

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G522	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 10264 N COLLEGE INDIANAPOLIS, IN 46280
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: 2/28, 2/29 and 3/1/12</p> <p>Facility Number: 001036 AIM Number: 100245250 Provider Number: 15G522</p> <p>Surveyor: Paula Chika, Medical Surveyor III-Team Leader</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 3/08/12 by Dotty Walton, 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 interview and record review for 1 of 4 sampled clients (#2), the facility failed to ensure a complete accounting of the client's cash kept on hand.</p> <p>Findings include:</p> <p>Client #2's finances were reviewed on 2/29/12 at 8:05 AM. Client #2's February 2012 Cash Ledger sheet indicated client #2 had \$39.00 cash on hand (COH). Client #2 had \$29.01 in her money pouch. Client #2 did not have any receipts in the money pouch with the cash.</p> <p>Interview with Team Leader (TL) #1 on 2/29/12 at 8:09 AM indicated she did not know why client #2's COH did not match with the amount on the cash ledger sheet. TL #1 indicated client #2 may have went out on an outing. TL #1 indicated receipts should be placed in the money bag with the cash if the client had made an expenditure/purchase.</p> <p>9-3-2(a)</p>	W0140	<p><i>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The individual had made a purchase and her cash envelope was updated. The receipt for purchase justified the purchase.</p> <p><i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p> <p>All residents have the potential to be affected by this practice. All resident funds were reviewed and no other resident funds were without proper documentation.</p> <p><i>What measures will be put in place or what systematic changes will be made to ensure that the deficient practices does not recur?</i></p> <p>Team Leader will retrain all staff on the in home cash procedures. Those procedures will be in writing. The Team Leader will review the cash envelopes 3 times a week to ensure that daily practice follows the in home procedures and that funds are accounted for.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p>	03/31/2012			

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			St. Vincent New Hope has established a money management policy for all individuals in which we have responsibility for their funds. The procedure includes a monthly review of all resident funds, cash and checking by the Team Leader and the Manager/QDDP of the home. The financial envelopes for all residents are then submitted to St. Vincent New Hope Quality Assurance at which point they are reviewed again to ensure purchases are appropriate, receipts are present and funds are accounted for.		

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W0263	<p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on interview and record review for 1 of 2 sampled clients with restrictive programs (#2), the facility failed to obtain written informed consent for the restrictive program.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 2/29/12 at 1:20 PM. Client #2's February 2012 physician's orders indicated client #2 received Risperdal 0.5 milligrams at bedtime for mood disorder/behaviors.</p> <p>Client #2's 11/1/11 Behavior Support Plan (BSP) indicated client #2 demonstrated physical aggression. Client #2's 11/1/11 BSP indicated facility staff could utilize a "clothing release...One wrist/one hand....One wrist/two hand..." and/or a "...Two wrists/two hand" techniques to get out of grabs/holds.</p> <p>Client #2's 4/26/11 Individual Support Plan (ISP) did not indicated the client had a guardian. Client #2's 4/26/11 ISP and/or 11/1/11 BSP indicated client #2 and/or her parents gave written informed consent in regard to the above mentioned</p>	W0263	<p><i>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>The Team Leader will set a specific time to go to the family home to obtain signatures from this particular family. Their compliance with signatures varies when attempted by mail.</p> <p><i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p> <p>All residents have the potential to be affected by this practice. All other resident signatures and consents were reviewed and found to be present or will be obtained by 3/31.</p> <p><i>What measures will be put in place or what systematic changes will be made to ensure that the deficient practices does not recur?</i></p> <p>The Team Leader will schedule all meetings at the New Hope main facility and obtain signatures in person to ensure that compliance is upheld. Plans will not be implemented if the signatures are not obtained.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into</i></p>	03/31/2012

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	<p>restrictions. The signature pages of the ISP and BSP were blank where client #2 and/or guardians were to sign.</p> <p>Interview with Team Leader (TL) #1 on 2/29/12 at 2:30 PM indicated client #2's parents were the client's guardian. TL #1 indicated the 11/1/11 restrictive program had been sent to client #2's parents for a signature/consent, but the client's guardians/parents had not returned the behavior plan/written informed consent as of 2/29/12.</p> <p>9-3-4(a)</p>		<p><i>place.</i></p> <p>The Team Leader, Manager, consultants for this home will meet weekly to review steps outlined toward compliance in this plan. The Director, Team Leader, Manager and consultants will continue to meet monthly to review all plans, ISPs, treatment needs. The Director will conduct random chart audits of the nursing/behavior and home chart to monitor timeliness of documentation, consents and plans.</p>		

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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, interview and record review for 1 of 4 sampled clients (#1), the facility's nursing services failed to ensure risk plans/nursing protocols included how the facility's nurse would monitor the client for aspiration as the client had an Gastronomy tube (G-Tube) feedings.</p> <p>Findings include:</p> <p>During the 2/28/12 observation period between 4:02 PM and 5:30 PM, at the group home, client #1 had a deep cough when the client coughed. At one point, client #1 started crying, whining and moving around in her wheelchair. Interview with Team Leader (TL) #1 on 2/28/12 at 5:10 PM stated client #1 did not feel good and had a "low grade temperature." TL #1 indicated the facility's nurse was called and TL #1 was instructed to give the client some Tylenol (PRN fever medication).</p> <p>During the 2/29/12 observation period between 6:08 AM and 9:40 AM, at the group home, client #4 complained to staff that client #1 kept her up as client #1 coughed throughout the night. During the</p>	W0331	<p><i>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>Immediate action taken was the nurse implemented lung sound checks 3 times per week pending review with her PCP.</p> <p><i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p> <p>No other residents have the potential to be affected by this particular practice. There are no other residents with tube feeding protocols in this facility.</p> <p><i>What measures will be put in place or what systematic changes will be made to ensure that the deificient practices does not recur?</i></p> <p>PCP reviewed on 3/6/12 ordering residual checks x 1 week for baseline and then PRN. Staff were trained on residual checks and documentation was established.</p> <p>Gastroenterologist reviewed on 3/20/12 and deferred to PCP to monitor tube feeding protocols going forward.</p> <p>Nurse Consultant will update High Risk Plan to continue residual checks PRN and establish parameters for signs and symptoms of residual issues to warrant PRN.</p> <p>All staff will be trained on residual</p>	03/31/2012			

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	<p>2/29/12 observation period, client #1's medication and feeding (Replete with fiber) was administered through client #1's G-Tube using a gravity syringe. Interview with staff #3 on 2/29/12 at 7:30 AM indicated client #1 received 5 G-Tube feedings daily. Staff #3 indicated client #1 was fed approximately every 3 hours. When asked how long client #1 had been coughing, staff #3 stated "It just started this week." When asked when client #1 coughed, staff #3 stated "Normally after G-Tube feeding but lately at night." Staff #3 indicated the staff did not do residual checks (checking amounts of unabsorbed nutrition/Replete) with client #1.</p> <p>Client #1's record was reviewed on 2/29/12 at 11:32 AM. Client #1's undated face sheet indicated client #1 was admitted to the group home on 1/25/12. Client #1's 1/26/11 physician's orders indicated client #1 was to receive her medications and feedings through the client's G-Tube. Client #1's 2/1/12 physician's order indicated "No residual checks needed."</p> <p>Client #1's 1/6/12 Risk Plan for Aspiration, Choking and Dysphagia indicated facility staff were to follow the "G-tube feeding plan." The 1/6/12 risk plan also indicated "...Staff will ensure</p>		<p>checks and final High Risk Plan by end of training meeting on 3/22/12. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i> Nurse Consultant will monitor PRN residuals when parameters indicate necessity. Nurse Consultant will also continue to physically assess resident routinely at one site and day program visits, at least monthly or when symptoms indicate more frequent.</p>				

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	<p>client sits upright during feedings. Staff will ensure client sits upright 30 minutes after feedings. Staff will monitor client for smell of vomit, or gagging, or chocking (sic) during/after feeding, wheezing or breathing is rapid or difficult. Staff will report any signs and symptoms to nurse consultant or nurse on call of dysphasia, chocking (sic), or aspiration or vomiting...." The 1/6/12 risk plan indicated "Nurse Consultant will assess client's health record monthly. Nurse Consultant will notify PCP (primary care physician) of any signs or symptoms of aspiration, chocking (sic), dysphasia or vomiting...." Client #1's 1/6/12 risk plan did not specifically indicate how often the facility's nurse would assess/monitor client #1's lung sounds as no residual checks were being completed.</p> <p>Interview with LPN #2, TL #1 and administrative staff #1 on 2/29/12 at 2:30 PM indicated client #1 received her medications and feedings through a G-Tube. LPN #2 indicated client #1's doctor did not order residual checks as client #1 came from a home environment where the grandparents did not do residual checks. LPN #2 indicated facility staff should monitor the client for aspiration. LPN #2, TL 1 and administrative staff #1 indicated coughing could be a sign of aspiration. LPN #2</p>			

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	<p>indicated she had listened to client #1's lung sounds last week and they were clear. LPN #2 indicated her 2/12 notes/assessments had not been placed in the client's record. LPN #2 indicated she visited the group home a couple of times a week. LPN #2 indicated client #1's lung sounds would need to be monitored to determine if the client aspirated. LPN #2 indicated client #1's aspiration protocol did not specifically indicate how often nursing staff should monitor client #1's lungs since no residual checks were being completed.</p> <p>9-3-6(a)</p>			

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W9999	<p>STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>1. 460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division:</p> <p>THE STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based observation, record review and interview for 1 additional client (#6), the facility failed to report a fall which resulted in an injury.</p> <p>Findings include:</p> <p>"Incidents to be reported to BQIS (Bureau of Quality Improvement Services) include any event or occurrence characterized by risk or uncertainty resulting in or having the potential to result in significant harm or injury to an individual including but not limited to:</p> <p>15. A fall resulting in injury, regardless of the severity of the injury."</p>	W9999	<p><i>What corrective actions will be accomplished for these residents found to have been affected by the deficient practice?</i></p> <p>All staff have been retrained on the reportable incidents. In addition, staff will complete a competency quiz monthly to retain information. <i>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</i></p> <p>All other residents have the potential to be affected by this practice. All resident records were reviewed to ensure that no other reportable incident had gone unreported.</p> <p><i>What measures will be put in place or what systematic changes will be made to ensure that the deficient practices does not recur?</i></p> <p>Team Leader will review quizzes monthly and follow up as needed with staff competence. Team Leader will also review the daily progress notes for each individual weekly to ensure no other incident goes without reporting. Team Leader will document this by signing the progress notes.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director will continue to monthly</p>	03/31/2012	

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	<p>During the 2/28/12 observation period between 4:02 PM and 5:30 PM and the 2/29/12 observation period between 6:08 AM and 9:40 AM, at the group home indicated client #6 had a nickel to quarter size open area in the center of the client's forehead. The red open area was missing skin showing client #6's flesh which was about 3/4 of an inch long.</p> <p>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 2/28/12 at 1:52 PM. The facility's 2/24/12 Occurrence Outside Practice Standards (OOPS) indicated "[Client #6] fell from her wheelchair to the bathroom floor after she was assisted with a shower. [Client #6] did not call for assistance during the transfer. She said she wanted to pick up her head band that was on the floor. She hit her forehead on the wall..." The 2/24/12 OOPS report indicated client #6 had a "...a scratch that was a little bit reddish..." The 2/24/12 OOPS report did not indicate client #6's fall which resulted in an injury was reported to the Bureau of Developmental Disabilities Services (BDDS).</p> <p>Interview with Team Leader (TL) #1 on 2/29/12 at 7:29 AM indicated client #6 fell out of her wheelchair and hit her head</p>		<p>onsite observations and random documentation and chart audits to oversee compliance.</p>				

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	<p>when the client bent over to pick up her head band. TL #1 indicated the client had a seizure and it caused the client to fall out of her chair when she bent over. TL #1 indicated the incident was not reported to BDDS as the incident was not considered a fall with injuries. TL #1 stated "She had a seizure which caused the fall."</p> <p>9-3-1(b)</p>				