New Hope will continue to implement its policy and procedure related to medication errors. This procedure outlines specifically when retraining and further disciplinary action occurs.</p>	

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	<p>error. Staff member [staff #9] had given [client #8] only 1 650 mg tablet of Acetaminophen on 1/15/13 at 9 pm med pass when order states to give 2 650 mg tablets or 1300 mg 2x daily. QDDP notified RN [name]...."</p> <p>01/23/13: "[Client #1] was not given his 7 pm dose of Baclofen (spasticity)...[staff #9] was responsible for the medication error...."</p> <p>02/19/13: "[Staff #4] did not give [client #2] his 5 pm dose of 10 mg Baclofen...."</p> <p>An interview with the RN (Registered Nurse) on 03/07/13 at 2:00 PM was conducted. The RN indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders.</p> <p>9-3-6(a)</p>				

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W000448	<p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents. 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 03/05/13 at 2:15 PM, record reviews were completed of the facility's evacuation drills for the period of 02/22/12 through 03/04/13. There were 4 evening shift drills conducted during that time period. On 08/30/12 an evening drill was conducted at 7:00 PM and the total evacuation time was recorded as 6 minutes. On 11/09/12 an evening drill was conducted and the total evacuation time was recorded as 25 minutes. There were 4 night shift drills conducted during the time period. On 03/17/12 a night drill was conducted at 2:00 AM and the total evacuation time was recorded as 1 hour 5 minutes. On 06/09/12 a night drill was conducted at 12:30 AM and the total evacuation time was recorded as 22 minutes. On 09/28/12 a night drill was conducted at 3:00 AM and the total evacuation time was 55 minutes. On 12/15/12 a night drill was conducted at</p>	W000448	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>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.</p> <p>Home evacuation scores and safety code are in compliance with the impractical to slow evacuation rating of the home. The home maintains life safety code requirements of direct monitoring as it was evaluated as an impractical evacuation in the last year. Full monitoring system was installed on 4/12.</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</i></p>	03/29/2013			

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	<p>4:02 AM and the total evacuation time was 6 minutes.</p> <p>On 03/07/13 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><i>not recur; what quality assurance program will be put into place.</i></p> <p>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.</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 prevent further incidents of lengthy evacuation drill times on the evening and night shifts.</p> <p>Findings include:</p> <p>On 03/05/13 at 2:15 PM, record reviews were completed of the facility's evacuation drills for the period of 02/22/12 through 03/04/13. There were 4 evening shift drills conducted during that time period. On 08/30/12 an evening drill was conducted at 7:00 PM and the total evacuation time was recorded as 6 minutes. On 11/09/12 an evening drill was conducted and the total evacuation time was recorded as 25 minutes. There were 4 night shift drills conducted during the time period. On 03/17/12 a night drill was conducted at 2:00 AM and the total evacuation time was recorded as 1 hour 5 minutes. On 06/09/12 a night drill was conducted at 12:30 AM and the total evacuation time was recorded as 22 minutes. On 09/28/12 a night drill was conducted at 3:00 AM and the total</p>	W000449	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>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.</p> <p>Home evacuation scores and safety code are in compliance with the impractical to slow evacuation rating of the home. The home maintains life safety code requirements of direct monitoring as it was evaluated as an impractical evacuation in the last year. Full monitoring system was installed on 4/12.</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</i></p>	03/29/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G545	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/08/2013
NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 9001 N HOLLIDAY DR INDIANAPOLIS, IN 46260		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>evacuation time was 55 minutes. On 12/15/12 a night drill was conducted at 4:02 AM and the total evacuation time was 6 minutes.</p> <p>On 03/07/13 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. The QMRP indicated the drills' times were not acceptable.</p> <p>9-3-7(a)</p>		<p><i>to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>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.</p>		