

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G747	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/13/2012
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NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 721 W 73RD INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for a fundamental recertification and state licensure survey and the investigation of complaint #IN00105257.</p> <p>Complaint #IN00105257: Substantiated, Federal/State deficiency related to the allegation(s) is cited at W368.</p> <p>Survey dates: April 9, 11, 12, 13, 2012</p> <p>Facility Number: 011516 Provider Number: 15G747 AIM Number: 200900320</p> <p>Survey Team: Brenda Nunan, RN, CDDN, PHNS III</p> <p>These deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 4/22/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, the governing body failed to exercise general policy and operating direction to ensure 5 of 10 reportable medication errors were reported to the appropriate oversight agencies within 24 hours of the occurrence for 2 of 2 sampled clients (clients A and B) and 2 additional clients (clients C and D).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations from 05/23/2011 through 03/03/2012 were reviewed on 04/09/2012 at 12:30 p.m.</p> <p>1. An Indiana Division of Disability and Rehabilitative Services report, indicated a medication error that occurred on 05/23/2011 at 8:00 a.m. was not reported until 09/01/2011. The record indicated client D did not receive his 8:00 a.m. dose of Vitamin D-3, 5000 units on 05/23/2011.</p> <p>2. An Indiana Division of Disability and Rehabilitative Services report, indicated a medication error that occurred on 07/02/2011 at 8:30 a.m. was not reported</p>	W0104	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i> Incident 5/23/11 and 7/2/11 were reported late after internal reporting policy change was revised to comply with BQIS medication error reporting change effective 3/1/11. In 8/2011 SVNH altered its reporting policy to include all medication errors and no longer discern whether it was reportable based on jeopardizing health and safety of the individual. Upon policy change it was determined to report prior incidents which should have been reported despite being late. These 2 errors occurred prior to policy change and were reported upon change in policy. For incidents 10/5/11 and 10/6/11, Manager discovered incidents during routine review of medication administration record. Reviews were scheduled and completed weekly, but had not consistently including pulling the bubble packs to compare to the medication administration record. Upon discovery of errors, TL responded swiftly with retraining, disciplinary action and increased oversight to medication administration. <i>How will other residents be identified as having the potential to be</i></p>	05/13/2012			

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	<p>until 09/01/2011. The record indicated client C was given Mirtazapine (antidepressant) 45 mg at 8:30 a.m. instead of the prescribed time of 8:30 p.m.</p> <p>3. An Indiana Division of Disability and Rehabilitative Services report, indicated a medication error that occurred on 10/05/2011 at 8:00 p.m., was not reported until 10/25/2011. The record indicated client C did not receive Mirtazapine on 10/05/2011 as prescribed at 8:00 p.m.</p> <p>4. An Indiana Division of Disability and Rehabilitative Services report, indicated a medication error that occurred on 10/05/2011 at 8:00 p.m. was not reported until 10/26/2011. The record indicated client A received an extra dose of Certizine (allergy medication) 10 mg on 10/05/2011 at 8:00 p.m.</p> <p>5. An Indiana Division of Disability and Rehabilitative Services report, indicated a medication error that occurred on 10/06/2011 at 8:30 p.m. was not reported until 10/26/2011. The record indicated client D received an extra dose of Calcium 500 mg on 10/06/2011 at 8:00 p.m.</p> <p>An undated, "Medication Error Guidelines" was reviewed on 04/11/2012</p>		<p><i>affected by the same deficient practice and what corrective action will be taken.</i> All residents have the potential to be affected by this practice. All other medication records were reviewed at the time of error and continued weekly. Medication administration records indicated no further errors have occurred. There was one additional error by staff on 3/2/12 which was documented as given and was discovered in investigation when a report from client B indicated there was an unreported error. <i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i> Team Leader has increased oversight to the medication administration to 2 times weekly. At least 1 time weekly the bubble packs will be reviewed to ensure they match the medication administration record. Team Leader also implemented a system in which the staff review the medication administration record for each other prior to entering or leaving a shift (buddy check system). These were implemented at the discovery of 10/5/11 and 10/6/11 medication errors, have been effective oversight and will continue. Team Leader and/or QDDP will conduct unannounced weekly medication administration observations to ensure compliance with standard of med pass as well as accurate</p>		

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	<p>at 3:45 p.m. The policy indicated, "...If the error is a reportable event the team leader will complete a web based report and will send to BDDS (Bureau of Developmental Disabilities Services), Quality Assurance and other applicable recipients within 24 hours of the occurrence or knowledge of the event..."</p> <p>During an interview on 04/09/2011 at 1:30 p.m., the Group Home Director indicated, the facility strives for 100 % accuracy.</p> <p>During an interview on 04/11/2011 at 1:50 p.m., the Qualified Developmental Disabilities Professional (QDDP) and House Manager indicated the medication errors were reported after they were discovered during record audits.</p> <p>9-3-1(a)</p>		<p>documentation. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Team Leader will continue routine review of medication administration record, bubble packs and observed med passes. QDDP will continue to complete routine oversight of Team Leader steps, at minimum weekly. Director will continue monthly nursing and program chart and site reviews.</p>		

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, interview, and record review, the facility failed to address clients identified program and behavioral needs for 2 of 2 sampled clients (clients A and B).</p> <p>Findings include:</p> <p>1. During observations on 04/09/2011 between 4:00 p.m. and 6:45 p.m. and on 04/11/2011 between 7:00 a.m. and 8:35 a.m., client B did not wear a hearing aid in her right ear.</p> <p>Client B's record was reviewed on 04/09/2012 at 11:30 a.m. A hearing evaluation, dated 06/15/2011, indicated hearing was normal in the left ear and the right ear had severe to profound hearing loss. The record indicated, "...pursue HA (Hearing Aid...."</p> <p>During an interview on 04/11/2011 at 1:50 p.m., the House Manager indicated client B had a hearing aid but refused to use it. She indicated the Interdisciplinary Team (IDT) did not develop or implement training to encourage client B to wear the</p>	W0227	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The IDT reviewed adaptive equipment issue for Client B and hearing aid consultation is scheduled to assess appropriate clinical need. At that point, team will implement hearing aid and support Client B in utilizing this equipment. Client A Behavior Support Plan was developed to include specific guidelines to implement redirection, block hitting herself and implementing helmet as well as guidelines on when to appropriately remove the interventions. Team outlined behavior plan on 4/2/12. Behavior consultant finalized plan and will train staff on 5/10/12. HRC approval obtained. Guardian approval is pending signature on 5/9/12. 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 other resident records were reviewed. All other identified adaptive equipment needs are addressed, implemented and integrated into the Individual Support Plan.</i></p>	05/13/2012			

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	<p>hearing aid.</p> <p>2. During observations on 04/11/2011 between 7:00 a.m. and 8:35 a.m., client A hit herself on the left side of her head with the palm of her left hand 14 times. DSP (Direct Support Professional) #4 stated, "It's okay, don't do that," after client A hit herself the fifth time. She did not block or redirect client A from continuing to hit her head.</p> <p>Client A's record was reviewed on 04/09/2012 at 11:45 a.m. A Behavior Support Plan (BSP), dated 06/10/2011, indicated, "...Interventions for Target Behavior Self Injury: 1. Block [client A] from hitting herself or banging her head. 2. Tell [client A] "No" in a firm voice. 3. [client A] may cry, ignore her crying. 4. Redirect [client A] to engage in an activity...5. Continue to engage [client A] in an activity. 6. If [client A] continues to hit herself, contact nurse for PRN (as needed) pain medication...."</p> <p>During an interview on 04/11/2011 at 8:35 a.m., DSP #4 indicated client A should have been redirected from hitting herself in the head.</p> <p>During an interview on 04/11/2011 at 8:55 a.m., DSP #2 indicated staff try to redirect client A from the self injurious</p>		<p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Monthly IDT review of progress on this and all other support needs for each individual in the home. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Continue monthly review of program needs within a team IDT meeting. Continue monthly case management and nursing follow along to hearing aid implementation plan as outlined. ISP will be updated to include hearing aid status and other adaptive equipment as relevant. ISP is reviewed at minimum every 6 months to ensure appropriate supports are in place. Behavior Consultant continues to participate in monthly meetings as well as routine visits to home to meet with individuals and monitor progress and data. Director will continue to conduct random nursing and home chart audits.</p>		

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	<p>behavior. She stated a soft helmet would be "used depending on how hard she hits herself."</p> <p>During an interview on 04/11/2011 at 1:50 p.m., the House Manager indicated staff should have followed the BSP to redirect client A from hitting herself.</p> <p>9-3-4(a)</p>			

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W0273	<p>483.450(a)(3) CONDUCT TOWARD CLIENT Clients must not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a client did not discipline another client in the group home for 1 of 2 sampled clients (client B).</p> <p>Findings include:</p> <p>During observations in the group home on 04/09/2011 from 4:00 p.m. to 6:45 p.m. client B was observed redirecting and interfering in housemates' business/behaviors..</p> <p>At 5:15 p.m. client B and the House Manger were in the kitchen preparing the evening meal. Client B responded to her housemate's (client A) loud noises by stating, "Okay [client A], I know you're hungry," and "Okay [client A], she's (staff) hurrying." The House manager did not redirect client B from the comments.</p> <p>At 5:35 p.m., client C indicated she did not want a menu item. Client B offered menu substitutions. Client C declined, but the House Manager did not redirect Client B from assuming a "staff role."</p> <p>At 5:55 p.m., client A threw her</p>	W0273	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Team outlined behavior plan on 4/2/12. Behavior consultant finalized plan and will train staff on 5/10/12. HRC approval obtained. Health Care Rep approval is pending return of signature. Anticipated to be compliant with 5/13/12 correction date. 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. As mentioned in W227, client A behavior plan was revised as well to better specify use of interventions when she hits herself in the head. All other behavior plans were reviewed and remain appropriate. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur Monthly IDT review of progress on this and all other support needs for each individual in the home. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Behavior Consultant continues to participate in monthly meetings</i></p>	05/13/2012			

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	<p>silverware on the floor. Client B stated, "Be nice." DSP (Direct Support Professional) #1 and the House Manager were present in the dining room but did not redirect client B.</p> <p>Client B's record was reviewed on 04/09/2012 at 11:30 a.m. An Interdisciplinary Team (IDT) note, dated 02/09/2012, indicated, "...[client B] has to be encouraged to not jump into other clients conversations or business...."</p> <p>A Behavior Monthly Progress Report, dated February 2012, indicated, "...Discussed at IDT) meeting how to verbally cue [client B] and how to appropriately redirect when getting involved in housemates (sic) business...."</p> <p>During an interview on 04/11/2012 at 1:40 p.m., the House Manager stated client B "takes on a Mom role." She indicated it was a long time habit of client B to redirect other clients. The House Manager indicated staff should have redirected client B from interfering in other client's behaviors.</p> <p>9-3-5(a)</p>		<p>as well as routine visits to home to meet with individuals and monitor progress and data. Director will continue to conduct random nursing and home chart audits.</p>				

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W0336	<p>483.460(c)(3)(iii) NURSING SERVICES</p> <p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on interview and record review, the facility failed to ensure quarterly nursing assessments for 2 of 2 sampled clients (clients A and B).</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Client A's record was reviewed on 04/09/2012 at 11:45 a.m. Documentation indicated quarterly nursing evaluations were completed on 03/31/2011 and 09/03/2011, and 01/09/2012. There was no documentation to indicate a quarterly nursing evaluation was completed between those dates</li> <li>Client B's record was reviewed on 04/09/2012 at 11:30 a.m. Documentation indicated quarterly nursing evaluations were completed on 03/31/2011 and 09/13/2011, and 01/19/2012. There was no documentation to indicate a quarterly nursing evaluation was completed between those dates</li> </ol> <p>During an interview on 04/11/2011 at 1:50 p.m., the Qualified Developmental Disabilities Professional (QDDP)</p>	W0336	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>6/2011 quarterly physical assessments are not present in the chart. There is no way to create the document. This deficiency was discovered upon a change in the personnel for this caseload.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents were affected by this practice.</p> <p>All quarterly nursing physical assessments are completed at the same time for all residents in the home to better coordinate completion.</p> <p>Upon discovery of incomplete assessments, facility nurse implemented a plan to complete and reorganize the timelines. All quarterly physical assessments and nursing notes have been completed since this corrective action occurred.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p>	05/13/2012			

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	indicated he was aware the nurse did not complete nursing quarterlies in June 2011.  9-3-6(a)		All quarterly nursing physical assessments are submitted to the GH Director by the 5 th of the following month and then forwarded to the home chart. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Director will continue to receive monthly nursing notes and quarterly assessments from nurse consultants. Any untimely or inaccurate documentation will be addressed with the nursing team immediately.		

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W0368	<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.</p> <p>Based on record review and interview, the facility failed to ensure medications were administered without error for 2 of 2 sampled clients (clients A and B).</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 04/09/2012 at 12:30 p.m.</p> <p>1. An Indiana Division of Disability and Rehabilitative Services report, dated 10/26/2012 at 10:44 a.m., indicated client A received 2 doses of Certizine (allergy medication) 10 mg at 8:00 p.m. when she should have only received one dose.</p> <p>Client A's record was reviewed on 04/09/2012 at 11:45 a.m. Client A's physician's orders, dated 10/01/2012-10/31/2012, indicated, "...Certizine 10 mg at bedtime...."</p> <p>During an interview on 04/09/2012 at 2:10 p.m., RN #1 indicated the staff involved in the medication error received additional medication administration training. Training records indicated training occurred on 11/11/2011 and</p>	W0368	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Manager discovered incidents during routine review of medication administration record. Reviews were scheduled and completed weekly, but had not consistently including pulling the bubble packs to compare to the medication administration record. Upon discovery of errors, TL responded swiftly with retraining, disciplinary action and increased oversight to medication administration. 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 affected by this practice. All other medication records were reviewed at the time of error and continued weekly. Medication administration records indicated no further errors have occurred. There was one additional error by staff on 3/2/12 which was documented as given and was discovered in investigation when a report from client B indicated there was an unreported error. What measure will be put into place or what systemic changes will be made to ensure that the</i></p>	05/13/2012			

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NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 721 W 73RD INDIANAPOLIS, IN 46260			
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	<p>11/16/2011.</p> <p>2. An Indiana Division of Disability and Rehabilitative Services report, dated 03/03/2012 at 7:08 a.m., indicated client B received Amlodipine (blood pressure medication) 10 mg at the incorrect time of 7:00 a.m.</p> <p>Client B's record was reviewed on 04/09/2012 at 11:30 a.m.</p> <p>Client B's physician's orders, dated 03/01/2012-03/31/2012, indicated, "...Amlodipine 10 mg at 4:30 p.m....."</p> <p>During an interview on 04/11/2012 at 1:50 p.m., the QDDP indicated the staff responsible for the medication error was terminated due to excessive medication errors.</p> <p>This federal tag relates to complaint #IN00105257.</p> <p>9-3-6(a)</p>		<p><i>deficient practices does not recur</i></p> <p>Team Leader has increased oversight to the medication administration to 2 times weekly. At least 1 time weekly the bubble packs will be reviewed to ensure they match the medication administration record. Team Leader also implemented a system in which the staff review the medication administration record for each other prior to entering or leaving a shift (buddy check system). These were implemented at the discovery of 10/5/11 and 10/6/11 medication errors, have been effective oversight and will continue. Team Leader and/or QDDP will conduct unannounced weekly medication administration observations to ensure compliance with standard of med pass as well as accurate documentation. Team will be retrained on medication administration and reporting. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Team Leader will continue routine review of medication administration record, bubble packs and observed med passes. QDDP will continue to complete routine oversight of Team Leader steps, at minimum weekly. Director will continue monthly nursing and program chart and site reviews.</p>				