

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 06/14/2012
--	---	--	---

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
W0000	<p>This visit was for the fundamental annual recertification and state licensure survey.</p> <p>Survey Dates: 6/5/12, 6/6/12, 6/7/12 and 6/14/12.</p> <p>Facility Number: 000620 Provider Number: 15G076 AIM Number: 100233810</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 6/22/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 06/14/2012
--	---	--	---

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
W0153	<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.</p> <p>Based on record review and interview for 1 of 27 allegations of abuse, neglect, mistreatment and/or injuries of unknown origin reviewed, the facility failed to immediately notify the administrator and the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law regarding an injury of unknown origin for client #2.</p> <p>Findings include:</p> <p>A review of the facility's BDDS reports and IIR's (Internal Incident Report) forms was conducted on 6/5/12 at 10:40 AM.</p> <p>-BDDS report dated 5/24/12 indicated on 5/19/12 client #2 had a "...bump on the back of her head. Nurse asked [client #2] what happened and [client #2] stated she, 'did not know.' The nurse called the group home and talked to staff to ask them if they had any knowledge of the incident or if something occurred at the home and they did not. [Day Services] staff did not observe any incident or have any knowledge of any incident where [client</p>	W0153	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Policy and procedure were reviewed and remain current. St. Vincent New Hope leadership were trained on 6/11/12 on Investigation procedures by Megan Brown, Forensic Nurse, St. Vincent Center of Hope. Team Leaders and Managers will review policy implementation for falls, unknown injuries and other reportable incidents on 6/29/12. Skills Trainers at site will review reportable incident information , including who and when to contact. Reportable incident guidelines were posted in the home.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents have the potential to be affected by this practice. All other notes were reviewed for this individual and the other individuals in the home. There were no further missed reportable incidents.</p> <p><i>What measure will be put into place or what systemic changes will be</i></p>	07/13/2012

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 06/14/2012
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>#2] had hurt her head."</p> <p>Interview with Group Home Manager (GHM) #1 on 6/6/12 at 1:30 PM indicated the incident regarding an injury of unknown origin for client #2 should have been reported to BDDS within the 24 hour guidelines.</p> <p>9-3-2(a) 9-3-1(b)(5)</p>		<p><i>made to ensure that the deficient practices does not recur</i></p> <p>Team Leader will review documentation weekly, initialing on the daily progress notes to improve oversight to appropriate and timely response to reportable situations. Manager will communicate daily with Team Leader and/or site staff to monitor daily operations and increase oversight to potential reportable situations or investigations.</p> <p>Further failure to call to report by staff will be addressed with disciplinary action as appropriate. Further failure by Team Leader to report incidents timely or conduct investigations as indicated will be addressed with progressive disciplinary action.</p> <p>Reportable incident guidelines posted at the home for continued reference and review.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director will continue to review all reportable incidents. Any untimely incidents will be addressed with QDDP immediately. Director will establish a system to more closely monitor that investigations are completed as required. Each reportable incident that meets criteria for investigation will be printed and monitored by Director</p>		

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 06/14/2012
---	--	--	--

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 PERCEDED 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
			that investigation is being completed thoroughly and accurately.	

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 06/14/2012	
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			
W0159	<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.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the QMRP (Qualified Mental Retardation Professional) failed to ensure ISP (Individual Support Plan) objectives identified the level of support/training needed to accomplish the objective for clients #1, #2, #3 and/or #4. The QMRP failed to ensure ISP objectives identified the frequency staff would implement and track objectives for clients #1, #2, #3 and/or #4.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The QMRP failed to ensure ISP (Individual Support Plan) objectives identified the level of support/training needed to accomplish the objective for clients #1, #2, #3 and/or #4. Please see W234. The QMRP failed to ensure ISP objectives identified the frequency staff would implement and track objectives for clients #1, #2, #3 and/or #4. Please see W235. <p>9-3-3(a)</p>	W0159	Please reference W234, W235	07/13/2012			

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 06/14/2012
---	--	--	--

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 PERCEDED 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

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 06/14/2012	
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			
W0234	<p>483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure ISP (Individual Support Plan) objectives identified the level of support/training needed to accomplish the objective.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 6/5/12 at 1:16 PM. Client #1's ISP dated 1/23/12 indicated the following training objectives:</p> <ul style="list-style-type: none"> -will wait for change after making a purchase. -will state the number of pills she takes. -will put soap on a washcloth during bath time. -will put on panties. -will comb front part of hair. -will spit toothpaste out of mouth. -will state what is on menu. 	W0234	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Managers, QDDP and Team Leaders will review the model for programming on 6/29/12. All goals for these individuals were revised to include the appropriate cueing level and direction for staff to implement. All staff at site will be retrained on cueing levels and methodology for each person's goals by 7/1/12.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All individuals living in this facility will have goals revised to include appropriate cueing levels.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>All goals will be written a standard format to include cueing levels. QDDP will continue to monitor in monthly case management reviews that format is followed, goals are appropriate and progress or revision is addressed timely.</p> <p><i>How the corrective action will be</i></p>	07/13/2012			

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 06/14/2012
--	---	--	---

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>-will wash hands after using toilet.</p> <p>-will complete a social activity.</p> <p>-will state the street she lives on.</p> <p>-will exercise.</p> <p>Client #1's training objectives did not indicate how staff were to implement the objective in regard to the level and type of supports needed or methodology to train client #1 to accomplish the objective. Client #1's Methodology Sheet indicated staff were to monitor client #1 and record with met, not met, refused, not offered, or leave of absence.</p> <p>2. Client #2's record was reviewed on 6/6/12 at 10:01 AM. Client #2's ISP dated 3/17/12 indicated the following training objectives:</p> <p>-will list needs for purchase.</p> <p>-will state the number pills she takes.</p> <p>-will wash hair thoroughly.</p> <p>-will wear clean clothing.</p> <p>-will comb front part of hair.</p>		<p><i>monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>QDDP will continue to oversee goal writing and implementation at routine site visits and monthly case management reviews. Director will continue to oversee with monthly random site and chart audits.</p>	

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 06/14/2012	
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>-will brush teeth after meals.</p> <p>-will retrieve items needed for meal preparation.</p> <p>-will dry hands after washing.</p> <p>Client #2's training objectives did not indicate how staff were to implement the objective in regard to the level and type of supports needed or methodology to train client #2 to accomplish the objective. Client #2's Methodology Sheet indicated staff were to monitor client #2 and record with met, not met, refused, not offered, or leave of absence.</p> <p>3. Client #3's record was reviewed on 6/6/12 at 10:56 AM. Client #3's ISP dated 3/23/12 indicated the following training objectives:</p> <p>-will state the amount of money needed to purchase cookies.</p> <p>-will state which PRN (As Needed) to use for a headache.</p> <p>-will rinse body with sprayer.</p> <p>-will put bra on.</p> <p>-will brush her hair.</p>						

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 06/14/2012
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>-will move toothbrush around in mouth.</p> <p>-will not talk with her mouth full of food.</p> <p>-will get recipe needed to prepare a meal.</p> <p>-will wash hands after toileting.</p> <p>-will attend an activity of interest.</p> <p>Client #3's training objectives did not indicate how staff were to implement the objective in regard to the level and type of supports needed or methodology to train client #3 to accomplish the objective. Client #3's Methodology Sheet indicated staff were to monitor client #3 and record with met, not met, refused, not offered, or leave of absence.</p> <p>4. Client #4's record was reviewed on 6/6/12 at 9:06 AM. Client #4's ISP dated 6/10/11 indicated the following objectives:</p> <p>-will make change from \$1.00 USD (United State Dollar)</p> <p>-will state reason for Loratadine.</p> <p>-will wash folds of skin.</p> <p>-will identify dials on iron.</p>				

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 06/14/2012	
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>-will take pads to work.</p> <p>-will brush teeth twice daily.</p> <p>-will measure salad dressing.</p> <p>-will make a simple salad.</p> <p>-will dry hands after washing.</p> <p>-will increase number of steps.</p> <p>Client #4's training objectives did not indicate how staff were to implement the objective in regard to the level and type of supports needed or methodology to train client #4 to accomplish the objective. Client #4's Methodology Sheet indicated staff were to monitor client #4 and record with met, not met, refused, not offered, or leave of absence.</p> <p>Interview with Group Home Manager (GHM) #1 on 6/6/12 at 1:30 PM indicated the training objectives did not include the level of support or training methods staff needed to train clients #1, #2, #3 and/or #4 toward independence with each goal. GHM #1 indicated each individual goal did not include if staff were to use prompts, gestures or other methods of training while implementing the objectives.</p>						

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 06/14/2012
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	
	9-3-4(a)				

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 06/14/2012	
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			
W0235	<p>483.440(c)(5)(ii) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the schedule for use of the method.</p> <p>Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure ISP (Individual Support Plan) objectives identified the frequency staff would implement and track the clients' training objectives.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 6/5/12 at 1:16 PM. Client #1's ISP dated 1/23/12 indicated the following training objectives:</p> <ul style="list-style-type: none"> -will wait for change after making a purchase. -will state the number of pills she takes. -will put soap on a washcloth during bath time. -will put on panties. -will comb front part of hair. -will spit toothpaste out of mouth. 	W0235	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Managers, QDDP and Team Leaders will review the model for programming on 6/29/12. All goals for these individuals were revised to include the frequency for implementation and direction for staff to implement. All staff at site will be retrained on frequency of goals for each person's goals by 7/1/12.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All individuals living in this facility will have goals revised to include frequency of implementation.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>All goals will be written a standard format to include frequency. Form was revised to include a specific location for frequency. QDDP will continue to monitor in monthly case management reviews that format is followed, goals are appropriate and progress or revision is addressed</p>	07/13/2012			

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 06/14/2012
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>-will state what is on menu.</p> <p>-will wash hands after using toilet.</p> <p>-will complete a social activity.</p> <p>-will state the street she lives on.</p> <p>-will exercise.</p> <p>Client #1's ISP and/or Methodology Sheet did not indicate the frequency with which staff were to implement the objective/goals in regard to daily, weekly, bi weekly or a specific day of the week or month to implement and track the objectives.</p> <p>2. Client #2's record was reviewed on 6/6/12 at 10:01 AM. Client #2's ISP dated 3/17/12 indicated the following training objectives:</p> <p>-will list needs for purchase.</p> <p>-will state the number pills she takes.</p> <p>-will wash hair thoroughly.</p> <p>-will wear clean clothing.</p> <p>-will comb front part of hair.</p> <p>-will brush teeth after meals.</p>		<p>timely.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>QDDP will continue to oversee goal writing and implementation at routine site visits and monthly case management reviews. Director will continue to oversee with monthly random site and chart audits.</p>		

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 06/14/2012	
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>-will retrieve items needed for meal preparation.</p> <p>-will dry hands after washing.</p> <p>Client #2's ISP and/or Methodology Sheet did not indicate the frequency with which staff were to implement the objective/goals in regard to daily, weekly, bi weekly or a specific day of the week or month to implement and track the objectives..</p> <p>3. Client #3's record was reviewed on 6/6/12 at 10:56 AM. Client #3's ISP dated 3/23/12 indicated the following training objectives:</p> <p>-will state the amount of money needed to purchase cookies.</p> <p>-will state which PRN (As Needed) to use for a headache.</p> <p>-will rinse body with sprayer.</p> <p>-will put bra on.</p> <p>-will brush her hair.</p> <p>-will move toothbrush around in mouth.</p> <p>-will not talk with her mouth full of food.</p>						

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 06/14/2012	
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>-will get recipe needed to prepare a meal.</p> <p>-will wash hands after toileting.</p> <p>-will attend an activity of interest.</p> <p>Client #3's ISP and/or Methodology Sheet did not indicate the frequency with which staff were to implement the objective/goals in regard to daily, weekly, bi weekly or a specific day of the week or month to implement and track the objectives.</p> <p>4. Client #4's record was reviewed on 6/6/12 at 9:06 AM. Client #4's ISP dated 6/10/11 indicated the following objectives:</p> <p>-will make change from \$1.00 USD (United State Dollar)</p> <p>-will state reason for Loratadine.</p> <p>-will wash folds of skin.</p> <p>-will identify dials on iron.</p> <p>-will take pads to work.</p> <p>-will brush teeth twice daily.</p> <p>-will measure salad dressing.</p>						

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 06/14/2012
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>-will make a simple salad.</p> <p>-will dry hands after washing.</p> <p>-will increase number of steps.</p> <p>Client #4's ISP and/or Methodology Sheet did not indicate the frequency with which staff were to implement the objective/goals in regard to daily, weekly, bi weekly or a specific day of the week or month to implement and track the objectives</p> <p>Interview with Group Home Manager (GHM) #1 on 6/6/12 at 1:30 PM indicated the training objectives did not include when the goal would be implemented in regard to daily, weekly or other established timeframes.</p> <p>9-3-4(a)</p>				

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 06/14/2012	
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			
W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure the HRC (Human Rights Committee) reviewed and approved the use of a sedative for client #1 prior to a dental appointment.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 6/5/12 at 1:16 PM. Client #1's Dentistry Order Form dated 6/9/11 indicated the use of Valium (Sedative) 10 MG (Milligram) prior to the scheduled dental appointment. Client #1's record did not indicate HRC review or approval for the use of Valium 10 MG prior to dental appointments.</p> <p>Interview with GHM (Group Home Manager) #1 on 6/6/12 at 1:30 PM indicated the Valium was used prior to a dental appointment for client #1. GHM #1 indicated the HRC had not reviewed and/or approved the use of the sedative prior to dental appointments.</p>	W0264	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice. Order for pre dental examinations will be added to behavior plan and reviewed by Human Rights. 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 were reviewed and no other PRNs or behavior medications were without appropriate approval. What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur Behavior Services team will be retrained on PRNs and appropriate approval. QDDP will decline behavior plan without specific guidelines for medical PRNs when indicated. 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 will decline behavior plan without specific</i></p>	07/13/2012			

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 06/14/2012
--	---	--	---

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
	9-3-4(a)		guidelines for medical PRNs when indicated. Director will continue random nursing and home chart audits. Chart audit form will be updated to include specific indicator for medical PRNs.	

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 06/14/2012
--	---	--	---

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 PERCEDED 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
W0368	<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.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#1 and #2), the facility nurse failed to ensure all drugs were administered in compliance with the clients' physicians orders.</p> <p>Findings include:</p> <p>A review of the facility's BDDS reports and IIR's (Internal Incident Report) forms was conducted on 6/5/12 at 10:40 AM.</p> <p>-BDDS report dated 8/29/11 indicated on 7/22/11, "[Client #1] did not receive her 0.75 MG (Milligram) (dose) of Lorazepam (Seizures) at 8:00 PM medication administration time."</p> <p>-BDDS report dated 8/29/11 indicated on 8/12/11, "... administered 50 MG more of Seroquel (Schizophrenia) totaling 200 MG to [client #2] during the 8:00 PM medication pass. [Client #2] was to receive only 150 MG of Seroquel."</p> <p>-BDDS report dated 8/29/11 indicated on 5/26/11, "...failed to administer proper dosage of desmoprossin (Incontinence) 1 of 2 tablets to [client #2] at 8:00 AM on 5/26/11."</p>	W0368	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>All staff will be retrained on medication administration.</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>Medication administration and support needs for all individuals will be reviewed and retrained.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Medication Error Guidelines were reviewed by nursing staff and approved to remain appropriate. All nursing staff will retrain associates when medication error occurs. In addition, Team Leader or appropriate supervisor will track medication administration errors for each associate. As errors occur, progressive disciplinary action will be followed as outlined in the error guidelines.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p>	07/13/2012

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 06/14/2012
--	---	--	---

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>-BDDS report dated 9/6/11 indicated on 9/6/11, "Staff administered 600 MG of Trileptal when 900 MG were supposed to be administered to [client #1]."</p> <p>-BDDS report dated 10/5/11 indicated on 10/4/11, "[Client #2] 8:00 AM Ferrous Sulfate 325 MG (Anemia) was omitted on 10/4/11."</p> <p>-BDDS report dated 11/7/11 indicated on 11/5/11 regarding client #2, "Seroquel 300 MG was to be administered at 4:00 PM medication pass. Only 100 MG of Seroquel was administered."</p> <p>-BDDS report dated 12/12/11 indicated on 12/11/11, "[Client #1] was to receive 4 and 1/2 tabs of Lorazepam for a total of 0.5 MG. [Client #1] received only 1 and 1/2 tabs by staff working."</p> <p>-BDDS report dated 12/21/11 indicated, "[Client #1] received Lorazepam (Seizures) 0.5 MG, take 2 tablets at bedtime for a total of 1 MG... On 12/21/11 [client #1] received 4 tablets for a total of 2 MG at bedtime."</p> <p>-BDDS report dated 3/23/12 indicated on 3/21/12, "On 3/21/12, [client #1] did not receive her Oxycabezepam (Anxiety) 600 MG at 8:00 PM. The error was not found</p>		<p>Team Leader will monitor medication administration record at minimum 2/week for oversight and follow up to accurate administration.</p> <p>Nurse consultant will conduct medication observations 2/month at site to ensure continued accuracy of medications and liquid consistency.</p>	

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 06/14/2012
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>until 3/22/12 at the 8:00 PM medication pass."</p> <p>Client #1's record was reviewed on 6/5/12 at 1:16 PM. Client #1's Physician's Order Form dated 5/21/12 indicated client #1 had an order for Lorazepam 0.5 MG and Oxycarbazepin/Trileptal 900 MG.</p> <p>Client #2's record was reviewed on 6/6/12 at 10:01 AM. Client #2's record indicated client #2 had an order for Desmoprossin 2 tablets during May 2011. Client #2's record indicated client #2 had an order for Seroquel 150 MG during August 2011 and November 2011. Client #2's record indicated client #2 had an order for Ferrous Sulfate 325 MG during October 2011.</p> <p>Interview with Group Home Manager (GHM) #1 on 6/6/12 at 1:30 PM indicated staff should be administering medication as ordered and following medication administration procedures.</p> <p>9-3-6(a)</p>				

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 06/14/2012
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	
W9999	<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.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 4 of 27 incident reports reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) within 24 hours in accordance with state law regarding medication administration errors for 2 of 4 sampled clients (#2 and #3) plus one additional client (#7). The facility failed to immediately notify BDDS within 24 hours in accordance with state law regarding a fall with injury for client #1.</p> <p>Findings include:</p> <p>A review of the facility's BDDS reports</p>	W9999	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Policy and procedure were reviewed and remain current. St. Vincent New Hope leadership were trained on 6/11/12 on Investigation procedures by Megan Brown, Forensic Nurse, St. Vincent Center of Hope. Team Leaders and Managers will review policy implementation for falls, unknown injuries and other reportable incidents on 6/29/12. Skills Trainers at site will review reportable incident information , including who and when to contact. Reportable incident guidelines were posted in the home.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents have the potential to be affected by this practice. All other notes were reviewed for this individual and the other individuals in the home. There were no further missed reportable incidents.</p> <p><i>What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur</i></p> <p>Team Leader will review documentation weekly, initialing on the daily progress notes to improve</p>	07/13/2012	

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 06/14/2012	
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>and IIR's (Internal Incident Report) forms was conducted on 6/5/12 at 10:40 AM.</p> <p>-IRR dated 4/26/11 indicated client #7 had been administered Metformin (Diabetes Management) instead of Trazodone (Depression) at 8:00 PM. The review did not indicate the incident of medication administration error had been reported to BDDS.</p> <p>-IRR dated 4/26/11 indicated client #3's 4:00 PM dose of Amoxicillin (Antibiotic) 250 MG (Milligrams), Cortisporin (Anti Bacterial Eye Drops) eye drops and Carbamide Peroxide (Ear Wax) ear drops had not been administered. The review did not indicate the incident of medication administration error had been reported to BDDS.</p> <p>-IRR dated 5/27/11 indicated, "Staff failed to administer proper dosage of Desmoprossin (Bladder Control) 1 of 2 tablets to client #2 at 8:00 PM on 5/27/11." The review did not indicate the fall with injury had been reported to BDDS.</p> <p>-IRR dated 5/3/12 indicated, "[Client #1] was going outside play ball with staff and peers and [client #1] fell on the grass. A body check was done. And [client #1] got an .25 inch on her right knee and also on</p>		<p>oversight to appropriate and timely response to reportable situations. Manager will communicate daily with Team Leader and/or site staff to monitor daily operations and increase oversight to potential reportable situations or investigations.</p> <p>Further failure to call to report by staff will be addressed with disciplinary action as appropriate. Further failure by Team Leader to report incidents timely or conduct investigations as indicated will be addressed with progressive disciplinary action.</p> <p>Reportable incident guidelines posted at the home for continued reference and review.</p> <p><i>How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place.</i></p> <p>Director will continue to review all reportable incidents. Any untimely incidents will be addressed with QDDP immediately. Director will establish a system to more closely monitor that investigations are completed as required. Each reportable incident that meets criteria for investigation will be printed and monitored by Director that investigation is being completed thoroughly and accurately.</p>				

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 06/14/2012	
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>the right elbow." The review did not indicate the fall with injury had been reported to BDDS.</p> <p>Interview with Group Home Manager (GHM) #1 on 6/6/12 at 1:30 PM indicated medication administration errors for clients #2, #3 and #7 should be reported to BDDS. GHM #1 indicated client #1's fall should have been reported to BDDS.</p> <p>9-3-1(b)</p>						