

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2012
NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268		
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W0000	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of survey: 1/25, 1/26, 1/27 and 1/31/12</p> <p>Facility Number: 001077 AIM Number: 100245490 Provider Number: 15G563</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team Leader Brenda Nunan, Public Health Nurse Surveyor-RN (1/26/12 to 1/27/12)</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/6/12 by Ruth Shackelford, 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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W0104	<p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on interview and record review for 2 of 4 sampled clients (#2 and #4), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure clients did not pay for haircuts.</p> <p>Findings include:</p> <p>Client #1's financial records were reviewed on 1/26/12 at 8:35 AM. Client #1's 12/11 Cash Ledger indicated client #1 paid \$9.70 for a haircut on 12/23/11.</p> <p>Client #4's financial records were reviewed on 1/26/12 at 8:35 AM. Client #4's 12/11 Cash ledger indicated client #4 paid \$13.00 for a haircut on 12/23/11.</p> <p>Interview with Team Leader (TL) #1 on 1/26/12 at 8:45 AM indicated clients #1 and #4 paid for their haircuts. TL #1 indicated the clients would pay for their haircuts and the facility would reimburse the clients afterwards from the group home's petty cash. TL #1 indicated clients #1 and #4 had not been reimbursed as the group home did not have the petty cash to reimburse the clients. TL #1 indicated the group home received \$75.00 a month in petty cash. TL #1 indicated</p>	W0104	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? All staff have been retrained on the per diem requirements for haircuts. All staff understand that facility residents are free from this charge. However, the procedure had varied in that the clients had paid with their own funds and had not been reimbursed timely. The identified individuals have been reimbursed. . How are other residents identified that could have the potential for also being affected by the same deficient practice? All the residents in the home have the potential to be affected by this deficient practice. All of the resident financial records were reviewed. No other instance of client reimbursement were noted. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Team Leader will no longer use client funds for haircuts, even if the intention is to reimburse timely. The home petty cash funds will be the only source of funds for the haircuts. How will the corrective action be monitored to ensure the deficient practice will not recur? The QMRP will monitor the the financial records of the residents monthly to ensure all funds are</i></p>	02/18/2012			

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	<p>the \$75.00 petty cash would be used to reimburse clients for haircut expenses and be used for other group home expenses/purchases. TL #1 indicated clients #1 and #4 would be reimbursed when she received her \$75.00 monthly petty cash disbursement.</p> <p>9-3-1(a)</p>		<p>expensed appropriately. The financial records for all individuals in all facilities are reconciled and submitted to SVNH Quality Assurance Department monthly for audit and review. This step provides additional oversight, monitoring and timeliness of recordkeeping. The Director receives a monthly report of the financial audits including late submissions, inaccuracies and returns for correction. The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards.</p>	

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W0136	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities.</p> <p>Based on interview and record review for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to ensure clients participated in activities in the community.</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 1/26/12 at 10:20 AM. Client #4's Community Integration sheets from 10/11 to 1/26/12 indicated client #4 had not participated in any community activities since 10/11. Client #4's 10/10/11 Community Integration sheets indicated client #4 last went out in the community for activity on 10/16/11 when the client went to a Flea Market to purchase a coloring book.</p> <p>Interview with client #4 on 1/25/12 at 4:38 PM indicated the client did not get to participate in activities in the community. Client #4 indicated she would like to go out to eat.</p> <p>Interview with staff #1 on 1/26/12 at 8:00 AM indicated clients were not participating in community activities. Staff #1 indicated the group home had</p>	W0136	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i> The identified individuals as well as the remaining individuals in the home were assessed to have appropriate and current community integration goals and objectives identified in their program plan. The staff will be retrained on how those events will be scheduled, how they will know of the events and the responsibility to carry out and document the scheduled events. The home has a calendar of events, including appointments, household duties as well as individual community activities. The home Team Leader will review the schedule each week to ensure that individual community activities are incorporated. The Team Leader will ensure that the appropriate documentation was recorded for these events. <i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i> All the residents in the home have the potential to be affected by this deficient practice. All of the records and treatment plans for all individuals were reviewed and included in the corrective action</p>	02/18/2012			

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	<p>undergone staff changes which prevented the clients from going out into the community.</p> <p>2. Client #2's record was reviewed on 1/26/12 at 12:15 PM. Client #2's Community Integration sheets from 10/11 to 1/26/12 indicated the following:</p> <p>-January 2012 no activities thus far</p> <p>-December 2011 one activity on 12/17/11 "mall with staff."</p> <p>-November 2011 no activities Client #2's 10/11 Community Integration sheet indicated the client went to a BINGO on 10/13/11 and to church with a staff person on 10/23/11.</p> <p>Interview with Team Leader (TL) #1 on 1/26/12 at 8:45 AM indicated clients #2 and #4 had not been out in the community for activities since 10/11. TL #1 stated "outings suffered since staff changes." TL #1 indicated the facility's staff had changed, due to an incident in the home, and there had not been enough staff to take the clients on outings/activities in the community.</p> <p>3. Client #1's record was reviewed on 01/26/2012 at 1:05 p.m.. The Community Integration sheet indicated community</p>		<p>noted above. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i> The Team Leader will review the community integration success each week. The documentation will be reviewed as well and the summary of events will be recorded in the monthly QMRP case management reviews. Any refusals by individuals will be reviewed by the IDT monthly. Any lack of compliance by staff will be addressed in a progressive disciplinary plan. <i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i> The QMRP will monitor the average number of community activities on a monthly basis to ensure they increase and remain at an appropriate level of participation by individuals and staff. The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards.</p>				

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	<p>outings on 10/04/2011 to a restaurant, 10/13/2011 to play Bingo, and 10/15/2011 to an electronics store. There was no documentation to indicate community outings after 10/15/2011.</p> <p>During an interview on 01/26/2012 at 8:45 a.m., Team Leader #1 (TL #1) stated, "outings suffered since staff changes," in October 2011. TL #1 indicated clients had not participated in community activities since October 2011.</p> <p>9-3-2(a)</p>			
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W0203	<p>At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on record review and interview, the facility failed to ensure a discharge summary included developmental, behavioral, social and nutritional status for 1 of 1 discharged client (additional client #9).</p> <p>Findings include:</p> <p>The discharge summary for additional client #9 was reviewed on 01/26/2012 at 11:00 a.m. The record indicated client #9 was discharged from the facility on 02/16/2011. The record did not include documentation of client #9's developmental, behavioral, social and nutritional status.</p> <p>During an interview on 01/26/2012 at 11:00 a.m., the QDDP (Qualified Developmental Disabilities Professional) indicated he had not written a discharge summary that included developmental, behavioral, social and nutritional status.</p> <p>9-3-4(a)</p>			W0203	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The BDDS Service Coordinator is responsible to approve that all necessary information is transitioned between providers, utilizing the BDDS Transition Form. In addition, this individual transitioned to a long term nursing facility by guardian choice. Guardian declined our involvement in the transition process, not informing us that she was seeking nursing facility placement until it had been acquired. This was not a traditional transition or discharge. Regardless of the incident details noted, SVNH has created a Discharge Summary document to supplement the BDDS Transition Form</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All the residents in the home have the potential to be affected by this deficient practice. All future discharges will incorporate the Discharge Summary Form.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The Group Home Director will be</p>		02/18/2012

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			responsible to complete the discharge summary information and document to be included in any future transition processes.	

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W0252	<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 to document behavioral interventions for 1 of 4 sampled clients (client #3).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 01/26/2012 at 1:05 p.m.</p> <p>An "Interdisciplinary Team Note," dated 01/24/2012, indicated, "...Discussion...Stated he is having thoughts of suicide...BC (Behavioral Consultant) recommend (sic) that staff complete 15 minute visual checks until further notice...." There was no documentation to indicate the 15 minute checks had been completed.</p> <p>During an interview on 01/27/2012 at 11:15 a.m., Team Leader #1 (TL #1) stated, "The 15 minute checks should have occurred around the clock." TL #1 indicated there was no documentation in the client's record to indicate the checks had been completed and indicated the work shop staff had not been informed of the 15 minute visual checks.</p>	W0252	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>Behavior plan addendum, suicide precautions and procedures as well as documentation sheet was provided to home and day program provider. Procedure was reviewed with IDT. ISP is updated to include all revised behavior information.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>No other residents were identified to have this particular psychiatric/behavior need. All individuals will continue to receive behavior services consistent with their identified need and as indicated by regulatory requirements. All other program needs and documentation were reviewed as noted in W255. Please see W255 for correction, monitoring of documentation.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The program implementation will be reviewed weekly by the Team Leader and/or QMRP for effectiveness in addition to the monthly overall case management</p>	02/18/2012			

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	9-3-4(a)		<p>review.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. Behavior Consultant is onsite at least monthly or as requested to monitor progress, concerns of behavior plan. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards. Director will complete random chart audit at least one chart per month for all facilities to provide oversight. All facility charts are audited by the QMRP team at least annually.</p>		

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W0255	<p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.</p> <p>Based on interview and record review for 2 of 4 sampled clients (#3 and #4), the Qualified Developmental Disabilities Professional (QDDP), failed to revise the clients' Individual Support Plan (ISP) objectives when the clients completed the objectives.</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 1/26/12 at 10:30 AM. Client #4's 3/8/11 ISP indicated client #4 had an objective to participate in an activity Wii game with a housemate 16/30 trials for 3 months. Client #4's 10/11 GH (Group Home) Case Management note indicated client #4 completed the objective 16/30 trials in 10/11, 24/30 trials in 11/11 and 18/30 trial in 12/11. Client #4's 1/12 data sheet indicated client #4's objective/criteria had not been revised as client #4 had achieved the stated objective.</p> <p>Client #4's 3/8/11 ISP indicated client #4 had an objective to serve herself 1/1/2 portions of an entree at dinner with 1 or less verbal cue for 20/30 trials for 3</p>	W0255	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>All goals for the identified individuals were reviewed and revised as indicated by assessment and IDT. Goals and overall ISP current.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All individuals have the potential to be affected by this deficient practice. All individuals records and treatment plans were reviewed and incorporated into the above corrective action. Any non current, non progressing goal or treatment plan will be revised.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The Team Leader/QDDP group for all facilities reviewed the documents used for goals, data, case management and monthly progress notes. These forms were revised to better facilitate the Team Leader and QDDP accurately reviewing and revising goals. See attached form</p>	02/18/2012			

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	<p>months. Client #4's 10/11 case management note indicated client #4 completed the objective 28/30 trials for 10/11, 28/30 trials for 11/11 and 23/30 trials for 12/11. Client #4's 1/12 data sheet indicated client #4's objective/criteria had not been revised as client #4 had achieved the stated objective.</p> <p>Interview with the QDDP and Team Leader #1 on 1/27/12 at 10:30 AM indicated client #4 had met the above mentioned objectives. TL #1 indicated client #4's objectives were due for review and would be revised at that time.</p> <p>2. Client #3's record was reviewed on 01/26/2012 at 10:15 a.m.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: November 2010," indicated client #3 had a toileting objective for "notify overnight staff when needing to use uringal (sic) 16/30 trials for 3 months." Program data indicated client #3 completed 26/30 trials</p>		<p>revisions.</p> <p>The Team Leader and/or QMRP are also reviewing the daily notes, the program data books and the medication administration record routinely, at minimum weekly to ensure staff are adequately documenting and implementing the goals as well as the effectiveness of said goals.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards. Director will conduct random home chart audits to monitor ongoing compliance. At minimum one chart from each facility will be randomly audited.</p>				

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	<p>in 01/2011, 28/30 trials in 02/2011, 18/30 trials in 03/2011, and 24/30 trials in 04/2011.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: November 2010," indicated client #3 had a bathing skills objective for "lather shampoo for hair w/staff assistance 16/30 trials for 3 months." Program data indicated client #3 completed 28/30 trials in 01/2011 and 02/2011, 30/30 trials in 03/2011, and 27/30 trials in 04/2011.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: November 2010," indicated client #3 had a dressing skills objective for "put on shirt w/staff assistance 16/30 trials for 3 months. Program data indicated client #3 completed 27/30 trials in 01/2011, 28/30 trials in 02/2011, 30/30 trials in 03/2011, and 25/30 trials in 04/2011.</p> <p>"GH (Group Home QMRP (Qualified Mental Retardation Professional) Case Management" notes dated, May 2011, June 2011, July 2011, and August 2011 indicated, "...All goals being revised....." "GH QMRP Case Management" note dated, September 2011, indicated, "...All goals being revised and set to begin October 1...."</p>			
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	<p>During an interview on 01/27/2012 at 11:15 a.m., Team Lead #1 (TL #1) indicated training objectives were not revised when criteria for skills acquisition was met. The QDDP (Qualified Developmental Disabilities Professional) indicated he was aware the skills training objectives had not been revised when client #3 obtained completion criteria prior to October 1, 2011.</p> <p>9-3-4(a)</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2012
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W0257	<p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>Based on record review and interview, the facility failed to revise individual program plan goals for 1 of 4 sampled clients (client #3) who failed to progress toward identified objectives.</p> <p>Findings include:</p> <p>Client #3's record was reviewed on 01/26/2012 at 10:15 a.m.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: November 2010," indicated client #3 had a personal interest objective to, "participate in a Wii activity 10/30 trials for 3 months." Program data indicated skill acquisition 0/30 trials for 01/2011, 02/2011, 03/2011 and 1/30 trials for 04/2011.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: November 2010," indicated client #3 had a medication knowledge objective to, "state reason for Primidone 16/30 trials for 3 months." Program data indicated</p>	W0257	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>All goals for the identified individuals were reviewed and revised as indicated by assessment and IDT. Goals and overall ISP current.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All individuals have the potential to be affected by this deficient practice. All individuals records and treatment plans were reviewed and incorporated into the above corrective action. Any non current, non progressing goal or treatment plan will be revised.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>The Team Leader/QDDP group for all facilities reviewed the documents used for goals, data, case management and monthly progress notes. These forms were revised to better facilitate the Team Leader and QDDP accurately reviewing and revising goals. See attached form</p>	02/18/2012	

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	<p>skill acquisition 1/30 trials in 01/2011, 0/30 trials in 02/2011, 03/2011, and 04/2011.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: November 2010," indicated client #3 had a money management objective to, "will turn in \$5 sent by parents to petty cash 4/30 trials for 3 months." Program data indicated skill acquisition 1/30 trials in 01/2011, 2/30 trials in 02/2011, 1/30 trials in 03/2011, and 0/30 trials in 04/2011.</p> <p>"GH (Group Home QMRP (Qualified Mental Retardation Professional) Case Management" notes dated, May 2011, June 2011, July 2011, and August 2011 indicated, "...All goals being revised...." "GH QMRP Case Management" note dated, September 2011, indicated, "...All goals being revised and set to begin October 1...."</p> <p>During an interview on 01/27/2012 at 11:15 a.m., Team Lead #1 (TL #1) indicated training objectives were not revised when criteria for skills acquisition was not met. The QDDP (Qualified Developmental Disabilities Professional) indicated he was aware the skills training objectives had not been revised when client #3 failed to make progress toward skill acquisition prior to October 2011.</p>		<p>revisions.</p> <p>The Team Leader and/or QMRP are also reviewing the daily notes, the program data books and the medication administration record routinely, at minimum weekly to ensure staff are adequately documenting and implementing the goals as well as the effectiveness of said goals.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The QMRP will review the monthly case management reviews to ensure that assessments remain current and accurate as well as monitor progression/regression on goals. The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards. Director will conduct random home chart audits to monitor ongoing compliance. At minimum one chart from each facility will be randomly audited.</p>				

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W0331	<p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed to ensure nursing services followed up on recommendations and/or obtained reports for 2 of 4 sampled clients (clients #1 and #4).</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 01/26/2012 at 1:05 p.m.</p> <p>A "Medical Appointment/New Order Form," dated 05/23/2011, indicated, "...Speech evaluation completed: Full report to follow...." The record did not include documentation to indicate a report with findings/recommendations had been received.</p> <p>A physician's order, dated 08/13/2011, indicated, "...CT (computed tomography: x-ray) scan of Abdomen & Pelvis....Dx diagnosis: LUQ (left upper quadrant) abdominal pain...." The record did not indicate the test had been completed and/or a report with findings/recommendations had been received.</p> <p>A "Quarterly Nutrition Review" dated 09/11/2011, indicated, "...Consult MD</p>	W0331	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice? Speech evaluation was obtained for identified individual. Evaluation indicated no recommended speech therapy or follow up. IDT reviewed eval and recommendations and ISP was updated with current information. CTScan is under evaluation by physician. IDT will review and implement follow up action once physician determines current necessity for this test. This individual is presently under close observation by physician pending a back rod repair surgery in March. Bone density test was reviewed with physician, ordered and appt is scheduled. Additional individual has seen her primary care physician, refused examination. She is presently referred to ob/gyn for exam under anesthesia. Present action at time of report is the signing of consent by her state appointed guardian and scheduling of appointment post consent. It is anticipated these actions will be completed by March 1, appt pending physician availability. How are other residents identified that could have the potential for also being affected by the same deficient practice? All residents have the potential to be affected by this deficient practice. All</i></p>	02/18/2012			

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	<p>(Medical Doctor) if bone test is needed due to dx (diagnosis) of seizure disorder and if on anti-seizure meds long term...."</p> <p>The record did not include documentation to indicate the physician had been consulted regarding a bone density test.</p> <p>During an interview on 01/27/2012 at 11:15 a.m. RN #1 indicated she could not verify the CT scan had been completed and did not have results from the speech evaluation. RN #1 indicated there was no documentation in the client's record to indicate the physician was consulted in regards to obtaining a bone density test.</p> <p>An email correspondence received from Administrative Staff #1 on 01/30/2012 at 1:41 p.m. indicated, "We were not able to produce the CTScan (sic) or Speech Evaluation documentation at this time...."</p>		<p>other resident records have been reviewed and are current on physician appointments. This deficient practice was a transition oversight during change in nursing role. <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i> The nurse consultant will review the medical chart monthly and submit an appointment form to the Team Leader of the home. The Team Leader will schedule the necessary appointments according to the home schedule and return the appointment form to the nurse with all necessary appointments documented as scheduled with date and time. All recommended tests, labs, consultations and appointments since transition of nurse role have been current and addressed timely. <i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i> The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards. Director will complete monthly random nursing chart audit to increase oversight.</p>	

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2.	<p>Client #4's record was reviewed on 1/26/12 at 10:20 AM. Client #4's 2/1/11 fax note indicated "[Client #4] has not had a menses since she moved in. She is unable to tell me if she had a hysterectomy. Do you want to get any labs to determine The (sic) reason for she isn't menstrating (sic)? She is on no medication to cause this." The 2/1/11 fax indicated client #4's doctor responded "No need (for labs). If she is due for pap will be happy to refer her to gyn (gynecologist) or do it in clinic."</p> <p>Client #4's record and/or medical notes from 2/1/11 to 1/26/12 indicated client #4 did not have a pap examination completed.</p> <p>Interview with RN #1, Team Leader (TL) #1 and the Qualified Developmental Disabilities Professional (QDDP) on 1/27/12 at 10:30 AM indicated client #4 had not seen a gynecologist and/or had a pap examination completed. QDDP #1 stated he thought the pap examination was "declined" by the client's guardian due to client #4's past sexual abuse. RN #1 indicated she was not able to locate a pap examination and/or documentation the examination was refused/declined.</p> <p>9-3-6(a)</p>			
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W0336	<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 interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's nursing services failed to conduct quarterly nursing assessments/examinations.</p> <p>Findings include:</p> <p>1. Client #4's record was reviewed on 1/26/12 at 10:20 AM. Client #4's record indicated client #4 had 3 quarterly nursing assessments completed in the past year dated 1/19/11, 4/26/11 and 10/27/11. Client #4 did not have a nursing quarterly assessment completed in 7/11. Client #4's 3/8/11 Individual Support Plan (ISP) did not indicate client #4 required a medical care plan.</p> <p>Client #2's record was reviewed on 1/26/12 at 12:15 PM. Client #2's record indicated client #2 had 2 nursing quarterly assessments completed on 3/31/11 and on 10/27/11 for the past year. Client #4's 11/29/11 ISP did not indicate client #2 required a medical care plan.</p> <p>Interview with administrative staff #1, RN #1 and Team Leader (TL) #1 on 1/27/12 at 10:30 AM indicated they could</p>			W0336	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>This deficiency was noted at time of change in nursing role. There was no ethical way to create the quarterly physical assessments that were noted to be missing during audit. Present nurse has all physical assessments scheduled, up to date since her assignment to role.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All other residents were assessed to have been affected by deficient practice. All resident records are current.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p>Deficient practice was being monitored by turning the quarterly assessments into the Director by the 5 th of the next month. That practice was occurring and the lack of consistent paperwork was being monitored by Director, resulting in a change in the nursing role.</p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p>		02/18/2012

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	<p>not locate any additional quarterly nursing assessments/examinations. RN #1 indicated she became the nurse for the group home on 12/1/11. Administrative staff #1 stated the facility "had nursing issues in the home" with a previous nurse for the group home.</p> <p>2. Client # 1's record was reviewed on 01/26/2012 at 1:05 p.m. Client #1's record indicated an admission nursing evaluation was completed on 05/12/2011 and a quarterly nursing evaluation was completed on 10/27/2011. There was no documentation to indicate a quarterly nursing evaluation was completed between those dates.</p> <p>Client #3's record was reviewed on 01/26/2012 at 10:15 a.m. Client #3's record indicated quarterly nursing evaluations were completed on 01/31/2011, 04/30/2011 and 10/27/2011. There was no documentation to indicate a quarterly nursing evaluation was completed between 04/30/2011 and 10/27/2011.</p> <p>During an interview on 01/27/2012 at</p>		<p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this an all other deficient standards. The Director will conduct random monthly nursing chart audit. At least one random chart from any facility will be audited monthly to ensure documentation compliance.</p>				

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	<p>10:55 a.m., RN #1 indicated a quarterly nursing evaluation had not been completed for clients #1 and #3 during July 2011.</p> <p>During an interview on 01/27/2012 at 10:55 a.m., administrative staff #1 indicated the previous facility nurse had not completed quarterly nursing evaluations in July 2011.</p> <p>9-3-6(a)</p>			
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W0488	<p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, interview and record review for 3 of 4 sampled clients (#1, #2 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure the clients participated in all aspects of meal preparation as their skills allow.</p> <p>Findings include:</p> <p>During the 1/25/12 observation period between 3:10 PM and 5:50 PM, at the group home, client #7 washed raw carrots at the sink. Client #2 stirred Splenda and butter in the carrots on the stove with hand over hand assistance from staff #2. Client #2 stirred the macaroni and cheese with hand over hand assistance. Client #2 also stirred/made the Koolaid with hand over hand assistance. Clients #4 and #8 set placemats and forks on the table. Staff #2 then went and placed spoons and butter knives at each place setting without encouraging clients #4 and #8 to finish setting the table as the clients were in the dining room area. Once the carrots, chicken patties and macaroni and cheese were done cooking, staff #2 placed the chicken patties, macaroni and cheese and carrots into serving bowls/dishes without involving clients #1, #2, #4, #5 and #8</p>	W0488	<p><i>What corrective action will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>Identified individuals have been assessed to have current appropriate meal preparation goals. ISP has been updated to include goals. All staff were retrained on the areas of improvement that were identified.</p> <p><i>How are other residents identified that could have the potential for also being affected by the same deficient practice?</i></p> <p>All other residents were assessed to current and appropriate goals and updated ISPs.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</i></p> <p><i>How will the corrective action be monitored to ensure the deficient practice will not recur?</i></p> <p>The Team Leader and/or QMRP will be onsite at the home at least daily. The Director will be onsite at the home routinely, no less than weekly. The Director will meet with the Team Leader, QMRP and nurse consultant weekly on progression toward corrective action for this and all other deficient standards. The Director will conduct random monthly nursing chart audit. At least one random chart from any</p>	02/18/2012			

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	<p>who were sitting at the dining room table watching staff. Staff #2 poured client #2's drink without involving the client. At 3:36 PM, client #5 went into the kitchen to get himself a cup of coffee. Staff #3 stopped client #5 and told client #5 she would get it for him. Staff #3 took the cup and poured client #5 a cup of coffee without allowing the client to get the coffee himself.</p> <p>During the 1/26/12 observation period between 6:10 AM and 8:30 AM, at the group home, staff #1 placed water on the stove to boil for oatmeal. Staff #1 then retrieved oatmeal packets, opened them and poured them into the boiling water on the stove. Staff #1 then placed slices of bread into a toaster, removed when done and placed the toast on a platter. Staff #1 then walked to the refrigerator and retrieved butter for the toast. At 6:58 AM, Team Leader (TL) #1 told staff #1 to have a client assist her. Staff #1 finished making the toast without involving clients #1, #2, #4, #5, #6, #7 and #8. Staff #1 retrieved cheese slices from the refrigerator and placed them in a dish. Staff #1 did not involve client #1 who was in the kitchen area, but had client #1 carry the platter of cheese to the table. Staff #2 served client #2 two slices of toast without involving the client, poured juice for clients #2 and #7 and served</p>		<p>facility will be audited monthly to ensure documentation compliance.</p>				

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	<p>clients #2 and #7 oatmeal without involving the clients.</p> <p>Interview with client #8 on 1/26/12 at 7:00 AM when asked who cooked breakfast at the group home, client #8 stated "Staff does." Client #8 indicated he would set the table and wash dishes.</p> <p>Interview with administrative staff #1, TL #1 and the Qualified Developmental Disabilities Professional (QDDP) on 1/27/12 at 10:30 AM indicated staff should encourage clients to participate in meal preparation. The QDDP and TL #1 indicated clients #2 and #7 could serve themselves and pour drinks with hand over hand assistance. Administrative staff #1, the QDDP and TL #1 indicated client #5 should be allowed to get his own coffee without staff doing it for him.</p> <p>9-3-8(a)</p>						