

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G487	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/04/2012
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NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4822 ALAMEDA ST INDIANAPOLIS, IN 46208
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W0000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00118856.</p> <p>Complaint #IN00118856: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149, W157 and W331.</p> <p>Dates of Survey: November 27, 28, 29, December 3, 4, 2012.</p> <p>Facility Number: 001001 AIMS Number: 100245000 Provider Number: 15G487</p> <p>Surveyor: Susan Reichert, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/7/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
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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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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based upon record review, observation and interview, the facility failed to follow policy and procedures to protect 1 additional client (client E) from abuse by staff, and failed to develop an effective plan of correction to prevent significant injury from falls for 1 of 4 sampled clients (client B).</p> <p>Findings include:</p> <p>1. The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/27/12 at 3:35 PM. A report dated 5/3/12 involving client E indicated staff noted client E's cheek was red. When asked about the cause, client E indicated staff #9 had hit him during the overnight shift. A follow up report dated 5/7/12 indicated the allegation of abuse and neglect had been substantiated. It was determined staff #9 had used a chair to barricade the door to client E and client H's bedroom so that they were unable to leave the room. The incident was reported to the police as a possible suspicion of a crime and staff #9 was terminated on 5/7/12. An attached police report dated 5/3/12 indicated per interview with the house manager staff #9</p>	W0149	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The facility has reviewed its policy and procedure for protection of abuse, neglect and exploitation. The policy remains appropriate and was reviewed with all facility staff. The facility provides initial and annual training regarding prevention of abuse as well as thorough prescreening of applicants for hire. The facility Team Leader provides onsite supervision of the home and activities, allowing open communication of concerns by staff or clients. The Nursing Department has reviewed the criteria and implementation of High Risk Plans. The High Risk Plan for Client B remains current to present status. His High Risk Plan will continue to be updated and staff will be trained as he continues to progress and change to his status occur. IDT anticipates the outcome to be a HRP with ambulation support at all times while walking, with walker and possibly gait belt. Final PT recommendations will finalize the IDT expectation. How will other residents be identified as having the potential to be affected by the same deficient</i></p>	12/21/2012			

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	<p>had become "annoyed" because client E was getting up too often during the night. Client E was not interviewed by the police as client E became anxious around the police "because he thinks he is in trouble." The house manager indicated client E told him that staff #9 "forced him into his room after he had gotten up and punched him in the face four times." Staff #9 then said, "Lay your f-----a--down and don't get back up." The police report indicated the house manager had been informed of the incident by staff #1 who relieved staff #9 on 5/3/12 and witnessed the barricaded door. Staff #9 informed staff #1 that he had punched client E and barricaded him in his room "because he kept getting out of bed." An attached statement from client B dated 5/7/12 indicated staff #9 "hit [client E] smack, smack, smack, smack and told him to go to bed." He indicated he didn't see the incident, but had heard it. Client B indicated staff #9 had put a chair against the door, and he "almost fell over it and broke my neck." A statement from staff #1 dated 5/4/12 indicated he had arrived at the group home (time not indicated) and all of the clients were asleep. Staff #9 said, "I had to prop a chair against [clients E and H's] door to keep him (not indicated) into his room because he kept getting up." When staff #1 asked staff #9 why, staff #9 indicated</p>		<p><i>practice and what corrective action will be taken.</i> The gentlemen residing in this home continue to receive ongoing support and are encouraged to express any concerns they may have. The Team Leader also continues to have ongoing contact with all shifts and clients to note any positive interactions as well as variances from policy and procedure. The gentlemen living in this home are very comfortable addressing the Team Leader with notes, letters or conversation. All staff reviewed St. Vincent New Hope policy and procedure for prevention of abuse as well as reporting guidelines. All High Risk Plans for Falls were reviewed for other clients as appropriate. All other High Risk Plans indicate appropriate ambulation supports consistent with recent PT and IDT assessment. No changes to current HRP were needed. Staff reviewed all Fall HRP as a retraining opportunity. <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> All High Risk Plans will continue to be reviewed by IDT at least annually or upon status change. The QDDP for that home will continue to review charts monthly to ensure that all plans are in place and accurate. <i>How the corrective action will be monitored to ensure the deficient practice will not</i></p>	

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	"because he was hungry." Staff #1 indicated he went towards client E and H's bedroom to remove the chair, but client E opened the door to his room and the chair fell to the ground. The report indicated client E had awakened client B and client B picked up the chair off the floor. Client B told staff #1 that staff #9 had placed the chair on client E's door because "He kept getting up." Staff #9 stated, "Yeah, that's right," after he heard client B and staff #1's conversation. Staff #1 did not see any bruising to client E's face until 11:30 AM at which time he noticed the left eye and side of client E's face was bruised. When client E was asked what had happened, he stated, "I'm scared. [Staff #9] hit me." Client E indicated staff #9 had hit him that morning. An interview with client H dated 5/5/12 indicated staff #9 "hit [client E]." A 5/5/12 interview with staff #9 indicated he had not documented client E's repeated times out of bed, and client E had hit himself twice when directed back to bed using his right hand. The investigation indicated the injury to client E's face was to the left side of his face. Staff #9 indicated he had not recorded client E's self injurious behavior or out of bed incidents and stated, "I'm horrible with notes." Staff #9 denied placing a chair to block exit from client E and H's room and indicated it had been propped		<i>recur; what quality assurance program will be put into place.</i> Group Home Manager and Team Leader are routinely in the home and will monitor staff interactions for continued adherence to St. Vincent New Hope policy and procedure. Group Home Manager and Team Leader also randomly interact with clients and staff and engage questions to indicate that treatment and activities are meeting expectations. The nurse consultant for this caseload had recent difficulty ensuring documentation was complete. She has left employment with St. Vincent New Hope. The nurse consultants now assigned have had no prior issue with timeliness and documentation. Group Home Director will continue random medical chart audits. The IDT will review any fall to investigate needed changes to treatment plan, current ambulation or transfer changes.		

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	<p>against the door upon his arrival at the group home for his overnight shift (time not indicated). A 5/7/12 investigation indicated the allegation of abuse and neglect had been substantiated, agency policy and procedures were not followed and federal and state regulations were not followed.</p> <p>The Director was interviewed on 11/27/12 at 4:42 PM and indicated staff #9 had violated the facility's policy to protect clients from abuse and neglect and staff #9 may have been been working too much. She stated, "He snapped it seems," and indicated staff #9 had been terminated immediately upon determination of the substantiated abuse.</p> <p>2. A BDDS report dated 8/18/12 indicated client B was found with a gash over his eye and taken to the emergency room. "The cause of the injury was undetermined at that time." The report indicated an investigation into the injury was ongoing. An attached incident report dated 8/18/12 and investigation dated 8/21/12 indicated client B fell while bending to pick up an item, and the investigation did not substantiate neglect or abuse. The corrective action indicated client B's health risk plan would be reviewed with staff.</p>			

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	<p>Observations were completed at the group home on 11/27/12 from 5:45 PM until 7:15 PM. Client B remained asleep in his room until 7:03 PM at which time he came from his bedroom in a wheelchair to have a snack.</p> <p>Observations were completed at the group home on 11/28/12 from 6:07 AM until 7:50 AM. Client B used a wheelchair for mobility during the observation.</p> <p>A BDDS report dated 10/26/12 involving client B was reviewed on 11/27/12 at 6:00 PM at the group home. The report indicated client B had been found on the floor of the bathroom after the two staff on duty had completed assisting another client in another bathroom. Client B said that he fell trying to use the restroom and his foot hurt. Client B was unable to stand on his leg and was taken for an x-ray and diagnosed with a fracture near the ankle. The report indicated client B was going to have surgery to repair the ankle and client B's fall risk plan was going to be reviewed. A follow up report dated 10/30/12 indicated client B had fallen while pulling down his pants to use the restroom, and "his gait has always been akward (sic) due to cerebral palsy." The report indicated client B was to remain non-weight bearing until the fracture was healed. A follow up report dated</p>				

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	<p>11/13/12 indicated client B used bed and chair alarms for safety, and a shower chair with drop arms in place. On 11/12/12 staples were removed in his leg and he was to continue non weight bearing for at least 4 weeks. An OOP'S (Occurrence Outside Practice Standards) dated 10/26/12 indicated client B was observed standing in the living room and was instructed by staff #1 to sit down in which client B did and watched TV. Staff #1 was called to assist client #3 in the restroom and after assisting client #3, staff heard client B calling his name and found him on the floor and unable to stand due to the pain. Included in the BDDS report information was an ISP (Individual Support Plan) dated 8/9/12 updated after client B's fall on 10/26/12 which indicated a fall protocol was in place. A 10/5/12 fall risk plan indicated client B had a history of falls with injury. Client B was able to ambulate independently at home, and to use transport chair for long distances and at day program. A fall risk plan dated 10/26/12 indicated client B was to be non-weight bearing and use a wheel chair for ambulation.</p> <p>Client B's records were reviewed on 11/28/12 at 2:15 PM. An ISP dated 8/9/12 included a Statement of Functional Limitations. In the area of mobility,</p>				

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	<p>client B "uses a manual wheelchair most of the time and a rolling walker part of the time. [Client B] walks in a very unsteady awkward gate, and he is prone to falling...." There was no indication of client B's needs for assistance in mobility during self care. An 8/9/12 Adaptive Equipment list indicated client B required a walker if unsteady as needed, a manual wheelchair for mobility for long distance at day services and as needed, a gait belt for unsteadiness daily and a shower chair for safety when bathing. A 10/26/11 Physical/Occupational Therapy assessment indicated client B had a "very unsteady gait," and a long term goal for "SBA (stand by assist) for most ADLs (adult daily living skills) in a group home setting."</p> <p>The Director was interviewed on 11/28/12 at 4:38 PM. She indicated client B's plan did not include instructions for stand by assistance.</p> <p>The group home Nurse Consultant, Team Leader and Director were interviewed on 11/29/12 at 10:40 AM. The Team Leader indicated client B had attempted to get up from the sofa on the morning of 10/26/12 to walk to another part of the house and staff #1 had asked him to sit down while he assisted another client. When asked if client B was to be within eyesight of staff</p>			

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	<p>due to his unsteadiness, he stated, "It's not a bad idea." He indicated there were to have been 3 staff in the home at the time of the incident, but that it was not unusual to have 2 staff on duty at the home. He indicated client B's needs for supervision during toileting had not been implemented when 2 staff were assisting the other client in the restroom, but that staff were unaware that client B needed to use the restroom. The Nurse Consultant indicated the need for stand by assistance for client B during ADLs had not been included in his fall risk plan. When asked if it should have been included, she stated, "Yes."</p> <p>The facility's Suspected Abuse policy dated 7/12 was reviewed on 11/28/12 at 1:45 PM. It indicated, "St. Vincent New Hope (SVNH) strives to treat individuals and families served with dignity, respect and consideration. SVNH will not condone abuse or violation of individual rights by anyone, including, but not limited to associates, consultants or volunteers, staff or other agencies serving the individual, family members or legal guardians, friends or any individuals. In the event there is an incident of suspected abuse, SVNH will comply with all applicable laws, statutes, and/or regulations with respect to reporting to authorities, investigation and warranted</p>			

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	<p>follow-up action to assure resolution...Indiana public law protects endangered adults (IC4-28-1) and children (IC 31-34-1) from abuse, battery, neglect, exploitation or mistreatment..."</p> <p>This federal tag relates to complaint #IN00118856.</p> <p>9-3-2(a)</p>			

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based upon record review, observation and interview, the facility failed to failed to develop an effective plan of correction to prevent significant injury from falls for 1 of 4 sampled clients (client B).</p> <p>Findings include:</p> <p>The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/27/12 at 3:35 PM. A BDDS report dated 8/18/12 indicated client B was found with a gash over his eye and taken to the emergency room. "The cause of the injury was undetermined at that time." The report indicated an investigation into the injury was ongoing. An attached incident report dated 8/18/12 and investigation dated 8/21/12 indicated client B fell while bending to pick up an item, and the investigation did not substantiate neglect or abuse. The corrective action indicated client B's health risk plan would be reviewed with staff.</p> <p>Observations were completed at the group home on 11/27/12 from 5:45 PM until 7:15 PM. Client B remained asleep in his room until 7:03 PM at which time he came from his bedroom in a wheelchair to</p>	W0157	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>The High Risk Plan for Client B remains current to his present status. As he continues to regain skills and ambulation abilities, his HRP will be updated accordingly. The coordination of his HRP was not meeting St. Vincent New Hope standard of care. The expectations for service delivery have continued to be conveyed to the nurse consultant for this caseload. The nurse consultant has since discontinued employment with St. Vincent New Hope. The present nurse consultant is coordinating care according to SVNH expectations.</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 High Risk plans have been reviewed and remain consistent with needs for the individuals and their PT recommendations. All staff were retrained on Fall HRPs.</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>Group Home Director will continue</p>	12/21/2012			

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	<p>have a snack.</p> <p>Observations were completed at the group home on 11/28/12 from 6:07 AM until 7:50 AM. Client B used a wheelchair for mobility during the observation.</p> <p>A BDDS report dated 10/26/12 involving client B was reviewed on 11/27/12 at 6:00 PM at the group home. The report indicated client B had been found on the floor of the bathroom after the two staff on duty had completed assisting another client in another bathroom. Client B said that he fell trying to use the restroom and his foot hurt. Client B was unable to stand on his leg and was taken for an x-ray and diagnosed with a fracture near the ankle. The report indicated client B was going to have surgery to repair the ankle and client B's fall risk plan was going to be reviewed. A follow up report dated 10/30/12 indicated client B had fallen while pulling down his pants to use the restroom, and "his gait has always been akward (sic) due to cerebral palsy." The report indicated client B was to remain non-weight bearing until the fracture was healed. A follow up report dated 11/13/12 indicated client B used bed and chair alarms for safety, and a shower chair with drop arms in place. On 11/12/12 staples were removed in his leg and he was to continue non weight bearing for at</p>		<p>to monitor the standard of care for the group home nursing department. All High Risk Plans are to be updated annually, or upon change in status and reviewed with the team. All falls are investigated and reviewed by IDT, including Director. Any investigation should include current ambulation status and review of HRP.</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 random nursing chart audits. Audits over the last several months have noted complete and thorough charts as well as any needed follow up. IDT for each facility will continue to meet monthly to review any outstanding issues or needs. Director will attend IDTs as available and meet with nursing department monthly. Director also reviews all fall investigations. Fall investigation files will contain a copy of the current PT and HRP.</p>		

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	<p>least 4 weeks. An OOP'S (Occurrence Outside Practice Standards) dated 10/26/12 indicated client B was observed standing in the living room and was instructed by staff #1 to sit down in which client B did and watched TV. Staff #1 was called to assist client #3 in the restroom and after assisting client #3, staff heard client B calling his name and found him on the floor and unable to stand due to the pain. Included in the BDDS report information was an ISP (Individual Support Plan) dated 8/9/12 updated after client B's fall on 10/26/12 indicated a fall protocol was in place. A 10/5/12 fall risk plan indicated client B had a history of falls with injury. Client B was able to ambulate independently at home, and to use transport chair for long distances and at day program. A fall risk plan dated 10/26/12 indicated client B was to be non-weight bearing and use a wheel chair for ambulation.</p> <p>Client B's records were reviewed on 11/28/12 at 2:15 PM. An ISP dated 8/9/12 included a Statement of Functional Limitations. In the area of mobility, client B "uses a manual wheelchair most of the time and a rolling walker part of the time. [Client B] walks in a very unsteady awkward gate, and he is prone to falling...." There was no indication of client B's needs for assistance in mobility</p>			

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	<p>during self care. An 8/9/12 Adaptive Equipment list indicated client B required a walker if unsteady as needed, a manual wheelchair for mobility for long distance at day services and as needed, a gait belt for unsteadiness daily and a shower chair for safety when bathing. A 10/26/11 Physical/Occupational Therapy assessment indicated client B had "very unsteady gait," and a long term goal for "SBA (stand by assist) for most ADLs (adult daily living skills) in a group home setting."</p> <p>The Director was interviewed on 11/28/12 at 4:38 PM. She indicated client B's plan did not include instructions for stand by assistance.</p> <p>The group home Nurse Consultant, Team Leader and Director were interviewed on 11/29/12 at 10:40 AM. The Team Leader indicated client B had attempted to get up from the sofa on the morning of 10/26/12 to walk to another part of the house and staff #1 had asked him to sit down while he assisted another client. When asked if client B was to be within eyesight of staff due to his unsteadiness, he stated, "It's not a bad idea." He indicated there were to have been 3 staff in the home at the time of the incident, but that it was not unusual to have 2 staff on duty at the home. He indicated client B's needs for</p>			

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	<p>supervision during toileting had not been implemented when 2 staff were assisting the other client in the restroom, but that staff were unaware that client B needed to use the restroom. The Nurse Consultant indicated the need for stand by assistance for client B during ADLs had not been included in his fall risk plan. When asked if it should have been included, she stated, "Yes."</p> <p>This federal tag relates to complaint #IN00118856.</p> <p>9-3-2(a)</p>			

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based upon record review, observation and interview, the facility's nursing services failed to implement interventions to prevent falls resulting in significant injury for 1 of 4 sampled clients (client B), and failed to ensure the medication label matched the physician's order and Medication Administration Record (MAR) for 1 additional client (client E).</p> <p>Findings include:</p> <p>1. The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 11/27/12 at 3:35 PM. A BDDS report dated 8/18/12 indicated client B was found with a gash over his eye and taken to the emergency room. "The cause of the injury was undetermined at that time." The report indicated an investigation into the injury was ongoing. An attached incident report indicated client B "fell while bending to pick up an item."</p> <p>Observations were completed at the group home on 11/27/12 from 5:45 PM until 7:15 PM. Client B remained asleep in his room until 7:03 PM at which time he came from his bedroom in a wheelchair to have a snack.</p>	W0331	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>The label that indicated the noncurrent dosage has been corrected with an Order Change Label.</p> <p>The High Risk Plan for Client B remains current to his present status. As he continues to regain skills and ambulation abilities, his HRP will be updated accordingly. The coordination of his HRP was not meeting St. Vincent New Hope standard of care. The expectations for service delivery have continued to be conveyed to the nurse consultant for this caseload. The nurse consultant has since discontinued employment with St. Vincent New Hope. The present nurse consultant is coordinating care according to SVNH expectations.</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 other labels and medication orders were checked to be accurate and current.</p> <p>All High Risk plans have been reviewed and remain consistent with needs for the individuals and their PT recommendations. All staff</p>	12/21/2012			

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	<p>Observations were completed at the group home on 11/28/12 from 6:07 AM until 7:50 AM. Client B used a wheelchair for mobility during the observation.</p> <p>A BDDS report dated 10/26/12 involving client B was reviewed on 11/27/12 at 6:00 PM. The report indicated client B had been found on the floor of the bathroom after the two staff on duty had completed assisting another client in another bathroom. Client B said that he fell trying to use the restroom and his foot hurt. Client B was unable to stand on his leg and was taken for an x-ray and diagnosed with a fracture near the ankle. The report indicated client B was going to have surgery to repair the ankle and client B's fall risk plan was going to be reviewed. A follow up report dated 10/30/12 indicated client B had fallen while pulling down his pants to use the restroom, and "his gait has always been akward (sic) due to cerebral palsy." Included in the BDDS report information was an ISP (Individual Support Plan) dated 8/9/12 updated after client B's fall on 10/26/12 which indicated a fall protocol was in place. A 10/5/12 fall risk plan indicated client B had a history of falls with injury. Client B was able to ambulate independently at home, and to use transport chair for long distances and at day program. A fall risk</p>		<p>were retrained on Fall HRP's.</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>A procedure to affix an order change label to any medication bottle or bubble pack was reviewed and implemented. The label will indicate a change in the order and reference the MAR. Nurse Consultants and Group Home staff were trained on this procedure.</p> <p>Group Home Director will continue to monitor the standard of care for the group home nursing department. All High Risk Plans are to be updated annually, or upon change in status and reviewed with the team. All falls are investigated and reviewed by IDT, including Director. Any investigation should include current ambulation status and review of HRP.</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>Team Leader will check labels routinely with medication supply check.</p> <p>Director will continue random nursing chart audits. Audits over the last several months have noted complete and thorough charts as well as any needed follow up. IDT for each facility will continue to meet monthly to review any</p>		

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	<p>plan dated 10/26/12 indicated client B was to be non-weight bearing and use a wheel chair for ambulation. There was no indication in the plans of client B's needs for staff assistance during ADLs.</p> <p>Client B's records were reviewed on 11/28/12 at 2:15 PM. An ISP dated 8/9/12 included a Statement of Functional Limitations. In the area of mobility, client B "uses a manual wheelchair most of the time and a rolling walker part of the time. [Client B] walks in a very unsteady awkward gate, and he is prone to falling...." There was no indication of client B's needs for assistance in mobility during self care included in the statement of client B's functional limitations. An 8/9/12 Adaptive Equipment list indicated client B required a walker if unsteady as needed, a manual wheelchair for mobility for long distance at day services and as needed, a gait belt for unsteadiness daily and a shower chair for safety when bathing. A 10/26/11 Physical/Occupational Therapy assessment indicated client B had a "very unsteady gait," and a long term goal for "SBA (stand by assist) for most ADLs (adult daily living skills) in a group home setting."</p> <p>The Director was interviewed on 11/28/12 at 4:38 PM. She indicated client B's plan</p>		<p>outstanding issues or needs. Director will attend IDTs as available and meet with nursing department monthly. Director also reviews all fall investigations. Fall investigation files will contain a copy of the current PT and HRP.</p>		

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	<p>did not include instructions for stand by assistance.</p> <p>The group home Nurse Consultant, Team Leader and Director were interviewed on 11/29/12 at 10:40 AM. The Nurse Consultant indicated the need for stand by assistance for client B during ADLs had not been included in his fall risk plan. When asked if it should have been included, she stated, "Yes."</p> <p>2. Observations were completed on 11/28/12 from 6:07 AM to 7:50 AM. Staff #1 administered client E's 7:00 AM medications on 11/28/12 at 6:38 AM. Client E's label for Novolog indicated he was to receive 50 units before breakfast.</p> <p>Client E's MAR for November, 2012 was reviewed on 11/28/12 at 6:45 AM and indicated he was to receive 46 units of Novolog before breakfast.</p> <p>Client E's physician's order dated 4/20/12 was reviewed on 11/28/12 at 6:45 AM and indicated he was to receive 46 units of Novolog before breakfast.</p> <p>Staff #1 was interviewed on 11/28/12 at 7:40 AM and indicated the medication label, MAR and physician's orders should match.</p>						

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	<p>The group home Nurse Consultant, Team Leader and Director were interviewed on 11/29/12 at 10:40 AM. The Nurse Consultant indicated the label on the Novolog should match the physician's orders and the MAR.</p> <p>This federal tag relates to complaint #IN00118856.</p> <p>9-3-6(a)</p>			