

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 8/6/13, 8/7/13, 8/8/13, 8/13/13 and 8/14/13.</p> <p>Facility Number: 000649 Provider Number: 15G112 AIMS Number: 100243110</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/27/13 by Ruth Shackelford, QIDP.</p>	W000000					

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 8 of 11 falls reviewed, the facility failed to develop safeguards to address client #1's reoccurring falls.</p> <p>Findings include:</p> <p>The facility's BDDS (bureau of developmental disabilities services) reports and investigations were reviewed on 8/7/13 at 11:48 AM. The review indicated the following:</p> <p>-BDDS report dated 9/7/12 indicated, "[Client #1] got out of bed to use the restroom. [Client #1] was very tired and not walking straight. Before staff could get to her to walk with her as is consistently done [client #1] fell backwards (sic) sitting on her backside. No injuries noted."</p> <p>-BDDS report dated 10/30/12 indicated client #1 fell while walking to the van for day service. The 10/30/12 BDDS did not indicate client #1 sustained injury from the fall.</p> <p>-BDDS report dated 5/3/13 indicated client #1 tripped over her feet while walking to the restroom. The 5/3/13</p>	W000157	IDT met to determine fall risk plans revisions for client #1. Team determined that a gait belt and stand by assistance will be present for walking to and from vehicle, entering exiting vehicle and going to the restroom at night. In addition, she will be assisted to restroom at 11p and 3a to provide more direct support before she attempts walking on her own. Additionally, there is a transport wheelchair present in the event she needs to be assisted to the bathroom in a hurried manner to avoid incontinence. Client #2 HRP and ISP will be updated to reflect all changes. All staff have been trained on the changes. This team meets regularly to review client support needs. St. Vincent New Hope will continue to follow up with a fall assessment/investigation each time a fall occurs. All falls are tracked and analyzed monthly for a trend.	09/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>BDDS report did not indicate client #1 sustained injury from the fall.</p> <p>-BDDS report dated 6/10/13 indicated, "When staff [unknown] was getting out of the van, staff heard a thump. Staff [unknown] walked around the van to see that [client #1] had fallen off the ramp that was leading to the van. Redness on back between shoulder blades and left arm."</p> <p>-BDDS report dated 6/13/13 indicated, "[Client #1] had a seizure this morning that caused her to fall in the kitchen. [Client #1] became glassy eyed, was drooling and could not talk. The staff noticed that she was starting to seizure (sic) but was not close enough to catch her from falling. [Client #1] did not hit anything besides the floor. Body check was completed with no injuries."</p> <p>-BDDS report dated 6/14/13 indicated, "On 6/14/13, [nurse consultant #1] informed... that she reviewed [client #1] upon arrive (sic) to day service and sent her to the ER (emergency room) because her right wrist was swollen. [Client #1] was sent to [hospital] ER where it was found that her right wrist was fractured. [Client #1] was splint (sic) and was referred to orthopedics to be cased." The 6/14/13 BDDS report indicated, "(2.)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Fracture was due to fall on 6/13/13 but at the time showed no signs of injury."</p> <p>-BDDS follow up report dated 6/20/13 indicated, "[Client #1] returned to [physician] for wrist cast on 6/18/13. At this appointment, [physician] stated the right wrist was not broken but sprained. [Physician] viewed the x-rays. [Client #1] was placed in a splint and is to wear the splint at all times except when bathing."</p> <p>-BDDS report dated 7/9/13 indicated, "Staff was getting [client #1] up to use the restroom around 1:00 AM. When [client #1] was coming out of the bedroom, she lost her balance and fell to the floor. Staff assisted her in getting up off of the floor and assisted her to the bathroom. Once [client #1] was finished in the bathroom, staff assisted her back to her bed." The 7/9/13 BDDS report indicated, "In the morning, staff was assisting [client #1] with her personal hygiene activities and noticed a small red scratch on (her) right arm."</p> <p>Client #1's record was reviewed on 8/8/13 at 10:05 AM. Client #1's IDT (interdisciplinary team meeting) form dated 7/30/13 indicated IDT discussion regarding client #1's falls and a 5/8/13 physical therapy evaluation. Client #1's IDT form dated 7/30/13 indicated the IDT</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>recommended, "Caregiver stand by assistance for safety PRN (as needed)" to address client #1's falls. Client #1's IDT form dated 7/30/13 did not indicate IDT discussion of the use of notification devices to alert staff of client #1 being out of bed at night, if client #1's nighttime use or non use of her AFO (ankle-foot orthotic) may affect her nighttime falls and/or if client #1 needed increased monitoring during nighttime hours to prevent further falls and/or potential injury.</p> <p>Interview with QIDP (qualified intellectual disabilities professional) #1 on 8/14/13 at 9:00 AM indicated the IDT had not assessed/discussed the use of notification devices to alert staff of client #1 being out of bed at night, if client #1's nighttime use or non use of her AFO (ankle-foot orthotic) may affect her nighttime falls and/or if client #1 needed increased monitoring during nighttime hours to prevent further falls and/or potential injury. When asked if the 7/30/13 IDT recommendations for staff stand by assistance was likely to prevent client #1 from falling or injury, QIDP #1 stated, "We should probably look to see if not having her AFO on at night may be a cause of her falls. We could look at her to see what she is wearing on her feet too. Like socks or some slippers to see if those</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	things are affecting her walking."  9-3-2(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on interview and record review for 1 of 3 sampled clients (#1), who received behavior controlling medication, the facility failed to ensure client #1's ISP (Individual Support Plan)/BSP (Behavior Support Plan) included an active treatment program which addressed the need for premedication prior to appointments.</p> <p>Findings include:</p> <p>The facility's BDDS (bureau of developmental disabilities services) reports and investigations were reviewed on 8/7/13 at 11:48 AM. The review indicated the following:</p> <p>-BDDS report dated 9/19/12 indicated client #1 was "... given PRN (as needed) of Ativan (sedation) 1 milligram prior to her dental appointment on 9/19/12. Last PRN was given on 9/7/12 for a medical appointment. [Client #1] receives PRN(s) prior to medical appointments due to her history of becoming verbally and physically aggressive when discussing</p>	W000312	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. All standing orders for medical appointment PRNs were removed from the physician's orders and discontinued. For Client 1 the medication addendum to her behavior plan was initiated. 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 individuals have the potential to be affected. No additional individual in the home were identified to need PRN medication to successfully participate in medical appointments. Addendum will be reviewed at the next scheduled HRC meeting 9/18/13. No PRN medication usage will be authorized until approvals are received. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance</p>	09/06/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>and/or going to medical appointments."</p> <p>-BDDS report dated 11/2/12 indicated, "[Client #1] was going to [PCP #1 (primary care physician)] for her annual physical and for a pap/pelvic exam. [Client #1] will usually allow the doctor to perform an annual physical but in the past has been physically aggressive in regards to pap/pelvic examinations. [Client #1] was given a PRN of Lorazepam (sedative) to assist her to calm down prior to medical appointments."</p> <p>Client #1's record was reviewed on 8/8/13 at 10:05 AM. Client #1's POF (physicians order form) dated 7/17/13 indicated a 3/2/13 order for "Lorazepam tablet 1 milligram. Give one tablet by mouth as needed one hour before medical appointment." Client #1's ISP dated 3/22/13 and/or BSP dated 6/1/13 did not include an active treatment program which addressed client #1's behavior in regards to dental/medical examinations.</p> <p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated the client #1's ISP/BSP should include an active treatment program which addressed the need for premedication prior to appointments.</p>		<p>program will be put into place. Director and Behavior Manager will continue to complete random audits for behavior services approvals. PRN usage is also a reportable incident and the report of such will trigger additional oversight that the PRN is within their behavior plan and appropriate procedure was followed.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	9-3-5(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000368	<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. Based on record review and interview for 2 of 3 sampled clients (#1 and #2) plus one additional client (#4), the facility failed to ensure the clients' routine medications were administered as ordered.</p> <p>Findings include:</p> <p>The facility's BDDS (bureau of developmental disabilities services) reports and investigations were reviewed on 8/7/13 at 11:48 AM. The review indicated the following:</p> <p>-BDDS report dated 9/7/12 indicated client #4 did not receive a 6:00 AM dose of Oxcarbazepine (mood stabilization) tablet 300 milligrams on 9/6/12.</p> <p>-BDDS report dated 9/19/12 indicated staff omitted giving client #2 Tylenol 500 milligrams (pain management) at the 7:00 AM medication pass.</p> <p>-BDDS report dated 10/23/12 indicated client #1 did not receive her Lyrica 100 milligram (pain management) on 10/22/12. The 10/23/12 BDDS report indicated, "Staff (unknown) documented</p>	W000368	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. The group home department, including this facility, had previously identified that the medication administration process could improve. While the facility maintains a relatively low rate of medication errors considering the amount of medication passed, it was deemed appropriate to find a different administration system to minimize further error. A multidose packaging system has been implemented for this facility. This system will provide medication doses for specific times prepackaged by the pharmacy to allow less opportunity for error by staff administering. All staff were trained on this system. 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 clients of this facility will have medication packaged to minimize error. The packaging clearly indicates the name, date and time to be given and includes all medications, with the exception of controlled substances which are to remain double locked. What measure will</p>	09/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/14/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>that it was given but the medication was not popped out of the bubble pack."</p> <p>-BDDS report dated 10/30/12 indicated client #4 did not receive her Mirtazapine 30 milligram tablet (antidepressant) on 10/29/12.</p> <p>-BDDS report dated 11/20/12 indicated client #1 did not receive her Oystershell Calcium 500 milligram tablet (osteoporosis) on 11/19/12 at 6:00 AM.</p> <p>-BDDS report dated 12/6/12 indicated client #2 did not receive her Citalopram/Celexa 40 milligram tablet (anxiety) on 12/5/12 at 7:00 AM.</p> <p>-BDDS report dated 1/9/13 indicated, "[Client #1] was to receive Oystershell Calcium medication at 4:00 PM. The medication record was documented but the medication was never given. [Client #1] was to receive Seroquel XR (extended release) 300 milligram (behavior) at 4:00 PM. [Client #1]...also gave (sic) an additional dose at 5:30 PM which was not part of her medication administration record." The 1/9/13 BDDS report indicated client #1's 5:00 PM daily Seroquel XR 300 milligram dose was administered at 4:30 PM and 5:30 PM.</p> <p>-BDDS report dated 2/18/13 indicated</p>		<p>be put into place or what systemic changes will be made to ensure that the deficient practices does not recur? How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place. Director receives all notifications of errors. Director has documented and analyzed medication errors and trends for all facilities over the past 3 years, indicating a decrease in medications overall. Director will continue to monitor med error trends to determine if this change in administration system has been effective. St. Vincent New Hope will continue to implement its policy and procedure related to medication errors. This procedure outlines specifically when retraining and further disciplinary action occurs.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/14/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client #1 did not receive her Oystershell Calcium 500 milligram tablet on 2/16/13 at 4:00 PM.</p> <p>-BDDS report dated 3/22/13 indicated, "6:00 AM Lyrica was documented but not administered for [client #1] on 3/20/13."</p> <p>-BDDS report dated 4/18/13 indicated, "At 4:00 PM, [client #4] received 300 milligrams of Oxycarpazem (sic). [Client #4] was also give (sic) her 8:00 PM dose of Oxycarpazem (sic) of 600 milligrams at 4:00 PM. Nurse on call was notified. Nurse advised to not give 8:00 PM dose as she received it at 4:00 PM."</p> <p>1. Client #1's record was reviewed on 8/8/13 at 10:05 AM. Client #1's POF (Physicians Order Form) dated 7/17/13 indicated client #1 had an order to receive Lyrica capsule 100 milligrams daily at 6:00 AM, 4:00 PM and 8:00 PM. Client #1's POF dated 7/17/13 indicated client #1 had an order to receive Oystershell Calcium 500 milligram tablet daily at 6:00 AM and 4:00 PM. Client #1's POF dated 7/17/13 indicated client #1's order for Seroquel XR 300 milligrams was for one tablet daily at 5:00 PM.</p> <p>2. Client #2's record was reviewed on 8/8/13 at 10:58 AM. Client #2's POF dated 7/17/13 indicated client #2 had an</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G112	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/14/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 130 E MERIDIAN ST ATLANTA, IN 46031		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>order to receive Acetaminophen/Tylenol 500 milligram tablet daily at 7:00 AM. Client #2's POF dated 7/17/13 indicated client #2 had an order to receive Citalopram 40 milligram tablet daily at 7:00 AM.</p> <p>3. Client #4's record was reviewed on 8/8/13 at 1:00 PM. Client #4's POF (physician order form) dated 7/17/13 indicated client #4 had an order to receive Oxcarbazepine tablet 300 milligrams daily at 6:00 AM and 4:00 PM. Client #4's POF dated 7/17/13 indicated client #4 had an order to receive Oxcarbazepine 600 milligram tablet daily at 8:00 PM. Client #4's POF dated 7/17/13 indicated client #4 had an order to receive Mirtazapine tablet 30 milligrams daily at 8:00 PM.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 8/8/13 at 11:30 AM. LPN #1 indicated clients' medications should be administered as ordered by the clients' physician.</p> <p>9-3-6(a)</p>				