

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 03/26/2012
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 post certification revisit (PCR) to the recertification and state licensure survey completed on 01/26/2012.</p> <p>This visit was in conjunction with the investigation of complaint #IN00104671.</p> <p>Dates of Survey: March 22, 23, and 26, 2012.</p> <p>Facility Number: 001077 Provider Number: 15G563 AIMS Number: 100245490</p> <p>Surveyor: Brenda Nunan, RN, CDDN, PHNS III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/2/12 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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W0140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview, the facility failed to maintain a complete accounting of the client's cash on hand at the group home for 1 of 4 sampled clients (client B).</p> <p>Findings include:</p> <p>Client B's financial records were reviewed on 03/22/2012 at 2:05 p.m. Client B's March 2012 Finance Ledger indicated the client had \$23.89 COH (cash on hand). Client B had \$23.99 actual COH in his pocket folder.</p> <p>During an interview on 03/22/2012 at 2:05 p.m., the House Manager indicated she did not know why client B's COH was off by ten cents.</p> <p>9-3-2(a)</p>	W0140	<p>What corrective action will be accomplished for these residents found to have been affected by the deficient practice</p> <p>Client B finances were reconciled. It is undetermined why he had an additional dime in his cash ledger. How will facility identify other residents who have the potential to have been affected by this action and what corrective action will be taken</p> <p>The client funds are well safeguarded by the following means. The Team Leader and Lead Skills Trainer have the only access to the cash ledgers. In the event cash is left out for outings, etc. the staff signs out the cash and returns the change in an envelope to be redeposited. At minimum, the Team Leader is in the cash envelopes weekly to reconcile, monitor expenses, etc.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>The QDDP will also monitor the cash ledger balances to cash on hand weekly</p> <p>How the corrective actions will be monitored to ensure the practice does not recur.</p>	04/10/2012	

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			The oversight by St. Vincent New Hope to all client finances is as follows. The check and cash ledger are reconciled at the end of each month and submitted to Quality Assurance Department. That department audits each financial envelope to ensure that expenses are legitimate, receipts are present and balances match. If there is any discrepancy the financial envelope is returned to the QDDP or the Director for correction. In addition, a full financial audit occurs annually for each individual.	

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W0257	<p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE 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 3 of 4 sampled clients who failed to progress toward identified objectives (clients A, C, and D).</p> <p>Findings include:</p> <p>1. Client A's record was reviewed on 03/23/2012 at 1:50 p.m.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: 10/1/2011," indicated client A had an objective for stirring a side dish with hand over hand assistance 16/30 trials for 3 months. Program data indicated skill acquisition 0/30 trials in 11/2011 and 12/2011, 1/30 trials in 01/2012, and 0/30 trials in 02/2012.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: 10/1/2011," indicated client A had an objective for applying toothpaste to bristles 50/60 trials for 6 months.</p>	W0257	<p>What corrective action will be accomplished for these residents found to have been affected by the deficient practice</p> <p>All goals for all individuals are revised. The general timeframe for revision in the past was determined at 6 months, unless there were gross indications for revision or if they achieved earlier. The new case management documents have worked well to facilitate that the goals in all areas are present and current progression is made. The Team Leader and QDDP team reviewed the findings and will be more diligent in revision at an earlier stage, at most quarterly.</p> <p>How will facility identify other residents who have the potential to have been affected by this action and what corrective action will be taken</p> <p>All resident records were reviewed and updated.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>QDDP will continue to complete monthly review of program</p>	04/10/2012	

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	<p>Program data indicated skill acquisition 10/11 trials in 10/2011, 26/60 trials in 11/2011, 5/60 trials in 12/2011, 3/60 trials in 01/2012, and 1/30 (data not collected for 60 trials) in 2/2012.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: 10/1/2011," indicated client A had an objective for handing money to the cashier 8/30 trials for 6 months. Program data indicated skill acquisition 1/30 trials in 10/2011, 0/30 trials in 11/2011, 0/30 trials in 12/2011, 1/30 trials in 01/2012, and 0/30 trials in 02/2012.</p> <p>During an interview on 03/23/2012 at 2:45 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated he was aware the skills training objectives had not been revised when client A failed to make progress toward skill acquisition.</p> <p>2. Client C's record was reviewed on 03/23/2012 at 11:15 a.m.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: (date not entered)," indicated client C had an objective for making a sandwich for lunch 20/30 trials for 3 months. Program data indicated skill acquisition 6/30 trials in 10/2011, 3/30 trials in 11/2011, 0/30</p>		<p>implementation and progress. Team has modified its timeframe for revision.</p> <p>How the corrective actions will be monitored to ensure the practice does not recur.</p> <p>Director will continue to conduct random home and nursing chart audits, one chart per month minimum, in addition to routine on site visits.</p>				

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	<p>trials in 12/2011, 0/30 trials in 01/2012, and 0/30 trials in 02/2012.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: (date not entered)," indicated client C had an objective for flossing her teeth 40/60 trials for 3 months. Program data indicated skill acquisition 42/60 trials in 10/2011, 35/60 trials in 11/2011, 37/60 trials in 12/2011, 35/60 trials in 01/2012 and 6/60 trials in 02/2012.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: (date not entered)," indicated client C had an objective for handing money to the cashier for transaction 8/30 days for 3 months. Program data indicated skill acquisition 4/30 trials in 10/2011, 0/30 trials in 11/2011, 12/2011, 01/2012, and 02/2012.</p> <p>During an interview on 03/23/2012 at 2:45 p.m., the QDDP (Qualified Developmental Disabilities Professional) indicated he was aware the skills training objectives had not been revised when client C failed to make progress toward skill acquisition.</p> <p>3. Client D's record was reviewed on 03/23/2012 at 10:02 a.m.</p>						

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	<p>The "Community Living Objective Progress" note, dated "Initiation Date: 10/1/2011," indicated client D had an objective for notifying staff after having a BM (bowel movement) 20/30 trials for 3 months. Program data indicated skill acquisition 17/30 trials in 10/2011, 13/30 trials in 11/2011, 10/30 trials in 12/2011, 0/30 trials in 01/2011. Data was not recorded for 02/2012.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: 10/1/2011," indicated client D had an objective for taking money to the workshop to buy a snack 10/30 trials. Program data indicated skill acquisition 0/30 trials in 10/2011, 11/2011, 12/2011, and 01/2012. Data was not recorded for 02/2012.</p> <p>The "Community Living Objective Progress" note, dated "Initiation Date: 10/1/2011," indicated client D had an objective for measuring laundry detergent 4/30 trials for 3 months. Program data indicated skill acquisition 2/30 trials in 10/2011, 0/30 trials in 11/2011, 12/2011, and 01/2012. Data was not recorded for 02/2012.</p> <p>During an interview on 03/23/2012 at 2:45 p.m., the QDDP (Qualified Developmental Disabilities Professional)</p>						

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	<p>indicated he was aware the skills training objectives had not been revised when client D failed to make progress toward skill acquisition.</p> <p>This deficiency was cited on 01/26/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			

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W0260	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section.</p> <p>Based on record review and interview, the facility failed to review and revise the Individual Support Plan (ISP) for 1 of 4 sampled clients (client C).</p> <p>Findings include:</p> <p>Client C's record was reviewed on 03/23/2012 at 11:15 a.m. The record indicated the current ISP was dated 03/08/2011.</p> <p>During an interview on 03/23/2012 at 12:35 p.m., the Qualified Developmental Disabilities Professional (QDDP) indicated the ISP had not been scheduled in time for the annual review.</p> <p>9-3-4(a)</p>	W0260	<p>What corrective action will be accomplished for these residents found to have been affected by the deficient practice Client C has had annual ISP on 3/29/12. The timeline for all residents was in the process of revision to move their annuals to 2 month span. This is to better coordinate ISP, consents, BDDS notification, etc. Client C had an annual scheduled in the timeframe to be compliant, but rescheduling did cause it to be delayed. How will facility identify other residents who have the potential to have been affected by this action and what corrective action will be taken All resident records were reviewed and all ISP are current and contained within the smaller timeframe for update. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur The process of revising the home annual ISP dates is the attempt to better manage 8 ISP dates and the corresponding documentation more efficiently. How the corrective actions will be monitored to ensure the practice</p>	04/10/2012	

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			does not recur. Director will continue to conduct random home and nursing chart audits, one chart per month minimum, in addition to routine on site visits.		

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W0323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview, the facility failed to ensure annual evaluation of vision was obtained for 1 of 4 sampled clients (client A).</p> <p>Findings include:</p> <p>Client A's record was reviewed on 03/23/2012 at 1:50 p.m.</p> <p>A Medical Summary Progress Report indicated client A had an eye examination on 10/29/2008. The record did not indicate client A had an annual vision screening.</p> <p>During an interview on 03/23/2012 at 2:20 p.m., the Qualified Developmental Disabilities Professional (QDDP) indicated he was unable to locate documentation of vision screening during the past year.</p> <p>9-3-6(a)</p>	W0323	<p>What corrective action will be accomplished for these residents found to have been affected by the deficient practice</p> <p>Vision screening was completed for client A.</p> <p>How will facility identify other residents who have the potential to have been affected by this action and what corrective action will be taken</p> <p>Team Leader and Nurse Consultant have a tracking system to monitor all appointments.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>QDDP will monitor the appointments monthly to ensure they are complete.</p> <p>How the corrective actions will be monitored to ensure the practice does not recur.</p> <p>Director will continue to conduct random home and nursing chart audits, one chart per month minimum, in addition to routine on site visits.</p>	04/10/2012	

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W0331	<p>483.460(c) NURSING SERVICES 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 followed up on health recommendations for 1 of 4 sampled clients (client D).</p> <p>Findings include:</p> <p>Client D's record was reviewed on 03/23/2012 at 10:02 a.m.</p> <p>During observations on 03/22/2012 between 3:00 p.m. and 6:15 p.m., client D did not wear a left knee immobilizer and did not apply ice to his knee after he returned from the work day.</p> <p>A Quarterly Nutrition Review, dated 11/21/2011, indicated, "...Monitor glucose (blood sugar)-hx (history) high glucose...."</p> <p>A "Notice of Medicaid Non-Covered Services," dated 02/01/2012 indicated, "...Short knee immobilizer...." The record did not indicate a schedule for wearing the immobilizer.</p> <p>A "Medical Appointment/New Order Form," dated 02/21/2012, indicated,</p>	W0331	<p>What corrective action will be accomplished for these residents found to have been affected by the deficient practice D/C order for ice and knee immobilizer was obtained. Glucose was reviewed with physician How will facility identify other residents who have the potential to have been affected by this action and what corrective action will be taken Group Home Director met with dietary staff to stream line and develop a format for recommendations as the present one did not facilitate adequate follow up. Dietary recommendations that need physician response will come with a physician communication memo from the dietician that the nurse will then be able to use to resolve recommendation.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur Director, QDDP, Nurse Consultant and Team Leader will continue to meet monthly to review each individual's care plan, risk issues, and overall needs. How the corrective actions will be monitored to ensure the practice</p>	04/10/2012			

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	<p>"...use ice (medical symbol for after) work day to (medical symbol for decrease) soreness."</p> <p>During an interview on 03/23/2012 at 12:30 p.m., RN #1 indicated she had not addressed the dietary recommendation regarding monitoring glucose. She indicated she was not aware of any concerns related to client D's blood sugars. The RN indicated she did not obtain an order for discontinuing ice to client D's left knee after the work day. She stated, "I didn't think I needed an order to discontinue ice." The RN indicated the knee immobilizer had been verbally discontinued on 02/28/2012 but she did not obtain a written order to discontinue the immobilizer prior to 03/23/2012.</p> <p>This deficiency was cited on 01/26/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a).</p>		<p>does not recur.</p> <p>Director will continue to conduct random home and nursing chart audits, one chart per month minimum, in addition to routine on site visits.</p>		