STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G716	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST VINCENT NEW HOPE INC	8521 CROWN POINT RD INDIANAPOLIS, IN 46278

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W000000	This visit was for a fundamental annual recertification and state licensure survey. Dates of survey: June 3, 4, 5 and 10, 2013. Facility Number: 004061 Provider Number: 15G716 AIMS Number: 200483530 Surveyor: Claudia Ramirez, RN The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/13/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview, the facility failed for 1 of 2 sampled clients (client #2) to prepare his Comprehensive Functional Assessment (CFA) within 30 days of his admission to the group home. Findings include: Client #2's records were reviewed on 06/04/13 at 11:02 AM. Client #2's ISP (Individual Support Plan) dated 10/10/12 indicated client #2 was admitted to the group home on 09/10/12. Client #2's CFA was dated 11/07/12. An interview was conducted on 06/05/13 at 11:30 AM with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated the CFA was completed late and it was not completed within 30 days of client #2's admission to the group home. 9-3-4(a)	W000210	*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.* Comprehensive Functional Assessments are included in the admission packet for each individual who transfers into services with St. Vincent New Hope. This assessment was a documentation oversight. The QDDP had adequately assessed the individual through observation and interaction, as well as developed and implemented a comprehensive training plan and ISP for the individual within the 30 day timeline. All individuals have the potential to be affected by this practice. There were no other admissions or admission documentation concerns. *What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur* St. Vincent New Hope maintains an admission checklist to be utilized during the admission process. This document, in	06/14/2013

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			conjunction with the BDDS Pre and Post Transition process is the system that can prevent future occurrences. *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 review admission checklist at regular intervals during the process, at minimum 21 days after admission. Checklist was changed to include a review signature. In addition, ISP and charts are audited at minimum annually.	

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 1 of 2 sampled clients (client #1), by not ensuring the client received nursing services according to her medical needs. Findings include: On 06/03/13 at 10:11 AM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and included the following: 10/08/12: A BDDS report submitted 10/09/12 for an incident dated 10/08/12 at 1:00 PM indicated, "On 10/08/12, Nurse [name] examined [client #1's] right foot after receiving a report from skills trainer, [staff #5], that [client #1's] foot was swollen. Nurse found [client #1's] right foot was swollen and had begun to bruise. Nurse [name] instructed staff to take [client #1] to the ER (Emergency Room). Staff took [client #1] to the ER at approximately 1pm (sic). The hospital took x-rays and determined that [client #1] had a fracture of her Right Great Toe. ER wrapped the toe and instructed staff to have [client #1] follow up with Dr [name] at [orthopedic facility] in 10 days. QDDP	W000331	*What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.* Client #1 foot is fully healed. She continues to be seen weekly at minimum by her nurse consultant. She is monitored daily at the site for any skin issues due to her status of using a wheelchair. Current nurse consultant team has been trained on the appropriate follow up procedures for any question to skin or bone integrity. *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 of this facility are seen by their nurse consultant at minimum weekly. All residents are monitored daily by the direct support staff for skin issues as 3 of the 4 individuals have skin integrity risks related to diabetes, wheelchair use and incontinence. *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.* Present nurses have indicated	06/14/2013

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	(Qualified Developmental Disability Professional) and Team Leader will conduct a thorough investigation to determine the cause of [client #1's] injury. [Client #1] is non-verbal and non-ambulatory. Investigation will include interviews with all staff that worked with [client #1] to establish a timeline and cause for this injury. Allegations of abuse/neglect have not yet been substantiated as investigation remains pending. If evidence of staff abuse/neglect is discovered, staff responsible will be suspended immediately." 10/04/12: Emergency Room Records indicated client #1 was seen in the ER due to vomiting and abdominal x-rays were obtained. Client #1 was discharged with medication to control the nausea and vomiting. 10/04/12 - 2:00 PM: Client #1's Individual Progress Notes (IPN) indicated, "[Client #1] was seen in ER tonight for vomiting and shilo (sic) breathing. Chest x-ray, blood work all was normal...." 10/05/12: Staff Communication Notes indicated, "Staff (staff #7) called on call regarding [client #1's] meds that was (sic) delivered. She said we should give the		proper assessment, follow up and judgment. All nurses on call document their calls and direction daily. Those records are scanned and emailed to all directors weekly to provide further oversight to proper direction and follow up.	

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	meds...this was according to NR (nurse) on call (nurse #1)." 10/05/12 - 8:45 AM: Client #1's IPN indicated, "[Client #1] cried most of the night...." 10/06/12 - no time documented: Client #1's IPN indicated, "[Client #1] cried on and off all night. Around 4 am she stopped til (sic) around 6:30 am and then started up again...staff has tried everything, finally staff gave her Tylenol (pain reliever) and after 45 min or so she calmed down." 10/06/12 - 9:00 PM: Client #1's IPN indicated, "...She had a swollen right feet (sic). Nurse notified and was told not to wear shoes at this time of the swollen feet." Staff #4's undated written statement indicated, "This happened on Saturday Oct 6th 2012. I clocked in around past (sic) 7:00 am...After [client #1's] feeding I got her up with Hoyer Lift to the shower chair, the staff (sic) walked in to tell me about her that she cried throughout the night. I put her on (sic) toilet...The night shift staff clocked out around 9:00 am and another staff clock (sic) in. He asked what (sic) left to be done (sic) I told him [client #1] was still on the toilet. He			

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	asked to give her (sic) shower and he did, dressed her up (sic). But the shoe was not on her...After lunch I tried to put shoe on [client #1] but she don't (sic) allowed (sic) me. I removed the socks on her right foot, in which I wanted to put the shoe. I saw it swelling (sic) up and dark and I said I need to call the nurse. I called the nurse and did the body check on her and I fax (sic) it to the nurse. I page (sic) her no respond (sic) and I called her in the present (sic) of the other staff. But nobody called back and it was about time for me to leave. I told the staff in case the nurse call (sic) to talk to the nurse and told the staff that, (sic) he should tell the incident to the evening shift staff so she can called (sic) the nurse again and do the nessary (sic) thing. On Monday (10/08/12) nurse (sic) was at the day service to check on her. I was told to take her to Immediate hospital on [location]. I did but they are not accepting Medicaid and I need to take her back home for evening shift staff to take her to emergency hospital." Staff #7's undated written statement indicated, "On Saturday 10/6/12 I was talking to [client #1] and the other staff came to her room and told me she has a swollen feet (sic). I asked him what did they do about it. He said they has (sic) paged the on call and nobody called back,			

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	also they as (sic) filled the OOPS (Occurrence Outside Practice Standards) form for her. I told him to let the Team Leader aware (sic) of what is happening, that the on-call has not called back. He called the Team Leader and left voice message for her. She called back immediately and I answered the call and gave the phone to the other staff (staff #9). I showed him the on-call number. He paged them right in my presence, the on-call called back in (sic) couple of minutes, like (sic) 5 minutes. The nurse told him that the staff should not wear shoe for her (sic)...." Staff #8's written statement dated 10/09/12 indicated, "On the 6th of October, 2012 I came to work for my 9A - 9P shift. [Client #1] was already in the restroom taken in by another staff (staff #4) in a bath (shower) chair. So at about 9:10 AM I ask the other staff that I want (sic) to give [client #1] a shower. After giving her shower and [client #1] was dressed up, staff (staff #8) put socks on her feet. She tend (sic) to pull her feet back when staff wanted to put shoes on her. Staff did not see any visible wound or sign of swollen feet but staff did not put the shoes on her since she was not going out at that moment...[Client #1] pull (sic) her right foot back when staff tires (sic) to put her shoes on her. This			

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	time staff (staff #8) took off her socks to notice that her right foot was a little swollen. Staff called the on-call with no return call. Then called again with no call back. Staff fax (sic) the physical report form. Staff (staff #8) called the team leader. The team leader ask (sic) staff to call the on-call again. Staff (staff #8) call (sic) the on-call who finally called back and said not to put shoes on her and her nurse will (sic) notified (sic)...." Staff #9's written statement dated 10/11/12 indicated, "Staff (staff #9) took [client #1] to ER (Emergency Room) for vomiting & shalo (sic) breathing. [Client #1] was out of staff sight for about 5 mins (minutes) to take x-ray. [Client #1] return (sic) back into room (sic) she was very quiet...." 10/12/12: Investigation Summary findings indicated, "Nurse on-call did not provide appropriate follow-up when skills trainer paged nurse to report injury to [client #1's] toe. Nurse has resigned and is no longer with [agency] program." 12/03/12: BDDS Follow-up indicated, "...QDDP interviewed all skills trainers involved as well as Nurse on call. QDDP reviewed [client #1's] progress notes and Nurse on call notes. QDDP was unable to conclusively determine the exact cause of			

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	[client #1's] broken toe...." On 06/04/13 at 11:30 AM an interview with the RN (Registered Nurse) was conducted. The RN indicated she was still out on leave when this incident occurred, however since client #1's foot was noted to be swollen and bruised on 10/06/12, she should have been seen and evaluated by a medical professional at that time. The RN indicated client #1 should not have waited until 10/08/12 for an assessment of her foot. 9-3-6(a)			