

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G563		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/02/2013	
NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2999 WESTLANE RD INDIANAPOLIS, IN 46268			
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W000000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 3/26/13, 3/27/13, 3/28/13, 4/1/13 and 4/2/13.</p> <p>Facility Number: 001077 Provider Number: 15G563 AIMS Number: 100245490</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/9/13 by Ruth Shackelford, Medical Surveyor III.</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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W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the governing body failed to exercise operating direction over the facility to ensure client #3's physical therapy recommendations were followed.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, OOPS (Occurrence Outside Practice Standards) forms and investigations were reviewed on 3/27/13 at 12:53 PM. The review indicated the following:</p> <p>-OOPS report dated 3/26/13 indicated, "[Client #3] was in the process of being transferred from wheelchair to shower chair by two staff... using the Hoyer lift when [HM #1 (Home Manager)] entered room. [Client #3] was stretched out due to spasticity and sliding toward the floor. [Staff #1] secured [client #3's] head and upper body while [staff #2] attempted to lift. During that time, the Hoyer sling gathered between her legs and the cradle was pressed against her shoulder. [HM #1] lifted [client #3] with assistance from</p>	W000104	<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 agency reviewed Procedure for Safe Lifts and Transfers and found it to remain within St. Vincent New Hope safety standards. As noted in the observation, this individual was assessed by St. Vincent Rehabilitation Services 9/19/2012 for appropriate lift recommendations. Those recommendations were reviewed and indicated her to be able to utilize a 2 person lift <u>OR</u> a stand pivot. The team identified the stand pivot transfer method to be the most appropriate lift and transfer process for her given the safety risks for 2 person transfers and her inability to use a Hoyer safely. Guardian was in agreement with stand pivot method as it maintains strength for her. ISP and High Risk Plans were revised. All staff were trained on stand pivot transfer and changes to High Risk Plan and ISP on 4/10/2013. St. Vincent New Hope also reviewed its policy for prevention of abuse and neglect with all associates to ensure that physical and medical care recommendations are</p>	04/19/2013			

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	<p>[staff #2] and transferred her to the shower chair while [staff #1] removed the sling. [Client #3] cried and complained of pain. [Staff #1] did a body check and reported to the [HM #1] the injuries." The 3/26/13 OOP's report did not include the extent of client #3's injuries.</p> <p>Client #3's record was reviewed on 3/27/13 at 8:46 AM. Client #3's Medical Appointment (MA) form dated 9/19/12 indicated, "[Client #3] evaluated for safe transfers. [Client #3] demonstrated tendency to move into extension capacity of lift. [Client #3's] caregivers note many instances of falls with Hoyer lift. Recommend two person transfer with each individual on side of patient, interlocking grip under bilateral knees and with support under ancillary vs anterior /posterior caregiver positioning (should achieve safer transfer for [client #3] and caregiver). Caregivers agree (sic) comfortable/safe transfer method. Can use pivot transfer for one on one transfer with good body mechanics." Client #3's Fall Risk plan dated 1/28/13 indicated, "[Client #3] is wheelchair bound and rely's (sic) on wheelchair to get around. [Client #3] is a two person transfer only and uses a shower chair to bathe."</p> <p>The facility's policy and procedures were reviewed on 4/1/13 at 3:30 PM. The</p>		<p>implemented as ordered to prevent neglectful action. <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> All individuals in this facility were reviewed to have appropriate PT recommendations, accurate HRP guidelines. Staff reviewed all High Risk Plans for ambulation, transfer and lift recommendations. <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> St. Vincent New Hope will maintain it's Procedure for Safe Lifts and Transfers which identifies that all individuals with ambulation concerns will be assessed by Rehabilitation Services (PT/OT). Those recommended ambulation, transfer or lift recommendations will be implemented in the individual's ISP and reviewed at minimum every 6 months at ISP review or as needed given a status change. All leadership and nursing staff were trained on Procedure for Safe Lifts and Transfers. All falls will continue to be investigated when they occur to review any needed change to High Risk Plan or procedures. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what</i></p>		

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	<p>undated facility policy entitled, "Procedure for Safe Lifts and Transfers" indicated, "Two person transfers are not allowed to be substituted for mechanical lifts."</p> <p>HM #1 was interviewed on 4/1/13 at 12:28 PM. HM #1 indicated client #3 should be transferred from her wheelchair using a two person or pivot transfer. HM #1 indicated client #3 should not be transferred using the Hoyer Lift. HM #1 indicated company policy prohibited the use of two person transfers. HM #1, when asked about the extent of client #3's injuries following the 3/26/13 fall, stated, "There was some redness to her thighs."</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 4/1/13 at 12:35 PM. QMRP #1 indicated company policy did not allow for the use of two person transfers. QMRP #1 indicated client #3's 9/19/12 recommendations for transfers included the use of two person transfers.</p> <p>9-3-1(a)</p>		<p><i>quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance department tracks all incidents. All reportable incidents are available and reviewed for trends and positive or negative change. Director reviews all investigations, including falls for appropriate change to plans as needed.</p>		

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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 of 4 sampled clients (#3), the facility failed to implement its policy and procedures to prevent neglect of client #3 in regard to following physical therapy recommendations for transfers for client #3.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, OOPS (Occurrence Outside Practice Standards) forms and investigations were reviewed on 3/27/13 at 12:53 PM. The review indicated the following:</p> <p>-OOPS report dated 3/26/13 indicated, "[Client #3] was in the process of being transferred from wheelchair to shower chair by two staff... using the Hoyer lift when [HM #1 (Home Manager)] entered room. [Client #3] was stretched out due to spasticity and sliding toward the floor. [Staff #1] secured [client #3's] head and upper body while [staff #2] attempted to lift. During that time, the Hoyer sling gathered between her legs and the cradle was pressed against her shoulder. [HM</p>	W000149	<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 agency reviewed Procedure for Safe Lifts and Transfers and found it to remain within St. Vincent New Hope safety standards. As noted in the observation, this individual was assessed by St. Vincent Rehabilitation Services 9/19/2012 for appropriate lift recommendations. Those recommendations were reviewed and indicated her to be able to utilize a 2 person lift <u>OR</u> a stand pivot. The team identified the stand pivot transfer method to be the most appropriate lift and transfer process for her given the safety risks for 2 person transfers and her inability to use a Hoyer safely. Guardian was in agreement with stand pivot method as it maintains strength for her. ISP and High Risk Plans were revised. All staff were trained on stand pivot transfer and changes to High Risk Plan and ISP on 4/10/2013. St. Vincent New Hope also reviewed its policy for prevention of abuse and neglect with all associates to ensure that physical and medical care recommendations are</p>	04/19/2013			

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	<p>#1] lifted [client #3] with assistance from [staff #2] and transferred her to the shower chair while [staff #1] removed the sling. [Client #3] cried and complained of pain. [Staff #1] did a body check and reported to the [HM #1] the injuries." The 3/26/13 OOP's report did not indicate the extent of client #3's injuries.</p> <p>Client #3's record was reviewed on 3/27/13 at 8:46 AM. Client #3's Medical Appointment (MA) form dated 9/19/12 indicated, "[Client #3] evaluated for safe transfers. [Client #3] demonstrated tendency to move into extension capacity of lift. [Client #3's] caregivers note many instances of falls with Hoyer lift. Recommend two person transfer with each individual on side of patient, interlocking grip under bilateral knees and with support under ancillary vs anterior /posterior caregiver positioning (should achieve safer transfer for [client #3] and caregiver). Caregivers agree (sic) comfortable/safe transfer method. Can use pivot transfer for one on one transfer with good body mechanics." Client #3's Fall Risk plan dated 1/28/13 indicated, "[Client #3] is wheelchair bound and rely's (sic) on wheelchair to get around. [Client #3] is a two person transfer only and uses a shower chair to bathe."</p> <p>HM #1 was interviewed on 4/1/13 at</p>		<p>implemented as ordered to prevent neglectful action. <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> All individuals in this facility were reviewed to have appropriate PT recommendations, accurate HRP guidelines. Staff reviewed all High Risk Plans for ambulation, transfer and lift recommendations. <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> St. Vincent New Hope will maintain it's Procedure for Safe Lifts and Transfers which identifies that all individuals with ambulation concerns will be assessed by Rehabilitation Services (PT/OT). Those recommended ambulation, transfer or lift recommendations will be implemented in the individual's ISP and reviewed at minimum every 6 months at ISP review or as needed given a status change. All leadership and nursing staff were trained on Procedure for Safe Lifts and Transfers. All falls will continue to be investigated when they occur to review any needed change to High Risk Plan or procedures. <i>How the corrective action will be monitored to ensure the deficient practice will not recur; what</i></p>				

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	<p>12:28 PM. HM #1 indicated client #3 should be transferred from her wheelchair using a two person or pivot transfer. HM #1 indicated client #3 should not be transferred using the Hoyer Lift. HM #1, when asked about the extent of client #3's injuries following the 3/26/13 fall, stated, "There was some redness to her thighs."</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 4/1/13 at 12:35 PM. QMRP #1 indicated client #3's 9/19/12 recommendations were for client #3 to be transferred with a two person lift or a pivot transfer.</p> <p>AS #1 (Administrative Staff) was interviewed on 4/1/13 at 12:40 PM. AS #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policies and procedures were reviewed on 4/2/13 at 2:36 PM. The facility's policy entitled, "Suspected Abuse" dated 12/2011 indicated, "Neglect is the repeated failure of a caregiver to provide supervision, training, appropriate care and the basic necessities of life: sleep, food, drink, shelter, clothing and medical care or treatment."</p> <p>9-3-2(a)</p>		<p><i>quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance department tracks all incidents. All reportable incidents are available and reviewed for trends and positive or negative change. Director reviews all investigations, including falls for appropriate change to plans as needed.</p>		

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 1 of 4 sampled clients (#3), the QMRP (Qualified Mental Retardation Professional) failed to ensure client #3's physical therapy recommendations for transfers were implemented.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, OOPS (Occurrence Outside Practice Standards) forms and investigations were reviewed on 3/27/13 at 12:53 PM. The review indicated the following:</p> <p>-OOPS report dated 3/26/13 indicated, "[Client #3] was in the process of being transferred from wheelchair to shower chair by two staff... using the Hoyer lift when [HM #1 (Home Manager)] entered room. [Client #3] was stretched out due to spasticity and sliding toward the floor. [Staff #1] secured [client #3's] head and upper body while [staff #2] attempted to lift. During that time, the Hoyer sling gathered between her legs and the cradle was pressed against her shoulder. [HM</p>	W000159	<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 agency reviewed Procedure for Safe Lifts and Transfers and found it to remain within St. Vincent New Hope safety standards. As noted in the observation, this individual was assessed by St. Vincent Rehabilitation Services 9/19/2012 for appropriate lift recommendations. Those recommendations were reviewed and indicated her to be able to utilize a 2 person lift <u>OR</u> a stand pivot. The team identified the stand pivot transfer method to be the most appropriate lift and transfer process for her given the safety risks for 2 person transfers and her inability to use a Hoyer safely. Guardian was in agreement with stand pivot method as it maintains strength for her. ISP and High Risk Plans were revised. All staff were trained on stand pivot transfer and changes to High Risk Plan and ISP on 4/10/2013. St. Vincent New Hope also reviewed its policy for prevention of abuse and neglect with all associates to ensure that physical and medical care</p>	04/19/2013			

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	<p>#1] lifted [client #3] with assistance from [staff #2] and transferred her to the shower chair while [staff #1] removed the sling. [Client #3] cried and complained of pain. [Staff #1] did a body check and reported to the [HM #1] the injuries." The 3/26/13 OOP's report did not indicate the extent of client #3's injuries.</p> <p>Client #3's record was reviewed on 3/27/13 at 8:46 AM. Client #3's Medical Appointment (MA) form dated 9/19/12 indicated, "[Client #3] evaluated for safe transfers. [Client #3] demonstrated tendency to move into extension capacity of lift. [Client #3's] caregivers note many instances of falls with Hoyer lift. Recommend two person transfer with each individual on side of patient, interlocking grip under bilateral knees and with support under ancillary vs anterior /posterior caregiver positioning (should achieve safer transfer for [client #3] and caregiver). Caregivers agree (sic) comfortable/safe transfer method. Can use pivot transfer for one on one transfer with good body mechanics." Client #3's Fall Risk plan dated 1/28/13 indicated, "[Client #3] is wheelchair bound and rely's (sic) on wheelchair to get around. [Client #3] is a two person transfer only and uses a shower chair to bathe."</p> <p>HM #1 was interviewed on 4/1/13 at</p>		<p>recommendations are implemented as ordered to prevent neglectful action. <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> All individuals in this facility were reviewed to have appropriate PT recommendations, accurate HRP guidelines. Staff reviewed all High Risk Plans for ambulation, transfer and lift recommendations. <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> St. Vincent New Hope will maintain it's Procedure for Safe Lifts and Transfers which identifies that all individuals with ambulation concerns will be assessed by Rehabilitation Services (PT/OT). Those recommended ambulation, transfer or lift recommendations will be implemented in the individual's ISP and reviewed at minimum every 6 months at ISP review or as needed given a status change. All leadership and nursing staff were trained on Procedure for Safe Lifts and Transfers. All falls will continue to be investigated when they occur to review any needed change to High Risk Plan or procedures. <i>How the corrective action will be monitored to ensure the deficient</i></p>				

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	<p>12:28 PM. HM #1 indicated client #3 should be transferred from her wheelchair using a two person or pivot transfer. HM #1 indicated client #3 should not be transferred using the Hoyer Lift. HM #1 indicated company policy prohibited the use of two person transfers. HM #1, when asked about the extent of client #3's injuries following the 3/26/13 fall, stated, "There was some redness to her thighs."</p> <p>QMRP #1 was interviewed on 4/1/13 at 12:35 PM. QMRP #1 indicated client #3's 9/19/12 recommendations were for client #3 to be transferred with a two person lift or a pivot transfer.</p> <p>9-3-3(a)</p>		<p><i>practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance department tracks all incidents. All reportable incidents are available and reviewed for trends and positive or negative change. Director reviews all investigations, including falls for appropriate change to plans as needed.</p>		

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W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure facility staff were trained to implement client #3's recommended two person transfer.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports, OOPS (Occurrence Outside Practice Standards) forms and investigations were reviewed on 3/27/13 at 12:53 PM. The review indicated the following:</p> <p>-OOPS report dated 3/26/13 indicated, "[Client #3] was in the process of being transferred from wheelchair to shower chair by two staff... using the Hoyer lift when [HM #1 (Home Manager)] entered room. [Client #3] was stretched out due to spasticity and sliding toward the floor. [Staff #1] secured [client #3's] head and upper body while [staff #2] attempted to lift. During that time, the Hoyer sling gathered between her legs and the cradle was pressed against her shoulder. [HM</p>	W000189	<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 agency reviewed Procedure for Safe Lifts and Transfers and found it to remain within St. Vincent New Hope safety standards. As noted in the observation, this individual was assessed by St. Vincent Rehabilitation Services 9/19/2012 for appropriate lift recommendations. Those recommendations were reviewed and indicated her to be able to utilize a 2 person lift <u>OR</u> a stand pivot. The team identified the stand pivot transfer method to be the most appropriate lift and transfer process for her given the safety risks for 2 person transfers and her inability to use a Hoyer safely. Guardian was in agreement with stand pivot method as it maintains strength for her. ISP and High Risk Plans were revised. All staff were trained on stand pivot transfer and changes to High Risk Plan and ISP on 4/10/2013.</p> <p>St. Vincent New Hope also reviewed its policy for prevention of abuse and neglect with all associates to ensure that physical</p>	04/19/2013
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	<p>#1] lifted [client #3] with assistance from [staff #2] and transferred her to the shower chair while [staff #1] removed the sling. [Client #3] cried and complained of pain. [Staff #1] did a body check and reported to the [HM #1] the injuries." The 3/26/13 OOP's report did not indicate the extent of client #3's injuries.</p> <p>Client #3's record was reviewed on 3/27/13 at 8:46 AM. Client #3's Medical Appointment (MA) form dated 9/19/12 indicated, "[Client #3] evaluated for safe transfers. [Client #3] demonstrated tendency to move into extension capacity of lift. [Client #3] caregivers note many instances of falls with Hoyer lift. Recommend two person transfer with each individual on side of patient, interlocking grip under bilateral knees and with support under ancillary vs anterior /posterior caregiver positioning (should achieve safer transfer for [client #3] and caregiver). Caregivers agree (sic) comfortable/safe transfer method. Can use pivot transfer for one on one transfer with good body mechanics." Client #3's Fall Risk plan dated 1/28/13 indicated, "[Client #3] is wheelchair bound and rely's (sic) on wheelchair to get around. [Client #3] is a two person transfer only and uses a shower chair to bathe."</p> <p>HM #1 was interviewed on 4/1/13 at</p>		<p>and medical care recommendations are implemented as ordered to prevent neglectful action. <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 individuals in this facility were reviewed to have appropriate PT recommendations, accurate HRP guidelines. Staff reviewed all High Risk Plans for ambulation, transfer and lift recommendations. <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>St. Vincent New Hope will maintain it's Procedure for Safe Lifts and Transfers which identifies that all individuals with ambulation concerns will be assessed by Rehabilitation Services (PT/OT). Those recommended ambulation, transfer or lift recommendations will be implemented in the individual's ISP and reviewed at minimum every 6 months at ISP review or as needed given a status change. All leadership and nursing staff were trained on Procedure for Safe Lifts and Transfers.</p> <p>All falls will continue to be investigated when they occur to review any needed change to High Risk Plan or procedures. <i>How the corrective action will be</i></p>	

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	<p>12:28 PM. HM #1 indicated client #3 should be transferred from her wheelchair using a two person or pivot transfer. HM #1 indicated client #3 should not be transferred using the Hoyer Lift. HM #1 indicated facility staff had not been trained to implement two person transfers. HM #1, when asked about the extent of client #3's injuries following the 3/26/13 fall, stated, "There was some redness to her thighs."</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 4/1/13 at 12:35 PM. QMRP #1 indicated facility staff were not trained regarding how to implement two person transfers.</p> <p>RN #1 (Registered Nurse) was interviewed on 4/1/13 at 12:45 PM. RN #1 indicated she had not trained facility staff regarding two person transfers.</p> <p>9-3-3(a)</p>		<p><i>monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>St. Vincent New Hope Quality Assurance department tracks all incidents. All reportable incidents are available and reviewed for trends and positive or negative change. Director reviews all investigations, including falls for appropriate change to plans as needed.</p>		

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W000250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to provide an active treatment schedule for staff to follow.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #1's record was reviewed on 4/1/13 at 10:12 AM. Client #1's record did not include an active treatment schedule that outlined her 2/20/13 ISP (Individual Support Plan) programming goals. Client #2's record was reviewed on 3/28/13 at 11:17 AM. Client #2's record did not include an active treatment schedule that outlined his 2/20/13 ISP programming goals. Client #3's record was reviewed on 3/27/13 at 8:46 AM. Client #3's record did not include an active treatment schedule that outlined her 2/24/13 ISP programming goals. Client #4's record was reviewed on 3/27/13 at 11:26 AM. Client #4's record did not include an active treatment 	W000250	<p><i>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.</i></p> <p>Active treatment schedules were developed and implemented for all individuals in the facility. All staff were trained on the active treatment schedule purpose, location and recommendations. <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> Active treatment schedules will remain in the active chart and be reviewed by the QMRP and Team Leader annually or upon change in program needs or status. <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> ISP and charts are audited at minimum annually. Each site chart is also monitored monthly by the QMRP as well as any random audit that may occur within the QMRP site visit.</p>	04/19/2013
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	<p>schedule that outlined her 1/3/13 ISP programming goals.</p> <p>HM #1 was interviewed on 4/1/13 at 12:28 PM. HM #1 indicated clients #1, #2, #3 and #4 did not have active treatment schedules.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 4/1/13 at 12:35 PM. QMRP #1 indicated clients #1, #2, #3 and #4 did not have active treatment schedules. QMRP #1 indicated clients should have active treatment schedules available for staff to review.</p> <p>9-3-4(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 1 of 4 sampled clients (#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, OOPS (Occurrence Outside Practice Standards) forms and investigations were reviewed on 3/27/13 at 12:53 PM. The review indicated the following:</p> <p>-BDDS report dated 7/18/12 indicated, "... took [client #3] to another group home for her monthly weight. Afterward they went to the store and gas station. [Staff #3] left prior to 5:00 PM medications and returned after 6:00 PM. [Staff #3] did not pack 5:00 PM medications; as a result, [client #3] missed her Baclofen (cerebral palsy). When [staff #3] returned to the group home, [staff #3] called the nurse to report and the nurse instructed her to hold the medications since [client #3] gets Baclofen again at 8:00 PM."</p>	W000368	<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 facility Team Leader, QMRP and nurse consultant were aware of this issue at the time of occurrences and took corrective action which has resulted in no further errors since the 12/28/12 occurrence. The 9/12 incident was the first occurrence and staff were retrained to follow the procedure to monitor the medication supply. The 11/12 and 12/12 incidents occurred due to delivery issues between the contracted pharmacy and a national package shipping company, in addition to holiday pharmacy closures. After each incident the nurse consultant took action with the pharmacy and rectified the outstanding issues after the 12/12 occurrence. The corrective action was as follows. The nurse consultant established contact with the national pharmacy provider. The pharmacy provider now sends the supply 10 days earlier in order to cover any gap in delivery, including a holiday weekend. In addition, the pharmacy also gives the nurse consultant a courtesy call when the item has been shipped so the delivery can be</p>	04/19/2013	

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	<p>-BDDS report dated 9/24/12 indicated, "[Client #3] receives Xenazine (chorea) 12.5 milligram twice per day. This medication is delivered routinely by [mail] from [pharmacy]. However, it did not arrive this morning. Staff attempted to call [pharmacy] over the weekend but the pharmacy was closed and [client #3] missed her PM dose on 9/23/12 and AM dose on 9/24/12."</p> <p>-BDDS report dated 11/29/12 indicated, "[Client #3] takes Xenazine 2.5 milligrams daily. [Client #3] ran out of her Xenazine and did not receive her 8:00 PM dose on 11/23/12. Staff did not notify on call nurse nor did they notify on call team leader. On 11/26/12, associate [staff #4] called nurse and stated that [client #3's] Xenazine had not arrived. [Staff #4] did not inform nurse that [client #3] was out of the medications." The 11/29/12 BDDS report indicated, "Xenazine arrived on 11/27/12 and [client #3] was given her 8:00 PM Xenazine on 11/27/12."</p> <p>-BDDS report dated 12/9/12 indicated, "On Saturday, 12/8/12, [staff #6] began passing 5:00 PM medications. [Staff #5] administered [client #5's] Rivastigmine (dementia) 6 milligrams before [staff #5] realized that another staff member had already administered and initialed the MAR (Medication Administration</p>		<p>better tracked as arrived. The medication has been in ample supply and no missed doses have occurred in the last 4 months. St. Vincent New Hope maintains a medication administration policy which indicates initial and ongoing training for any associate who will be administering medication. Upon error, each associate is retrained by the nurse and a progressive disciplinary process is followed. This procedure was followed for both medication administration errors noted (7/18/12 and 12/9/12). It was strictly a performance issue, and St. Vincent New Hope does not indicate that this was due to a policy or procedural gap. Associate was terminated due to inability to successfully pass medications and maintain St. Vincent New Hope confidence in her abilities.</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>The facility also continues its procedure of accounting for all medications, etc to ensure a 7 day supply is present. This accounting occurs weekly and any discrepancies are conveyed to the nurse consultant to rectify. The nurse consultant continues to monitor the delivery and supply of the medication delivered from the national supplier.</p> <p><i>What measure will be put into</i></p>				

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	<p>Record) for all 5:00 PM medications. [Staff #5] immediately called the nurse on call and reported the medication error." The 12/9/12 BDDS report indicated, "Staff were instructed to take [client #5's] vitals every 2 hours and report abnormalities to nurse. [HM #1 (Home Manager)] called group home and immediately suspended [staff #5] until committee meets and discussed follow up measures on Monday 12/10/12. [Staff #6] called [HM #1] approximately an hour later and stated that [client #5] was very 'shaky' and that staff had to follow him closely when he ambulated for fear that he would fall. Nurse instructed staff to take [client #5] to the ER (Emergency Room). [Client #5] was checked out and released with instructions to administer prescribed medications in the AM if he appeared normal."</p> <p>-BDDS report dated 12/28/12 indicated client #3 missed her 8:00 PM dose on 12/27/12 and 8:00 AM dose on 12/28/12 of Xenazine 12.5 milligrams.</p> <p>1. Client #3's record was reviewed on 3/27/13 at 8:46 AM. Client #3's Physicians Order Form (POF) dated 2/21/13 indicated a prescription dated 4/6/12 for client #3 to receive Xenazine tablet 12.5 milligrams crush one tablet and give in applesauce by mouth twice</p>		<p><i>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.</i></p> <p>The Team Leader and Nurse consultant oversee that the supply of medications is accounted for weekly as the procedure outlines. All medication errors are reported and the reason for the error is identified. Any further lack of supply or failure to follow procedure will be addressed with the responsible parties. The medication administration policy and procedure will continue to be followed with all associates. Medication errors are also tracked by Quality Assurance and a monthly review of facility status is reviewed by Director. The status contains number of errors as well as indicated an increase or reduction in events. Increases in events will trigger continued follow up with corrective actions identified.</p>				

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	<p>daily for chorea movements. Client #3's POF dated 2/21/13 indicated client #3 had a physicians order to receive Baclofen 20 milligrams at 5:00 PM daily.</p> <p>2. Client #5's POF dated 3/1/13 was reviewed on 3/27/13 at 11:04 AM. Client #5's POF dated 3/1/13 indicated client #5 had a physicians order to receive Rivastigmine 6 milligrams at 5:00 PM.</p> <p>AS #1 (Administrative Staff) was interviewed on 4/1/13 at 12:40 PM. AS #1 indicated medication should be administered as ordered by the clients' physician.</p> <p>RN #1 (Registered Nurse) was interviewed on 4/1/13 at 12:45 PM. RN #1 indicated clients' medications should be administered as ordered by the clients' physician.</p> <p>9-3-6(a)</p>			