

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G467	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/22/2011
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3538 JULIE LN INDIANAPOLIS, IN46208
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W0000	<p>This visit was for the post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on 10/7/11.</p> <p>Dates of Survey: 12/21/11 and 12/22/11</p> <p>Facility Number: 000981 Provider Number: 15G467 AIM Number: 100249390</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>Saint Vincent New Hope was found to be in compliance with 42 CFR 483 Subpart I. This also reflects a state deficiency in accordance with 460 IAC 9. Quality Review completed 12-30-11 by C. Neary, Program Coordinator.</p>	W0000		
W9999	<p>State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rules were not met.</p> <p>410 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the</p>	W9999	All staff will be retrained on BDDS Reportable Incident requirements. In addition to the training, each staff will complete a competency quiz that indicates their understanding of these requirements. Each staff will complete the competency quiz monthly to retain and ensure continued competency. The	01/17/2012

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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	<p>division by telephone no later than the first business day followed by written summaries as requested by division.</p> <p>This rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 1 incident reports reviewed affecting client #1, the facility failed to notify the Bureau of Developmental Disabilities Services (BDDS) within 24 hours in accordance with state law, of a fall resulting in injury.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/21/11 at 12:30 PM. The review indicated the following:</p> <p>-BDDS report dated 12/21/11, "At 9:12 PM, on call supervisor [AD #1 (Administrative Staff)] received a page that [client #1] was behaving wildly. No PRN (As Needed) was administered at this time. On the following day, [TL #1 (Team Leader)] noted abrasions around the eyebrow and cheekbone of [client #1]. Upon investigation it was determined that [client #1] had lost her balance when pursuing a staff member through the house. this was verified with two staff and one high functioning client. [Client #1] injured herself during the fall...."</p> <p>Interview with TL #1 on 12/22/11 at 9:25 AM indicated the incident was not an injury of unknown origin. TL #1 indicated staff and a client observed client #1 fall. TL #1 indicated the staff on duty contacted the on call supervisor to report the behavior of client #1 and to request the use of a PRN but did not report the fall. TL #1 indicated staff on duty should have reported client #1's fall</p>		<p>Team Leader and/or QMRP will review the progress notes weekly to ensure no further incidents go unreported.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	<p>and a BDDS report should have been submitted within 24 hours of the incident.</p> <p>Interview with AS (Administrative Staff) #1 on 12/22/11 at 9:40 AM indicated the staff on duty had contacted her to report client #1's behavior but did not report the fall. AS #1 indicated staff did not observe any injury at the time of the fall.</p> <p>9-3-1(b)</p>				