

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G076		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 515 S 10TH ST NOBLESVILLE, IN 46060			
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: 8/5/13, 8/6/13, 8/7/13, 8/12/13, 8/13/13 and 8/14/13.</p> <p>Facility Number: 000620 Provider Number: 15G076 AIM Number: 100233810</p> <p>Surveyor: Keith Briner, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/22/13 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.

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W000149	<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 on record review and interview for 1 additional client (#7), the facility failed to implement its policy and procedures to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of sexual misconduct for client #7.</p> <p>Findings include:</p> <p>The facility's BDDS reports, investigations and incident reports were reviewed on 8/5/13 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 8/27/12 indicated on 8/24/12, "[Client #7] self reported that she and her boyfriend (unknown) at work had been touching each other's private areas under the table while at workshop."</p> <p>-Investigation dated 8/26/12 regarding client #7's 8/24/12 allegation indicated, "Partially substantiated...."</p> <p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated allegations of abuse, neglect, mistreatment, exploitation</p>	W000149	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? This incident is the only occasion in which this delay in reporting was made by day program staff. It appears to be an isolated situation in which St. Vincent New Hope policy and procedure remain appropriate. This particular day service typically demonstrates immediate communication and follow up. 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. All other reports were made by St. Vincent New Hope staff. No further reports by this day service provider were reported late, causing a failure to follow policy. This includes all day service providers for all women living in this home. 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 program will be put into place? QDDP reviewed</p>	09/06/2013	

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	<p>and injuries of unknown origin should be reported to BDDS within 24 hours of knowledge of the incident. QIDP #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policy and procedures were reviewed on 8/12/13 at 4:07 PM. The facility's 7/2013 Suspected Abuse policy indicated, "... will comply with all applicable laws, statutes, and/or regulations with respect to reporting to authorities..." The 7/2013 Suspected Abuse policy indicated, "Abuse is... sexual molestation, rape, sexual misconduct, sexual coercion and sexual exploitation..."</p> <p>9-3-2(a)</p>		<p>St. Vincent policy and procedure with day program manager. Director is copied and notified on all incidents within 24 hours. Reportable incidents are tracked by St. Vincent New Hope Quality Assurance. Director receives a weekly copy of this spreadsheet for oversight purposes. Late reports are highlighted to identify problem areas or trends. In addition, QDDP and Team Leader will maintain routine contact with day program staff to oversee appropriate communication and reporting. Contact will be maintained at minimum monthly or upon any future incident of concern. St. Vincent New Hope will continue to follow policy and procedure for abuse, neglect and exploitation should further incidents occur.</p>		

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W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 4 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) in accordance with state law regarding an allegation of sexual misconduct for client #7.</p> <p>Findings include:</p> <p>The facility's BDDS reports, investigations and incident reports were reviewed on 8/5/13 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 8/27/12 indicated on 8/24/12, "[Client #7] self reported that she and her boyfriend (unknown) at work had been touching each other's private areas under the table while at workshop."</p> <p>-Investigation dated 8/26/12 regarding client #7's 8/24/12 allegation indicated, "Partially substantiated...."</p>	W000153	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? This incident is the only occasion in which this delay in reporting was made by day program staff. It appears to be an isolated situation in which St. Vincent New Hope policy and procedure remain appropriate. This particular day service typically demonstrates immediate communication and follow up. 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. All other reports were made by St. Vincent New Hope staff. No further reports by this day service provider were reported late, causing a failure to follow policy. This includes all day service providers for all women living in this home. 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</p>	09/06/2013			

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	<p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin should be reported to BDDS within 24 hours of knowledge of the incident.</p> <p>9-3-2(a)</p>		<p>practice will not recur; what quality assurance program will be put into place? QDDP reviewed St. Vincent policy and procedure with day program manager. Director is copied and notified on all incidents within 24 hours. Reportable incidents are tracked by St. Vincent New Hope Quality Assurance. Director receives a weekly copy of this spreadsheet for oversight purposes. Late reports are highlighted to identify problem areas or trends. In addition, QDDP and Team Leader will maintain routine contact with day program staff to oversee appropriate communication and reporting. Contact will be maintained at minimum monthly or upon any future incident of concern. St. Vincent New Hope will continue to follow policy and procedure for abuse, neglect and exploitation as well as incident reporting.</p>		

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W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#2 and #4), the facility failed to ensure there were adequate staff levels to implement clients #2 and #4's BSPs (Behavior Support Plans) during transportation to/from day services.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, investigations and incident reports were reviewed on 8/5/13 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 10/15/12 indicated, "[Client #4] and [client #5] were riding on the van to go to day services. [Client #4] was agitated this AM. [Client #4] asked [client #5] why she was looking at her. [Client #5] did not answer. [Client #4] turned to [client #5] and hit her on the back several times. [Client #5] stayed turned away from [client #4]. The staff</p>	W000186	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? The facility has rearranged its schedule and staffing to allow for an increased staff to client ratio for transportation. The a.m. van transportation will be 2:4 staff to client, the afternoon transportation will be 2:6 staff to client. 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 individuals were assessed during the analysis to determine the best outcome for each person. No other individuals have been assessed to have behavior support needs that could not be provided. There is a seating arrangement to best mitigate any further interactions or behavior that would interfere with safe transport. In addition, a second staff is available to respond while the driver remains in control of the vehicle. There have been no further incidents during van</p>	10/08/2013			

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	<p>member (unknown) told [client #4] to stop. [Client #4] turned around (sic) [Client #4] was quiet for a few minutes then she yelled and asked another housemate why she was looking at her." The 10/15/12 BDDS report indicated client #5 had "Slight redness on back...."</p> <p>-BDDS report dated 4/2/13 indicated on 4/1/13, "When [client #2] was being picked up by staff at the day services program, [client #2] was agitated. There was no known reason except transitioning from work to home. When [client #2] got on the van. (sic) [Client #2] pulled staff (sic) hair from behind. [Client #2] yelled, hit and kicked at staff. [Client #2] also was flailing arms and feet as if to hit and kick peers." The 4/2/13 BDDS report indicated, "All was not witnessed due to chaos of getting everyone on the van and out of harms way. Day services staff member also got on van to assist group home staff/van driver in getting [client #2] to calm, sit and be able to get back to the group home."</p> <p>1. Client #2's record was reviewed on 8/6/13 at 12:28 PM. Client #2's BSP dated 12/14/12 indicated client #2's targeted behaviors included physical aggression. Client #2's 12/14/12 BSP indicated, "If [client #2] displays a physically aggressive behavior (takes (1</p>		<p>transportation since the one noted on 4/1/13. 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 program will be put into place?The staff involved in the transportation each day will document any behavior support needs that were provided. The QIDP will review this documentation with behavior services at minimum monthly. Any physical altercation will be reported immediately and will be reviewed immediately according to reporting procedures.</p>				

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	<p>swing with hand/arm/foot/leg toward someone) first make sure that all housemates are safe from harm, and that staff is as safe as possible." Client #2's 12/14/12 BSP indicated, "If the behavior occurs while on the van ride, pull over in a safe spot until the behavior stops. (A hold may be necessary.) Due to safety concerns, [client #2] must earn her spot in the divers (sic) side seat on the van seat rotation." Client #2's 12/14/12 BSP indicated, "If [client #2] is not able to calm herself and continues to escalates (sic) to hitting/kicking staff repeatedly a level 4 hold is necessary. (a) level 4 hold: (restrictive measure) Staff will utilize a 1 arm hold as learned in staff PIA (physical management) training until [client #2] has calmed down."</p> <p>2. Client #4's record was reviewed on 8/6/13 at 2:59 PM. Client #4's BSP dated 6/7/13 indicated client #4's targeted behaviors included physical aggression. Client #4's 6/7/13 BSP indicated, "If [client #4] begins to hit, kick, bite, or push people... (2.) A level 1 PIA approach may be used if necessary." Client #4's 6/7/13 BSP indicated, "If [client #4] is attacking a housemates, intervene by stepping between [client #4] and the other person. You may use PIA interventions to block hits, kicks, bites, etcetera."</p>						

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	<p>DSP #1 (Direct Support Professional) was interviewed on 8/5/13 at 4:45 PM stated, "We do transport with the [group home]. Their staff will drop off clients that go to one day service and we send clients with them that go to a different day service." DSP #1 indicated one staff person drove clients #1, #4 and #5 with other facility clients to day service and one staff drove clients #2, #6 and #7 with other facility clients to a second day service location. DSP #1 indicated one staff was on the facility van for transport to both day service locations.</p> <p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated the facility conducted transportation to/from day services with one staff person on the van. QIDP #1 indicated clients #2 and #4 have had incidents of physical aggression while on the facility van with one staff person. QIDP #1 indicated client #2 has attempted to hit and pull staff's hair while driving the facility van. QIDP #1 indicated clients #2 and #4's BSP's should be implemented while on the facility van. QIDP #1 indicated clients #2 and #4's BSP's included the use of PIA interventions to prevent injury to their housemates and staff. When asked if the driver of the van could implement a PIA intervention during transport to/from day</p>			

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	<p>services, QIDP #1 stated, "They could pull over to a safe spot." When asked if a staff could pull over to a safe spot while being hit and having their hair pulled, QIDP #1 stated, "I guess if they are being hit while driving, they should pull over." QIDP #1 indicated staff could not provide PIA interventions while driving the facility van.</p> <p>9-3-3(a)</p>						

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W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview for 1 of 4 sampled clients with restrictive programs (#2), the facility's HRC (human rights committee) failed to review, monitor and approve the use of psychotropic medications for the management of client #2's behavior.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 8/6/13 at 12:28 PM. Client #2's Monthly Behavior Consultation Report (MBCR) for June 2013 indicated, "[Client #2] saw [psychiatrist] on the 28th of this month and was prescribed Clonazepam/Klonopin (anxiety) to help with her anxiety..." Client #2's Health Care Coordination Monthly Health Review (HCCMHR) form dated June 2013 indicated, "Clonazepam/Klonopin start on 7/1/13, 6/28/13 [psychiatrist] for anxiety." Client #2's PO's dated 6/24/13 indicated, "7/1/13: Clonazepam tablet 0.5 milligrams, give one 1/2 tablet by mouth every morning. Give one tablet by mouth at bedtime." Client #2's record did not</p>	W000262	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? The initiation of medication did have verbal approval prior to implementation, however, it was not documented appropriately and was not available to produce for the survey process. Medication addendum for client 2 was established and final approvals were obtained. Additional medication (Gabapentin) was brought on board on 8/20/13 after clearing all verbal and written consents appropriately. 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 plans were reviewed and have appropriate reviews and approvals. 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
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	<p>indicate review/approval by the facility's HRC for the use of psychotropic medications.</p> <p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated the use of psychotropic medications should be reviewed and approved by the facility's HRC.</p> <p>9-3-4(a)</p>		<p>program will be put into place? Nursing and behavior services developed a system in which the Behavior Consultant will leave a note on any new or changing order that derives from psychiatry rounds. The note will hold any implementation of the new/changed medication until all approvals are obtained. Nurse consultants will not address order change until notice from the behavior team is received to move forward with change.</p>		

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W000263	<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 record review and interview for 1 of 4 sampled clients with psychotropic medications (#2), the facility's HRC (human rights committee) failed to obtain the client's guardian's written approval before the use of behavior controlling medications for client #2.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 8/6/13 at 12:28 PM. Client #2's Monthly Behavior Consultation Report (MBCR) for June 2013 indicated, "[Client #2] saw [psychiatrist] on the 28th of this month and was prescribed Clonazepam/Klonopin (anxiety) to help with her anxiety...." Client #2's Health Care Coordination Monthly Health Review (HCCMHR) form dated June 2013 indicated, "Clonazepam/Klonopin start on 7/1/13, 6/28/13 [psychiatrist] for anxiety." Client #2's PO's dated 6/24/13 indicated, "7/1/13: Clonazepam tablet 0.5 milligrams, give one 1/2 tablet by mouth every morning. Give one tablet by mouth at bedtime." Client #2's ISP (Individual Support Plan) dated 3/29/13 indicated client #2 had a legal guardian. Client #2's record did not indicate documentation of written informed consent by client #2's guardian for the use of Clonazepam/Klonopin for behavior control.</p> <p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated written informed</p>	W000263	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? The initiation of medication did have verbal approval prior to implementation, however, it was not documented appropriately and was not available to produce for the survey process. Medication addendum for client 2 was established and final approvals were obtained. Additional medication (Gabapentin) was brought on board on 8/20/13 after clearing all verbal and written consents appropriately. 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 plans were reviewed and have appropriate reviews and approvals. 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 program will be put into</p>	09/06/2013			

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	consent was needed before the use of psychotropic medications used for behavior control. 9-3-4(a)		place? Nursing and behavior services developed a system in which the Behavior Consultant will leave a note on any new or changing order that derives from psychiatry rounds. The note will hold any implementation of the new/changed medication until all approvals are obtained. Nurse consultants will not address order change until notice from the behavior team is received to move forward with change.		

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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 2 of 3 sampled clients, who received behavior controlling medication, the facility failed to ensure client #1's ISP (Individual Support Plan) included active treatment programs which addressed the need for premedication prior to appointments. The facility failed to incorporate client #2's Clonazepam/Klonopin into client #2's BSP (Behavior Support Plan), failed to include an active treatment program which addressed the client #2's behavior and/or failed to include a plan of reduction for its use.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/6/13 at 1:52 PM. Client #1's PO's (Physician Order's) dated 6/24/13 indicated an order dated 1/2/13 for Triazolam 0.25 milligram tablet (sedative/anxiety) one hour prior to 1/23/13 appointment for an x-ray. Client #1's Medical Appointment/New Order Form (MANOF) dated 1/23/13 indicated</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. Client 4 had a one time usage of PRN for an oral xray and extraction. She does not have any further routine need for medical prn. In the event another consultation will require a PRN, a medication addendum will be developed for her. It is not deemed necessary at this time. For Client 2 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. One additional individual in the home was identified to need PRN medication to successfully participate in medical appointments. A behavior plan addendum was also initiated for her. All staff were trained on addendums. Addendums will be reviewed at the next scheduled</p>	09/06/2013			

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	<p>client #1 was seen for "X-rays with sedation" and was given a new order for Triazolam 0.75 milligrams by mouth one hour before (2/6/13) dental appointment. Client #1's ISP dated 6/24/13 and/or 6/6/13 BSP did not include an active treatment program which addressed client #1's behavior in regards to dental examinations.</p> <p>2. Client #2's record was reviewed on 8/6/13 at 12:28 PM. Client #2's Monthly Behavior Consultation Report (MBCR) for June 2013 indicated, "[Client #2] saw [psychiatrist] on the 28th of this month and was prescribed Clonazepam/Klonopin (anxiety) to help with her anxiety...." Client #2's Health Care Coordination Monthly Health Review (HCCMHR) form dated June 2013 indicated, "Clonazepam/Klonopin start on 7/1/13, 6/28/13 [psychiatrist] for anxiety." Client #2's PO's dated 6/24/13 indicated, "7/1/13: Clonazepam tablet 0.5 milligrams, give one 1/2 tablet by mouth every morning. Give one tablet by mouth at bedtime." Client #2's ISP dated 3/29/13 and/or BSP dated 12/10/12 did not include the use of Clonazepam/Klonopin for behavior management. Client #2's 3/29/13 ISP and/or 12/10/12 BSP did not include a plan of reduction for the use of Clonazepam/Klonopin.</p>		<p>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 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>				

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	<p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated the use of psychotropic medications should be included in a ISP/BSP and include a plan of reduction/titration.</p> <p>9-3-5(a)</p>				

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W000331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to ensure nursing services met the needs of clients #1 and #4.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 8/6/13 at 1:52 PM. Client #1's Prescription form dated 3/12/13 indicated, "Discontinue (D/C) halcion/Triazolam (sedative/anxiety) PRN (as needed) dental appointment." Client #1's PO's (Physician Order's) dated 6/24/13 indicated an order dated 1/2/13 for Triazolam 0.25 milligram tablet one hour prior to 1/23/13 appointment for an x-ray. Client #1's Hearing Assessment form dated 6/4/13 indicated, "Noticed wax in both ears that should be checked by family doctor or ENT (ear, nose, throat specialist)." Client #1's record did not indicate documentation of client #1 being assessed by a PCP (primary care physician) or ENT regarding the 6/4/13 hearing assessment recommendation.</p> <p>2. Client #4's record was reviewed on 8/6/13 at 2:59 PM. Client #4's Quarterly Nursing Physical Assessment (QNPA) note dated 1/28/13 indicated, "Had a fall,</p>	W000331	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? All standing orders were removed from the client records. HRP for falls for client #4 was appropriately updated. Consultation to follow up on ENT recommendations was scheduled for 9/10/13. 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? This team of consultants and management meets bimonthly to discuss any IDT recommendations. In the event something arises prior, there is an additional meeting called. Any member not present will get a copy of the IDT notes to review and make appropriate changes. All other High Risk Plans were reviewed to be appropriate. 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 program will be put into place? Director and QDDP continue to do random audits of nursing and program chart. Audits include</p>	09/06/2013			

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	right eye blackened with stitches." Client #4's QNPA note dated 4/24/13 indicated on 3/24/13, "Fall resulting in right black eye." Client #4's IDT (Interdisciplinary Team Meeting) form dated 3/27/13 indicated, "Due to most recent fall activity and injury IDT discussed the events surrounding the fall. [Client #4] does not have the reflexes to stop herself or put arms out to protect self in the event of a fall. [Client #4] usually carries items in her hands such as a purse or a bag. At the time of this incident she had a purse and a bag that she was carrying. [Client #4] has a history of falls around getting in and out of vehicles. Recommendations: (1) high risk plan for falls to be completed for [client #4]; (2) staff to encourage [client #4] not to have items in her hands while getting in or out of vehicles; (3) staff to encourage [client #4] to let staff hold items if [client #4] is needing or wanting them while she is getting in or out of vehicles; (4) staff to encourage [client #4] to wait for staff assistance or close presence while she is getting in or out of vehicles." Client #4's Fall Risk Plan (FRP) dated 2/5/13 indicated, "[Client #4] is at risk for falls due to having 2 falls with injury requiring medical treatment in a 2 year period. (Dates 4/7/12 and 8/8/10). Client #4's FRP dated 2/5/13 did not indicate review or revisions had been made to incorporate the 3/27/13 IDT		recommendations and high risk plan procedures. QDDP will ensure that all members of the team receive a copy of IDT recommendations for follow up in the event a member is not present.	

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	<p>recommendations into the FRP.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 8/7/13 at 11:30 AM. LPN #1 indicated client #1 had not been scheduled to see an ENT or PCP regarding her 6/4/13 hearing assessment recommendations. LPN #1 indicated client #1's Halcion/Triazolam PRN for dental appointment should be D/C'd from the PO dated 6/24/13. LPN #1 indicated client #4's FRP dated 2/5/13 should be updated to include recommendations from the 3/24/13 IDT.</p> <p>9-3-6(a)</p>			

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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 3 of 4 sampled clients (#1, #2 and #3) plus one additional client (#5), 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, investigations and incident reports were reviewed on 8/5/13 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 2/25/13 indicated on 2/23/13, "[Client #3] went home with her family for a weekend visit 2/22/13 through 2/24/13. Medication for overnight visit was packed incorrectly by staff [staff #1]. [Client #3] was to receive 2 pills of Doxymono tablet for rosacea at 5:00 PM each day. [Client #3] only received 1 pill of Doxymono each day."</p> <p>-BDDS report dated 3/12/13 indicated on 3/10/13, "[Client #1] did not receive her 4:00 PM dose of Levothyroxine (thyroid). [Client #1] had returned to the group home from a home visit with her mother.</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, recently 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</p>	09/06/2013
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	<p>Mother did not give the 4:00 PM dose and staff did not give the 4:00 PM dose."</p> <p>-OOPS (Occurrence Outside Practice Standards) form dated 3/14/13 indicated, "[Client #1] was given a (dose of) Trazodone (anxiety) instead of Abilify (depression) at 8:00 AM. Abilify was omitted."</p> <p>-BDDS follow up report dated 4/1/13 indicated, "At 8:00 AM medication pass [client #1] did not receive her Abilify 10 milligram but did receive her Trazodone 100 milligram that was to be administered at 8:00 PM."</p> <p>-BDDS report dated 7/7/13 indicated on 7/6/13, "[Client #5] only received 0.5 milligrams of Lorazepam (seizures), should have received 1.0 milligrams at 8:00 PM."</p> <p>-BDDS report dated 7/7/13 indicated on 7/6/13, "[Client #2] was given 0.25 milligrams Carnazepam (sic) (sedative) at 8:00 PM. [Client #2] should have received 0.5 milligrams Carmazepam (sic)."</p> <p>-BDDS report dated 7/14/13 indicated, "... [client #5] went on LOA (leave of absence) with her mom. When staff packed LOA medications, [client #5's]</p>		<p>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 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 medication errors 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>				

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	<p>8:00 PM dose of Lorazepam 1 milligram was omitted, therefore not administered. When [client #5] arrived home, she had 4 seizures in 2 hours."</p> <p>-BDDS report dated 8/4/13 indicated on 8/3/13, "... [client #5] received the incorrect dose of medications. [Client #5] at 8:00 PM should have received 2 tablets of Ativan/Lorazepam 0.5 milligrams. [Client #5] only received one tablet."</p> <p>1. Client #1's record was reviewed on 8/6/13 at 1:52 PM. Client #1's POF (Physicians Order Form) dated 6/24/13 indicated client #1 had an order to receive Levothyroxine tablet 112 micrograms, one tablet daily at 4:00 PM. Client #1's POF dated 6/24/13 indicated client #1 had an order to receive Abilify 10 milligrams one tablet daily at 8:00 AM.</p> <p>2. Client #2's record was reviewed on 8/6/13 at 12:28 PM. Client #2's 6/24/13 POF indicated client #2 had an order for 0.5 milligrams of Clonazepam one tablet at bedtime.</p> <p>3. Client #3's record was reviewed on 8/6/13 at 10:16 AM. Client #3's POF dated 6/24/13 indicated a prescription dated 12/17/12 to receive Doxycyc Mono tablet 50 milligrams "give 2 tablets by mouth twice daily with food at 8:00 AM</p>			

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	<p>and 5:00 PM" for rosacea.</p> <p>4. Client #5's record was reviewed on 8/7/13 at 11:19 AM. Client #5's 6/24/13 POF indicated client #5 had an order to receive Lorazepam 0.5 milligrams two tablets daily at 8:00 PM.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 8/7/13 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>			

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>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 division (15) A fall resulting in injury, regardless of the severity of the injury; (18) Use of any PRN (as needed) medication related to an individuals behavior; (19) Use of any physical or manual restraint regardless of: (a) planning; (b) human rights committee approval; (c) informed consent).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 6 of 29 incidents of physical/manual restraints, medication errors and use of PRN medication, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) regarding one incident of PRN use behavior controlling medications for client #1, one incident of physical/manual</p>	W009999	<p>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice? 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? It has been indicated that this facility has had an increase in late reporting. The manager and Team Leader of this facility have been made aware of the late reporting issues and it has been addressed with performance management. Also, additional technology supports are being explored to support the facility in efficiently submitting reports. Computer and internet access have been improved so that reports can be filed from the facility more timely. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur A current system for monitoring timeliness of reports has been implemented? St. Vincent New Hope Quality Assurance tracks all reports submitted and flags those that are submitted late. Director reviews this spreadsheet weekly and will continue to address late reporting with performance management. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality</p>	09/06/2013			

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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 515 S 10TH ST NOBLESVILLE, IN 46060			
(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>restraint for client #1, two incidents of physical/manual restraint for client #2 and 2 incident of falls with injury for client #4.</p> <p>Findings include:</p> <p>1. The facility's BDDS reports and investigations were reviewed on 8/5/13 at 11:40 AM. The review indicated the following:</p> <p>-BDDS report dated 6/11/13 indicated on 6/7/13, "[Client #1] was awake and stating, 'but-----' for a few hours. At 10:45 AM staff administered her Trazodone (sedative) PRN." The review indicated client #1 received a PRN of Trazodone on 6/7/13 PRN and was reported to BDDS on 6/11/13.</p> <p>-BDDS report dated 9/19/12 indicated on 9/14/12 client #1 was refusing to leave the day services facility and was attempting to harm herself. The 9/19/12 BDDS report indicated, "A day services staff, [day service staff #1], picked [client #1] up and carried her out to the van to eliminate the potential risk of injury to [client #1]." The review indicated client #1 was physically/manually escorted/carried to the van on 9/14/12 and reported to BDDS on 9/19/12.</p>		<p>assurance program will be put into place? Director will review all incident reports as they are submitted. Should any further incident report be submitted late, Director will follow up with the reporting person directly.</p>				

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	<p>-BDDS report dated 2/13/13 indicated on 2/11/13 client #2 "Aggressed toward a staff, attempted to grab around her neck" and was placed in a level 4 hold. The 2/13/13 BDDS report indicated client #2 was held in a "Wrap around 1 arm hold for 7 minutes until calm." The review indicated client #1 was physically/manually restrained on 2/11/13 and reported to BDDS on 2/13/13.</p> <p>-BDDS report dated 5/20/13 indicated on 5/16/13 client #2 "... began to get aggressive. Staff attempted to redirect and talk to her. [Client #2] then began to hit staff and staff placed [client #2] in a restraint. Restraint lasted approximately 5 minutes." The review indicated client #2 was physically/manually restrained on 5/16/13 and reported to BDDS on 5/20/13.</p> <p>2. Client #4's record was reviewed on 8/6/13 at 2:59 PM. Client #4's Quarterly Nursing Assessment (QNA) narrative note dated 1/28/13 indicated, "Had a fall. Right eye blackened with stitches." Client #4's Health Care Coordination Monthly Health Review (HCCMHR) dated 3/27/13 indicated, "right eye blackened from fall."</p> <p>The facility's BDDS reports and investigations were reviewed on 8/5/13 at 11:40 AM. The review did not indicate</p>						

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	<p>client #4's 1/28/13 fall with injury and/or client #4's 3/27/13 fall with injury had been reported to BDDS.</p> <p>Interview with QIDP #1 (Qualified Intellectual Disability Professional) on 8/6/13 at 2:12 PM indicated falls with injuries, use of PRN medications and the use of physical/manual restraints should be reported to BDDS within 24 hours.</p> <p>9-3-1(b)</p>			