

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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
W000000	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00120779.</p> <p>Complaint #IN00120779: Substantiated-Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W125, W126, W130, W149, W153, W154, W227, W331, W369, W382 and W460.</p> <p>Unrelated deficiencies cited.</p> <p>Dates of Survey: October 2, 3, 4 and 11, 2013.</p> <p>Provider number: 15G458 Facility number: 000972 AIM number: 100244840</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed October 21, 2013 by Dotty Walton, QIDP.</p>	W000000		

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

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000102	<p><b>483.410 GOVERNING BODY AND MANAGEMENT</b> The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 4 of 4 sampled clients (A, B, C and D) and for 5 additional clients (E, F, G, H and I). The Governing Body failed to ensure the facility implemented sufficient measures to protect client F from repeated abuse from client I, to ensure the staff immediately reported all client to client abuse to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law in regard to clients F and I. The Governing Body failed to ensure the facility conducted thorough investigations of all allegations of client to client abuse for clients C, D, E, F and I. The Governing Body failed to ensure clients A, B, C, D, E, F, G and H were not restricted from the sharps and chemicals/cleaning supplies and clients D and E were not restricted from access to their clothing. The Governing Body failed to ensure the facility maintained the clients' records in regard to clients A, B, C, D, E, F, G and H, provided client B training in money management skills and maintained client C's personal privacy. The Governing Body failed to ensure the facility maintained the group home in regard to the flooring and appliances in the home.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient measures were implemented to protect client F from repeated abuse from client I,</p>	W000102	Please see corrective action plan for each specific issue in W111, 122, 125, 126, 130, 149, 153, 154, 227, 249, 252, 322, 331, 369, 382, 436, 455, 460, 488	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>all allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law and all allegations of abuse for clients C, D, E, F and I were thoroughly investigated. The governing body failed to exercise general policy and operating direction over the facility to ensure client A's, B's, C's, D's, E's, F's, G's and H's rights were ensured in regard to restricting the clients from access to the sharps and chemicals/cleaning supplies and restricting clients D and E from their clothing, to ensure client A's, B's, C's, D's, E's, F's, G's and H's records were maintained, to ensure client B was provided training in money management skills and to ensure client C was prompted to maintain her personal privacy. The governing body failed to exercise general policy and operating direction over the facility to ensure the group home floors and appliances were maintained. Please see W104.</p> <p>2. The Governing Body failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and 5 additional clients (E, F, G, H and I). The facility failed to implement its written policy and procedures to ensure sufficient measures were implemented to prevent client to client aggression/abuse and further injury due to client to client abuse, all allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law, all allegations of abuse for clients C, D, E, F and I were thoroughly investigated and to ensure clients A, B, C, D, E, F, G and H were not restricted from access of the sharps, chemicals/cleaning supplies and/or their clothing.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2013
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>Please see W122.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-1(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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	
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and 5 additional clients (E, F, G, H and I), the facility's governing body failed to exercise general policy and operating direction over the facility to ensure:</p> <p>__ Sufficient measures were implemented to protect client F from repeated abuse from client I.</p> <p>__ All allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law.</p> <p>__ All allegations of abuse for clients C, D, E, F and I were thoroughly investigated.</p> <p>__ Client A's, B's, C's, D's, E's, F's, G's and H's rights were ensured in regard to restricting the clients from access to the sharps and chemicals/cleaning supplies and restricting clients D and E from their clothing.</p> <p>__ Client A's, B's, C's, D's, E's, F's, G's and H's records were maintained.</p> <p>__ Client B was provided training in</p>	W000104	Please see W111, 122, 125, 126, 130, 149, 153, 154, 227, 249, 252, 322, 331, 369, 382, 436, 455, 460, 488	11/08/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>money management skills.</p> <p>__ Client C was prompted to maintain her personal privacy.</p> <p>__ The group home floors and appliances were maintained.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. The governing body failed to exercise general policy and operating direction over the facility to ensure the documentation of the clients' ISP (Individualized Support Plan) objectives was maintained and accounted for in regards to clients A, B, C, D, E, F, G and H. Please see W111.</li> <li>2. The governing body failed to exercise general policy and operating direction over the facility to ensure client A's, B's, C's, D's, E's, F's, G's and H's rights in regard to restricting them from access to the sharps and chemicals/cleaning supplies and restricting clients D and E from their clothing. Please see W125.</li> <li>3. The governing body failed to exercise general policy and operating direction over the facility to ensure client B was provided training in money management skills. Please see W126.</li> <li>4. The governing body failed to exercise general policy and operating direction</li> </ol>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>over the facility to ensure client C was prompted to maintain her personal privacy. Please see W130.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure sufficient measures were implemented to prevent client to client aggression/abuse and further injury due to client to client abuse in regard to clients I and F. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law and to ensure all allegations of abuse for clients C, D, E, F and I were thoroughly investigated. Please see W149.</p> <p>6. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to BDDS and to APS in accordance with state law. Please see W153.</p> <p>7. The governing body failed to exercise</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>general policy and operating direction over the facility to ensure all allegations of abuse for clients C, D, E, F and I were thoroughly investigated. Please see W154.</p> <p>8. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services developed and implemented a health care plan in regard to client D's diagnosis of CHF (Congestive Heart Failure), to ensure the staff notified nursing when client B experienced frequent coughing during a meal, to ensure the staff followed client B's and C's dining plans and to ensure client B's, C's and D's medical needs were monitored. Please see W331.</p> <p>9. Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM and on 10/3/13 between 5:15 AM and 7:30 AM. A small chest freezer was in the hallway outside the bathroom. The outside of the freezer was rusted and the inside plastic seal was broken. The freezer contained frozen meat and vegetables for all of the clients in the group home (clients A, B, C, D, E, F, G and H). The hall carpet outside of clients F's and D's bedrooms was dark brownish/black with large dark stained areas. The carpet contained small particles of unidentifiable pieces of trash. The carpet in the living room near the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>kitchen and at the edge of the carpet between the living room and kitchen had a large area that was frayed and unraveled.</p> <p>Interview with staff #3 on 10/2/13 at 5 PM indicated the carpet had not been vacuumed recently. Staff #3 stated the carpet should be vacuumed daily but "obviously" had not been. When asked to describe the carpet, staff #3 stated, "I would say it's dirty, even filthy and stained and I wouldn't sit on it." Staff #3 indicated the freezer needed to be replaced and was not sure if a repair order had been submitted or not. Staff #3 indicated the living room carpet was frayed and unraveled from clients D, G and H running their walkers over the carpet.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the TL (Team Leader) on 10/4/13 at 1 PM indicated the clients' home was to be maintained and repairs made in a timely manner. The QIDP stated, "It sounds like the freezer needs to be replaced."</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-1(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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
W000111	<p><b>483.410(c)(1)</b> <b>CLIENT RECORDS</b> The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights.</p> <p>Based on record review and interview for 4 of 4 sampled clients (A, B, C and D), the facility failed to ensure the clients' records were maintained in regards to the clients' documentation of their ISP (Individualized Support Plan) objectives.</p> <p>Findings include:</p> <p>Client A's record was reviewed on 10/3/13 at 11 AM. Client A's ISP of 8/27/13 indicated client A had objectives to bathe daily, to brush her teeth, to apply deodorant, to go on a non-food related outing, to add quarters to equal 1 dollar, to take her dish to the kitchen sink, to put her clothes in her hamper and to pack an entrée in her lunch box.</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's ISP of 7/29/13 indicated objectives to wash her left leg, to brush her teeth, to pick up her deodorant, to put her left leg in her pants while dressing, to get her plate out of the kitchen cabinet for meals, to use the bathroom after dinner, to use a drinking bottle at meals and to identify a piece of</p>	W000111	<p>3 months' of data for the mentioned request was provided at the survey. There was data and program information from 7/1/2013 through present in the chart. The prior 3 months (4/2013, 5/2013, 6/2013) had been bulked upon goal revision. Those documents were not available at chart review because they were removed from the filing system in which they are maintained. There is no certainty for what purpose they were removed, but going forward, Team Leader will secure patient records in a locked cabinet until they are ready for electronic storage. Team Leaders and Managers will be retrained on Procedure for Bulk Filing, storage of records. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put into place? The QIDP will check the bulk filing records monthly while in home to ensure that they are secure and that they excess will be transported to the main office for electronic storage.</p>	11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>clothing.</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's ISP of 8/15/13 indicated client C had objectives to color pictures in a coloring book, to put her clothes in a clothes hamper, to wash her hands after toileting, to clean the sink after brushing her teeth, to chew her food thoroughly, to wash her feet, to apply a cream to her elbows, to put her drink in her lunch bag and to match a quarter to a picture of quarter.</p> <p>Client D's record was reviewed on 10/3/13 at 1 PM. Client D's ISP of 8/30/13 indicated client D had objectives to stir the thickener in his drink, to put a napkin in his lunch box, to call a family member weekly, to wash his private area, to assist with putting on his left sock, to swab his mouth out, to drop an envelope in the mailbox, to use the bathroom before going to the day program and to wash his hands before dinner.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the TL (Team Leader) on 10/4/13 at 1 PM, when asked to see 3 months of data in regard to client A's, B's, C's and D's training objectives, the TL indicated she had looked for the clients' records but could not find them. The TL</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>indicated October 2013 was the only month available for review for 2013. The QIDP stated the clients' records "should be available for review upon request" and did not know where the clients' records were.</p> <p>9-3-1(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 4 of 4 sampled clients (A, B, C and D) and 5 additional clients (E, F, G, H and I). The facility failed to implement its written policy and procedures to ensure:</p> <p>___ Sufficient measures were implemented to prevent client to client aggression/abuse and further injury due to client to client abuse.</p> <p>___ All allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law.</p> <p>___ All allegations of abuse for clients C, D, E, F and I were thoroughly investigated.</p> <p>___ Clients A, B, C, D, E, F, G and H were not restricted from access of the sharps, chemicals/cleaning supplies and/or their clothing.</p> <p>Findings include:</p> <p>1. The facility failed to ensure client A's, B's, C's, D's, E's, F's, G's and H's rights in</p>	W000122	As noted in the investigations, the client I and F were separated by moves to other home (client I). It was November of 2012 at which time the incidents increased in intensity and frequency. After Client I hysterectomy, her ability to reside with client F became more difficult and she began striking out toward client F. At that time, several interventions were engaged including increased behavior consultant contact, increased staff interactions, room changes, increased psychiatric and medical reviews. As the incidents became more aggressive, staff became frightened and were retrained on how to safely intervene using approved support plan interventions. At the first move opportunity, client I was transferred to another home. This occurred 7/1/13. All reportable incidents, including those of peer to peer aggression are tracked by St. Vincent New Hope Quality Assurance. Group Home Director reviews incidents and investigations as they occur and are reported. The Quality Assurance spreadsheet allows a further analysis of the incidents occurring by person, location, date, time, timeliness of report, etc. St. Vincent New Hope feels	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>regard to restricting the clients from access to the sharps, chemicals and/or their clothing. Please see W125.</p> <p>2. The facility failed to implement its policy and procedures to ensure sufficient measures were implemented to prevent client to client aggression/abuse and further injury due to client to client abuse, to ensure all allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to BDDS and to APS in accordance with state law and to ensure all allegations of abuse for clients C, D, E, F and I were thoroughly investigated. Please see W149.</p> <p>3. The facility failed to ensure all allegations of client to client abuse were reported immediately to the administrator, BDDS and APS in accordance with state law for clients F and I. Please see W153.</p> <p>4. The facility failed to provide evidence thorough investigations were conducted for all allegations of client to client abuse for clients C, D, E, F and I. Please see W154.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-2(a)</p>		<p>this system remains appropriate and will continue. In the instances that continued physical aggression is a concern, there will be more concentrated effort to staff the aggressor more stringently to prevent further contact. Increased staffing beyond license limitations and direct staffing assignments are possible solutions that could be utilized. Director will also continue to work with the St. Vincent New Hope Director of Placement to ensure that opportunities for movement continue to be considered. St. Vincent New Hope dates all its reports. The investigation folder includes the initial and any follow up reports. The folder is also labeled on the exterior with the date of incident. The final page of the investigation summary includes the date of the summary report (investigation end) and the administrative review (within 5 days or extended). The summary report did not include a date on the front page of it and that seems to be what is being indicated as undated. St. Vincent New Hope added a date of incident line to the front page of the summary. All Team Leaders, Managers will review the feedback and be retrained on increasing thoroughness and timeliness of investigations. A checklist for all individuals and staff involved is within the investigation report.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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	
			Investigations will be include all interviews as relevant before finalizing.SVNH Quality Assurance and GH Director will continue to track compliance and address untimely reports. Untimely reports will be addressed in quarterly performance management reviews and overall trend analysis for department benchmarks. All individuals were reviewed by IDT and restrictions were removed as IDT deemed appropriate. IDT felt that the restriction to full access to all clothing for client C remained appropriate for her treatment plan. However, the Behavior Support Plan and techniques for training were revised. All staff will be retrained on all plans.All closets were cleaned and organized. A room assignment was implemented for staff to review and inspect each room daily. These room assignment will be documented and returned to manager monthly. Manager will also conduct random room checks during routine weekly visits to sites.All other clothing and belongings are maintained in client rooms. All knives and sharps are available to all residents to access as needed. All household and cleaning chemicals are availbe for access.Client B and E have a clothing care goal added to ISP.Client C has privacy goal added to ISP.Client E has goal to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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	
			maintain skills regarding appropriate clothing. Her deteriorating neurological condition related to dementia prevents any valid success in gaining independence in this area.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000125	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to ensure the clients' rights in regard to restricting the clients from access to the sharps, chemicals/cleaning supplies and their clothing.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records for October 2012 through October 2013 were reviewed on 10/2/13 at 1 PM. The facility records indicated no incidents and/or attempts of improper use of sharps and/or chemicals for clients A, B, C, D, E, F, G and H.</p> <p>Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM and on 10/3/13 between 5:15 AM and 7:30 AM.</p> <p>___ The sharp knives were stored in a locked plastic box inside a locked cabinet in the staff office that was also locked.</p> <p>___ Chemicals/cleaning supplies were</p>	W000125	<p>All individuals were reviewed by IDT and restrictions were removed as IDT deemed appropriate. IDT felt that the restriction to full access to all clothing for client C remained appropriate for her treatment plan. However, the Behavior Support Plan and techniques for training were revised. All staff will be retrained on all plans. All closets were cleaned and organized. A room assignment was implemented for staff to review and inspect each room daily. These room assignment will be documented and returned to manager monthly. Manager will also conduct random room checks during routine weekly visits to sites. All other clothing and belongings are maintained in client rooms. All knives and sharps are available to all residents to access as needed. All household and cleaning chemicals are available for access. Client B and E have a clothing care goal added to ISP. Client C has privacy goal added to ISP. Client E has goal to maintain skills regarding appropriate clothing. Her</p>	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>stored in a locked hallway closet.</p> <p>__ Client D's pants/shorts and shirts were not folded and stored on the shelves in the hallway closet with the blankets and comforters.</p> <p>__ Client E's clothing was stored in large plastic tubs in her closet. Three of the tubs were on the closet shelf and out of client E's reach. There were no clothes hanging in client E's closet.</p> <p>Client A's record was reviewed on 10/3/13 at 11 AM. Client A's record indicated no need to restrict client A from sharp objects and/or chemicals/cleaning supplies.</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's record indicated no need to restrict client B from sharp objects and/or the chemicals/cleaning supplies.</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's record indicated no need to restrict client C from sharp objects and/or chemicals/cleaning supplies.</p> <p>Client D's record was reviewed on 10/3/13 at 1 PM. Client D's record indicated no need to restrict client D from sharp objects and/or chemicals/cleaning supplies. Client D's BSP (Behavior</p>		deteriorating neurological condition related to dementia prevents any valid success in gaining independence in this area.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>Support Plan) indicated client D had a targeted behavior of tearing clothing as a result of his diagnosis of, but not limited to, anxiety. The BSP indicated no restriction of clothing and/or to keep client D's clothing in the hall closet of the group home.</p> <p>Client F's record was reviewed on 10/4/13 at 12:15 PM. Client F's 5/1/13 BSP (Behavior Support Plan) indicated client F had self injurious behaviors of cutting or puncturing her skin with sharp items and banging her head. Client F's BSP indicated all sharps at the group home were to be locked and use of the knives was to be closely supervised. Client F's plan of removal indicated when client F has gone a period of a year without reported incidents of SIB (self injurious behaviors) and threats to self harm, the group home staff will allow client F to use sharps on an independent basis. Review of client F's behavior data sheets from March 2013 through October 2013 indicated no incidents of SIB. Client F's record did not indicate a need to restrict client F from the chemicals/cleaning supplies in the home.</p> <p>Interview with staff #3 on 10/2/13 at 5 PM stated the sharps were locked "initially" because of client F. Staff #3 indicated no memory of any incidents of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>client F threatening and/or misusing sharps. Staff #3 stated, "I think it's a precautionary thing for everyone cause most of them don't know how to use a knife." Staff #3 stated the chemicals were locked "I think" because of client C. Staff #3 stated client C would not drink the chemicals but "supposedly" would try to use them in inappropriate ways. Staff #3 stated "We keep [client D's] shorts and shirts in the closet because he gets nervous and shreds them up." Staff #3 indicated clients A, B, C, D, E, F, G and H did not have keys to freely access the sharps locked in the staff office and/or the chemicals/cleaning supplies locked in the hallway.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the TL (Team Leader) on 10/4/13 at 1 PM, the TL indicated the knives were locked because of client F. The QIDP and the TL indicated no specific history and/or incident of self harm/threats in regard to client F and the inappropriate use of sharps. The QIDP stated the facility did not want the clients to hurt themselves and the knives were locked also because "It's a safety issue." The QIDP indicated clients A, B, C, D, E, F, G and H were not independent in using sharp objects and would need to be supervised. The TL indicated client H had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>a key to a lock box to a single knife on top of the refrigerator and could use that knife with staff supervision whenever she wanted to use a knife. The TL stated, "I think it's a small paring knife." The TL indicated client D shreds his clothing. The QIDP indicated client D should not be restricted from his clothing. The TL indicated the chemicals/cleaning supplies were locked because of clients C and E. The TL indicated client C and E could not distinguish between some of the cleaners and might mistake the chemicals/cleaning supplies for something else like bubble bath. The QIDP indicated clients C and E required supervision while bathing. The TL stated, "I think she (client C) has a history of that but I'll have to check with the BS (Behavior Specialist) for sure."</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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	
W000126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on interview and record review for 1 of 4 sampled clients (B), the facility failed to provide client B training in money management skills.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's CFA (Comprehensive Functional Assessment) of 7/29/13 indicated client B required staff assistance for all financial transactions. Client B's CFA indicated client B could not identify basic coins and/or dollar bills. Client B's 7/29/13 ISP (Individual Support Plan) indicated client B did not receive training in regard to money management.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/4/13 at 1 PM indicated client B did not have a money management goal.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-2(a)</p>	W000126	<p>Money management goal was written for client B. ISP contains specific page for money skills and financial informtion, such as payee representation, etc. all other ISPs and client charts were reviewed to have money management goals consistent and current. Team Leaders and managers will be trained on appropriate assessment for skills and deferral if relevant.</p>	11/08/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000130	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 1 of 4 sampled clients (client C), the facility failed to prompt client C to maintain her personal privacy.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/3/13 between 5:15 AM and 7:30 AM. At 5:15 AM client C was walking around the group home wearing a bath robe with no under garments and her robe not secured around her. At 5:20 AM client C sat down on the couch near client D, her legs open and exposing her private area. Staff #5 prompted client C to go to the office to choose her clothing for the day to get dressed. Client C went to the office, sat down cross legged on the floor in front of a plastic tub full of shoes and began sorting through the shoes. Client C sat exposing her private area and breasts. Client A and staff #4 walked into the office to ask staff #5 a question and walked out. Staff #4 and staff #5 did not prompt client C to maintain her personal privacy.</p> <p>Interview with the TL (Team Leader) on</p>	W000130	Client C has a training goal to address privacy and cue when it is lacking. All staff will be trained on ways to assist Client C in maintaining privacy and dignity. She does not want staff intervention and is very clear about her disinterest in being modest. It is not for lack of effort that she continues to be less than dignified in this manner. QIDP will continue to approach IDT as progress on goal becomes clearer.	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>10/4/13 at 12:30 PM indicated the staff were to prompt client C to keep herself covered. The TL indicated client C had a problem maintaining her own personal privacy.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
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 interview and record review for 2 of 4 sampled clients (C and D) plus 3 additional clients (E, F and I), the facility failed to implement its policy and procedures to ensure:</p> <p>___ Sufficient measures were implemented to prevent client to client aggression/abuse and further injury due to client to client abuse.</p> <p>___ All allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law.</p> <p>___ All allegations of abuse for clients C, D, E, F and I were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 10/2/13 at 1 PM. The facility records indicated:</p> <p>A 10/12/12 BDDS report indicated on 10/11/12 at 5:15 PM client F was helping to set the table for the evening meal. Client I rushed toward client F and</p>	W000149	As noted in the investigations, the client I and F were separated by moves to other home (client I). It was November of 2012 at which time the incidents increased in intensity and frequency. After Client I hysterectomy, her ability to reside with client F became more difficult and she began striking out toward client F. At that time, several interventions were engaged including increased behavior consultant contact, increased staff interactions, room changes, increased psychiatric and medical reviews. As the incidents became more aggressive, staff became frightened and were retrained on how to safely intervene using approved support plan interventions. At the first move opportunity, client I was transferred to another home. This occurred 7/1/13. All reportable incidents, including those of peer to peer aggression are tracked by St. Vincent New Hope Quality Assurance. Group Home Director reviews incidents and investigations as they occur and are reported. The Quality Assurance spreadsheet allows a further analysis of the incidents occurring by person, location, date, time, timeliness of report, etc. St. Vincent New Hope feels	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>knocked the plates out of her hands. "Staff tried to separate the two, but during the altercation [client F] was bitten on one of her fingers. The bite did not break the skin. She also has a circular bruise on her right arm about the size of a quarter. [Client F and client I] also both pulled at each others (sic) hair before the three staff present could get them separated." The report indicated the BC (Behavior Coordinator) would continue to counsel with client F and client I and help the staff to deal with and prevent altercations effectively. The undated investigative summary for the incident of 10/11/12 indicated 3 staff were in the home at the time of the incident. The investigative summary indicated no staff interviews and/or statements. The summary indicated interviews from clients F and I. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A BDDS report of 10/20/12 indicated on 10/19/12 at 7 PM client I became upset with client F and pulled her hair and hit her on the head. The 10/29/12 follow up BDDS report of the incident dated 10/19/12 indicated the IDT (Interdisciplinary Team) reviewed client I's behaviors and felt the recent increase in her Premarin (a hormone replacement) was the cause of the increase of her behaviors. The Premarin was</p>		<p>this system remains appropriate and will continue. In the instances that continued physical aggression is a concern, there will be more concentrated effort to staff the aggressor more stringently to prevent further contact. Increased staffing beyond license limitations and direct staffing assignments are possible solutions that could be utilized. Director will also continue to work with the St. Vincent New Hope Director of Placement to ensure that opportunities for movement continue to be considered. St. Vincent New Hope dates all its reports. The investigation folder includes the initial and any follow up reports. The folder is also labeled on the exterior with the date of incident. The final page of the investigation summary includes the date of the summary report (investigation end) and the administrative review (within 5 days or extended). The summary report did not include a date on the front page of it and that seems to be what is being indicated as undated. St. Vincent New Hope added a date of incident line to the front page of the summary. All Team Leaders, Managers will review the feedback and be retrained on increasing thoroughness and timeliness of investigations. A checklist for all individuals and staff involved is within the investigation report.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>discontinued on 10/26/12. The undated investigative summary of the incident of 10/19/12 indicated 3 staff were present at the time of the incident. The investigative summary indicated 1 staff statement. The summary indicated 1 interview from client F. The summary did not indicate interviews from all the staff and/or clients present in the group home at the time of the incident. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>An undated investigative summary indicated on 11/3/12 (no time indicated), client I grabbed client F's shirt at the neck line and pulled it to the point of causing red marks on client F's neck. The facility records indicated a note from the BC dated 11/6/12. The note indicated the staff reported "severe behaviors" from client I over the weekend, with repeated physical attacks against client F. The note indicated "Problem was resolved for the moment by her (client I's) family taking her home. Called [name of doctor] who authorized a medication increase." The investigative summary indicated 3 staff were in the group home at the time of the incident. The summary indicated no staff interviews and/or statements and no client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p>		Investigations will be include all interviews as relevant before finalizing.SVNH Quality Assurance and GH Director will continue to track compliance and address untimely reports. Untimely reports will be addressed in quarterly performance management reviews and overall trend analysis for department benchmarks.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>A 12/5/12 BDDS report indicated on 12/4/12 at 7:45 PM client F stated client E hit her in the mouth and client F in turn hit client E in the nose, giving client E a bloody nose. The investigative summary indicated interviews from client F and client E. The investigation did not indicate the location of all of the clients in the home and/or interviews from all clients. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 1/2/13 BDDS report indicated on 1/1/13 client I directed client E to go to bed. Client E became "more upset than she already was and hit [client I] in the face." The undated investigative summary for incident of 1/1/13 indicated no client interviews. The summary indicated 3 staff were in the home at the time of the incident. The summary indicated no staff interviews and/or staff statements. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 1/6/13 BDDS report indicated on 1/4/13 at 7 PM the on call TL was informed client I had "become uncontrollable and had refused to be redirected by staff. She (client F) lunged at another client (client F), breaking a coffee table and attacking the other client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>(client F).... Staff indicated there were injuries to both clients involved...." The follow up BDDS report dated 2/27/13 indicated client I had obtained 2 scratches to the right side of her cheek and client F obtained a 1 inch scratch to her right upper forearm and had some of her hair pulled out. The follow up BDDS report indicated client F's medications were reviewed and her Risperdal (an antipsychotic medication) was increased. The report indicated the administrator was not immediately notified of the client to client abuse and BDDS and APS were not notified within 24 hours of the client to client abuse. The undated investigative report for the incident of 1/4/13 indicated interviews from clients F and I. The investigative report did not indicate interviews with all the clients in the group home and/or staff interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 1/28/13 BDDS report indicated at 8 AM the TL (Team Leader) was informed on 1/26/13 client I was "engaging in physical aggression towards staff (kicking, swinging at staff like she was going to hit them) as well as spitting." The report indicated the TL did a body check of client I and noted client I "had bruising on her upper forearms" and the TL would complete an investigation of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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 bruising. The 2/27/13 follow up BDDS report indicated "staff were holding [client I], which caused the bruising...." The 3/1/13 follow up BDDS report indicated "[Client I] was felt to be a threat/danger to other clients and staff...." The investigation of the incident included client I's progress note for 1/26/13. The note indicated client I refused to take her shower and yelled at another housemate and pulled the other housemate's shirt. When the staff redirected client I, client I swung and spit at the staff. Client I was escorted by 3 staff to her room. Client I laid on the floor until she calmed herself. Client I returned to the main part of the home and continued to "taunt" client F. The facility records indicated the administrator was not notified immediately of the client to client abuse and the need for restraint in regard to client I. The investigative report of the incident reported on 1/28/13 indicated no staff and/or client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 2/4/13 BDDS report indicated on 2/3/13 at 8:40 PM client F was sitting in the living room when client I began yelling at client F, grabbing client F's arms and trying to pull client F's hair. The undated investigative summary indicated no staff or client interviews, record</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>reviews and/or the completion date of the investigation. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 2/15/13 BDDS report indicated on 2/14/13 at 6 PM client F was in the group home office talking with the staff when client I, "without provocation or warning" grabbed client F's right arm above the wrist. The staff prompted client I several times to let go of client F's arm. Client F's arm was red after the incident. The follow up BDDS report of 2/25/13 indicated client F was seen by her PCP (Primary Care Physician) on 2/19/13. "X-rays revealed a fracture of the ulnar bone in her right arm. [Name of doctor] referred [client F] to an Orthopedist on 2/20/13 where [client F's] right arm was placed in a full arm cast." The follow up report indicated an investigation into the cause of client F's arm fracture was conducted and indicated an incident on 2/12/13 that was witnessed by team leader (TL). The report indicated client F "...angrily flung open the door, striking her right arm against the edge of the door. Due to the location and type of fracture that occurred, the investigation concluded this incident was the cause of [client F's] right arm fracture. There had been 2 previous incidents between [client F] and a housemate (client I) where [client I]</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>grabbed [client F] by the right arm, wrist. However, [client F's] fracture is consistent with blunt force, not a spiral fracture that may occur when an individual's arm is grabbed and potentially twisted." The undated investigative record indicated "It is believed" the injury occurred at the group home on 2/12/13. The investigative report indicated no staff or client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>The BDDS report of 2/17/13 indicated on 2/16/13 client I was sitting on the couch watching television when client F came into the same room and sat down next to a staff. "Without any warning" client I got up and grabbed client F's shirt and scratched client F. The corrective actions resulting from the investigation indicated the facility would continue to follow the clients' BSPs. The undated investigative summary indicated no staff or client interviews and/or when the investigation was completed. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 3/12/13 BDDS report indicated at 5:30 PM client I became upset when she saw client F talking to one of the staff and began yelling, spitting, grabbing and pulling client F's hair. As the staff tried to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>separate the two clients, client F struck client I in the face. Client I "has a reddened area next to her left eye that will most likely become a bruise." The 3/12/13 body check sheet indicated client F obtained a scratch on her right lower leg, a scratch to her left upper arm and a bruise on her hand. The summary indicated client I's BSP (Behavior Support Plan) was to be reviewed and revised and the IDT (Interdisciplinary Team) was to review and discuss moving client I's bedroom. The undated investigative summary indicated 2 staff were in the home at the time of the incident. The summary indicated 1 staff interview and no client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>The 3/20/13 BDDS reports indicated on 3/19/13 at 8:30 PM clients C, E, F and I were involved in altercations. The reports indicated client I was in the living room when she became upset at 2 of her housemates (clients F and E). Client I grabbed client E by the wrist and scratched client E's arm. After staff separated clients I and E, client I became upset when she heard client F talking and she ran after client F, pulling client F's hair out and spitting at her. Client C was in the living room and witnessed clients I and F fighting. Client C attempted to help</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>client F when client I pulled client C to the floor. Client C slapped client I and client I bit client C on her right forearm. Clients F and C hit client I back, causing client I to have a bruise under her left eye and a reddened scratch on the bridge of her nose. The report indicated the staff were in the process of moving client I's room in an effort to decrease likelihood of further altercations. The undated investigative report indicated no client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 4/5/13 BDDS report indicated on 4/4/13 at 8 PM, "[Client I] was in the music room and asked a housemate (client D) to watch her blanket as she went to the bathroom. When housemate (client D) refused [client I] yelled and spit at him. Staff separated them. Another housemate (client F) walked by and [client I] became angry and grabbed this housemate (client F) hitting and spitting at her. This housemate (client F) has scratches on her left breast and she has scratches on her left and right upper arms. Staff were able to separate them and [client I] was asked to go to her room. As [client I] went to her room another housemate (client C) was playing with her dolls in the hallway and [client I] began yelling at this housemate (client C).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>Housemate (client C) jumped on [client I] and threw [client I] to the ground as staff was (sic) separating the 2 housemates (client C and client I) [client I] bit her housemate (client C) on the upper left arm. Housemates (client C's) skin was not broken but there is a bruise where [client I] bit her. [Client I] has bruises on both of her knees and a scratch on her abdomen.... Maintenance is pulling up carpet in a client room to facilitate moving [client I] to another room. [Client I] is currently in a room directly next to the housemate (client F) that [client I] has shown increased aggression towards." The undated investigative report for the incident of 4/4/13 indicated 3 staff were in the home at the time of the incident. The investigative report indicated the 3 staff involved were not interviewed until 4/6/13 and written statements were obtained on 4/10/13. The investigative summary did not indicate where the other clients in the group home were at the time of the altercation. The investigative summary did not indicate any client interviews and did not include the abuse toward client D. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>The undated investigative report for the incident of 4/4/13 indicated "There was a fight that occurred involving three clients</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>(clients I, F and C). During the fight, all three clients sustained minor injuries. [Client I] had scratches on her chest and bruises to both knees. [Client C] was bitten and had a bruise on her upper left arm. [Client F] had scratches on her chest, left arm, and a swollen lip...." The report indicated the incident occurred in the group home at 8 PM and started in the music room. "The incident then moved into the kitchen and finally the living room area." The report indicated 3 staff were in the home at the time of the incident. The investigative report did not include the abuse toward client D. The undated investigative summary indicated client I was moved to another bedroom on 4/10/13 and was seen by an OB/GYN doctor and was kept on her hormone replacement therapy. The summary indicated the BC "will facilitate bonding exercises between [client I and client F] to promote a greater degree of cooperation."</p> <p>A 4/27/13 OOPS (Occurrence Outside Practice Standards) form indicated at 9:30 PM, after staff prompted client I to take a shower, client I refused and instead began yelling at client F, throwing a "baby doll" at client F and pulling client F's shirt and hair. Client F kicked client I to get her to turn loose of her shirt. Staff pulled client F's shirt from client I's "grip." The investigative summary indicated as a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>result of the investigation client I was moved to a different room "on the other side of the house from [client F]." The undated investigative summary did not indicate any client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 5/2/13 BDDS report indicated on 5/2/13 at 4:30 PM client F was sitting in the living room watching television. Client I had just returned from the day program and heard client F's voice. Client I became upset and began yelling at client F, spitting at client F and pulling her hair. The Body Check Sheet of 5/2/13 indicated client F obtained bruises and scratches to her right wrist and "all along" her left arm. The undated investigative summary did not indicate any client interviews.</p> <p>A 7/13/13 BDDS report indicated on 7/12/13 at 8 AM client F told client E to "Shut up!" Client F then "punched [client E] in her left shoulder." The undated investigative summary indicated 3 staff were present in the home at the time of the incident. The investigative summary indicated 1 staff was interviewed. The summary indicated no client interviews. The facility records did not indicate a thorough investigation was conducted.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>Client F's record was reviewed on 10/4/13 at 1 PM. Client F's Description of Target Behaviors data sheets for 2012 through 2013 indicated on 2/10/13 client F "hit another housemate." The facility records indicated the administrator, BDDS and APS were not notified of the client to client abuse.</p> <p>Interview with client H on 10/4/13 at 9:30 AM indicated it was upsetting to her to be around all the fighting. Client H stated, "I think sometimes the staff would take their time to break it up." When asked to explain, client H stated, "Cause sometimes they would just stand there."</p> <p>Confidential Interview (CI) #1 indicated client I was moved to another home due to the physical aggression between clients I, F and E. CI #1 stated "[Client I] started it most of the time. Some of the staff were afraid of breaking them up and would take their time to stop the fight cause they were afraid of getting hurt. I know when [names of staff] were there, it seemed like somebody would always get hurt."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/4/13 at 1 PM, when asked how 4 clients can get into an altercation with 3 or 4 staff present in the group home the QIDP stated, "I thought</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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 very same thing."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the GHD (Group Home Director) on 10/4/13 at 3 PM indicated client I targeted client F and the clients did not get along very well. The GHD indicated client I was moved to another group home on 7/1/13 and prior to that client I's medications were changed, both of the clients were provided counseling to help them to get along and client I's bedroom was changed. The GHD indicated all allegations of abuse/neglect were to be immediately reported to the administrator and to BDDS/APS within 24 hours of discovery or notification of the abuse/neglect. The GHD indicated all allegations of abuse were to be thoroughly investigated. The QIDP stated all clients in the group home were not always interviewed "Depending on the situation." The GHD indicated with the multiple client to client incidents involving clients I and F, all clients were not interviewed each time. The GHD indicated if the staff witnessed the incident then there was no need to interview the other clients.</p> <p>Review of the revised 7/2012 facility policy of "Suspected Abuse" on 10/2/13 at 1 PM indicated __All allegations of abuse were to be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>immediately reported to the supervisor or the on-call team leader. "This includes incidents of aggression between individuals which results in physical injury or the potential for harm."            ___ All reported allegations "will be investigated and documented."            ___ A report "must be filed within 24 hours of incident or initial report" of abuse/neglect with BDDS, BQIS (Bureau of Quality Improvement Services) and APS.            ___ "Neglect is the practice that denies an individual any of the following without a physician's order: the repeated failure of a care giver to provide supervision, training, appropriate care and the basic necessities of life such as denial of sleep, food, drink, shelter, clothing and medical care or treatment."</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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	
W000153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on interview and record review for 3 of 19 allegations of abuse, the facility failed to ensure all allegations of client to client abuse in regards to clients F and I were reported immediately to the administrator, to the Bureau of Developmental Disabilities Services (BDDS) and to Adult Protective Services (APS) in accordance with state law.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 10/2/13 at 1 PM. The facility records indicated:</p> <p>A 1/6/13 BDDS report indicated on 1/4/13 at 7 PM the on call TL (Team Leader) was informed client I had "become uncontrollable and had refused to be redirected by staff. She (client I) lunged at another client (client F), breaking a coffee table and attacking the other client (client F).... Staff indicated there were injuries to both clients involved...." The report indicated the administrator was not immediately</p>	W000153	<p>All reportable incidents are tracked by St. Vincent New Hope Quality Assurance. Group Home Director reviews incidents and investigations as they occur and are reported. The Quality Assurance spreadsheet allows a further analysis of the incidents occurring by person, location, date, time, timeliness of report, etc. St. Vincent New Hope feels this system remains appropriate and will continue. increasing thoroughness and timeliness of investigations. Director was aware of the status of all incident reports prior to the survey and performance action continues to occur as appropriate. SVNH Quality Assurance and GH Director will continue to track compliance and address untimely reports. Untimely reports will be addressed in quarterly performance management reviews and overall trend analysis for department benchmarks.</p>	11/08/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>notified of the client to client abuse and BDDS and APS were not notified within 24 hours of notifications of the client to client abuse.</p> <p>A 1/28/13 BDDS report indicated on 1/28/13 the TL was informed of an incident of client to client abuse that happened on 1/26/13. The report indicated client I was "engaging in physical aggression towards staff (kicking, swinging at staff like she was going to hit them) as well as spitting." The report indicated the TL did a body check of client I and noted client I "had bruising on her upper forearms" and the TL would complete an investigation of the bruising. The 2/27/13 follow up BDDS report indicated "staff were holding [client I], which caused the bruising...." The investigation of the incident included client I's progress note for 1/26/13. The note indicated client I yelled at another housemate and pulled the other housemate's shirt. When the staff redirected client I, client I swung and spit toward the staff. Three staff escorted client I to her room. The facility records indicated the administrator was not notified immediately of the client to client abuse and the need for restraint in regard to client I.</p> <p>Client F's record was reviewed on 10/4/13</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>at 1 PM. Client F's Description of Target Behaviors data sheets for 2012 through 2013 indicated on 2/10/13 client F "hit another housemate." The facility records indicated the administrator, BDDS and APS were not notified of the client to client abuse.</p> <p>The facility records indicated the administrator was not immediately notified of the client to client abuse and BDDS and APS were not notified within 24 hours of notification of the client to client abuse in regard to the incidents of 1/4/13, 1/26/13 and 2/10/13 for clients F and I.</p> <p>Interview with the GHD (Group Home Director) on 10/2/13 at 1 PM indicated all allegations of abuse/neglect were to be immediately reported to the administrator and to BDDS/APS within 24 hours of discovery or notification of the abuse/neglect.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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	
W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 17 of 19 allegations of abuse reviewed, the facility failed to ensure all allegations of abuse for clients C, D, E, F and I were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 10/2/13 at 1 PM. The facility records indicated:</p> <p>A 10/12/12 BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/11/12 at 5:15 PM client F was helping to set the table for the evening meal. Client I rushed toward client F and knocked the plates out of her hands. "Staff tried to separate the two, but during the altercation [client F] was bitten on one of her fingers. The bite did not break the skin. She also has a circular bruise on her right arm about the size of a quarter. [Client F and client I] also both pulled at each others (sic) hair before the three staff present could get them separated." The undated investigative summary indicated 3 staff were in the home at the time of the incident. The investigative summary indicated no staff</p>	W000154	<p>It is agreed there were multiple investigations that were not completed in a thorough manner toward the beginning of this time period. Director and Manager were aware that investigations could improve and the Manager/QIDP assumed the primary role of conducting the investigations to improve their compliance and thoroughness. We do believe this to be shown in the investigations following March 2013. In addition, 6 of those investigations including and following March 2013 were involving the disputes between client I and client F. Our understanding of the situation in general at that time led us to determine that client interviews for each of these situations was not warranted based on the situations. The two clients did not like each other and did not get along. At that time, we were pursuing alternate placement options and implementing strategies to best keep them apart. The client census at this home is one of significant intellectual disability which also led us to choose at that time to not obtain or document that we were not able to obtain information from most of them.</p>	11/08/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>interviews and/or statements. The summary indicated interviews from clients F and I. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A BDDS report of 10/20/12 indicated on 10/19/12 at 7 PM client I became upset with client F and pulled her hair and hit her on the head. The undated investigation summary of the incident of 10/19/12 indicated 3 staff were present at the time of the incident. The investigative summary indicated 1 staff statement. The summary indicated 1 interview from client F. The summary did not indicate interviews from all the staff and/or clients present in the group home at the time of the incident. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>An undated investigative summary indicated on 11/3/12 (no time indicated), client I grabbed client F's shirt at the neck line and pulled it to the point of causing red marks on client F's neck. The summary indicated 3 staff were in the group home at the time of the incident. The summary indicated no staff interviews and/or statements and no client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p>		<p>We feel our overall policy provides effective investigations and that was the intent of stating our policy remains appropriate. We did not intend to violate our policy but felt at the time we were making appropriate discernment of the situations and focusing on the action plan. St. Vincent New Hope will attempt to obtain and document all client statements regardless of the incident in all future investigations. Director reviews all investigations and has reviewed investigations for other such facilities. The facility has not had an additional investigation as yet to review. Quality Assurance Department also reviews all investigations and will be asked to double check that all relevant statements are present.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>A 12/5/12 BDDS report indicated on 12/4/12 at 7:45 PM client F stated client E hit her in the mouth and client F in turn hit client E in the nose, giving client E a bloody nose. The investigative summary indicated interviews from client F and client E. The investigation did not indicate the location of all of the clients in the home and/or interviews from all clients. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 1/2/13 report indicated on 1/1/13 client I directed client E to go to bed. Client E became "more upset than she already was and hit [client I] in the face." The undated investigative summary for incident of 1/1/13 indicated no client interviews. The summary indicated 3 staff were in the home at the time of the incident. The summary indicated no staff interviews and/or staff statements. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 1/6/13 BDDS report indicated on 1/4/13 at 7 PM the on call TL (Team Leader) was informed client I had "become uncontrollable and had refused to be redirected by staff. She (client F) lunged at another client (client F), breaking a coffee table and attacking the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>other client (client F).... Staff indicated there were injuries to both clients involved...." The undated investigative report for the incident of 1/4/13 indicated interviews from clients F and I. The investigative report did not indicate interviews with all the clients in the group home and/or staff interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 1/28/13 BDDS report indicated on 1/28/13 the TL was informed of an incident of client to client abuse that happened on 1/26/13. The report indicated client I was "engaging in physical aggression towards staff (kicking, swinging at staff like she was going to hit them) as well as spitting." The report indicated the TL did a body check of client I and noted client I "had bruising on her upper forearms" and the TL would complete an investigation of the bruising. The 2/27/13 follow up BDDS report indicated "staff were holding [client I], which caused the bruising...." The investigation of the incident included client I's progress note for 1/26/13. The note indicated client I refused to take her shower and yelled at another housemate and pulled the other housemate's shirt. When the staff redirected client I, client I swung and spit toward the staff. Three staff escorted</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>client I to her room. Client I laid on the floor. The report indicated client I continued to "taunt" client F the remainder of the evening. The investigative report of the incident reported on 1/28/13 indicated no staff and/or client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 2/4/13 BDDS report indicated on 2/3/13 at 8:40 PM client F was sitting in the living room when client I began yelling. Client I grabbed client F's arms and tried to pull client F's hair. The undated investigative summary indicated no staff or client interviews, record reviews and/or the completion date of the investigation. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 2/15/13 BDDS report indicated on 2/14/13 at 6 PM client F was in the group home office talking with the staff when client I, "without provocation or warning" grabbed client F's right arm above the wrist. The staff prompted client I "several times" to let go of client F's arm. Client F's arm was red after the incident. The follow up BDDS report of 2/25/13 indicated client F was seen by her PCP (Primary Care Physician) on 2/19/13. "X-rays revealed a fracture of the ulnar</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>bone in her right arm. [Name of doctor] referred [client F] to an Orthopedist on 2/20/13 where [client F's] right arm was placed in a full arm cast." The follow up report indicated an investigation into the cause of client F's arm fracture was conducted and indicated an incident on 2/12/13 that was witnessed by the team leader (TL). The report indicated client F "...angrily flung open the door, striking her right arm against the edge of the door. Due to the location and type of fracture that occurred, the investigation concluded this incident was the cause of [client F's] right arm fracture. There had been 2 previous incidents between [client F] and a housemate [initials of client I] where [client I] grabbed [client F] by the right arm, wrist. However, [client F's] fracture is consistent with blunt force, not a spiral fracture that may occur when an individual's arm is grabbed and potentially twisted." The undated investigative record indicated "It is believed" the injury occurred at the group home on 2/12/13. The investigative report indicated no staff or client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>The BDDS report of 2/17/13 indicated on 2/16/13 client I was sitting on the couch watching television when client F came into the room and sat down next to a staff.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>"Without any warning" client I got up and grabbed client F's shirt and scratched client F. The undated investigative summary indicated no staff or client interviews and/or when the investigation was completed. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 3/12/13 BDDS report indicated on 3/13/13 at 5:30 PM client I became upset when she saw client F talking to one of the staff and began yelling, spitting and grabbing at client F, pulling her hair. As the staff tried to separate the two clients, client F struck client I in the face. Client I "has a reddened area next to her left eye that will most likely become a bruise." The 3/12/13 body check sheet indicated client F obtained a scratch on her right lower leg, a scratch to her left upper arm and a bruise on her hand. The undated investigative summary indicated 2 staff were in the home at the time of the incident. The summary indicated 1 staff interview and no client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>The 3/20/13 BDDS report indicated on 3/19/13 at 8:30 PM clients C, E, F and I were involved in altercations. The reports indicated client I was in the living room when she became upset at 2 of her</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>housemates (clients F and E). Client I grabbed client E by the wrist and scratched client E's arm. After staff separated clients I and E, client I became upset when she heard client F talking and she ran after client F, pulling client F's hair out and spitting at her. Client C was in the living room and witnessed clients I and F fighting. Client C attempted to help client F when client I pulled client C to the floor. Client C slapped client I and client I bit client C on her right forearm. Clients F and C hit client I back, causing client I to have a bruise under her left eye and a reddened scratch on the bridge of her nose. The undated investigative report indicated no client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 4/5/13 BDDS report indicated on 4/4/13 at 8 PM, "[Client I] was in the music room and asked a housemate (client D) to watch her blanket as she went to the bathroom. When housemate (client D) refused [client I] yelled and spit at him. Staff separated them. Another housemate (client F) walked by and [client I] became angry and grabbed this housemate (client F) hitting and spitting at her. This housemate (client F) has scratches on her left breast and she has scratches on her left and right upper arms. Staff were able to separate them and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>[client I] was asked to go to her room. As [client I] went to her room another housemate (client C) was playing with her dolls in the hallway and [client I] began yelling at this housemate (client C). Housemate (client C) jumped on [client I] and threw [client I] to the ground as staff was (sic) separating the 2 housemates (client C and client I) [client I] bit her housemate (client C) on the upper left arm. Housemates (client C's) skin was not broken but there is a bruise where [client I] bit her. [Client I] has bruises on both of her knees and a scratch on her abdomen...." The undated investigative report for the incident of 4/4/13 indicated 3 staff were in the home at the time of the incident. The investigative report indicated the 3 staff involved were not interviewed until 4/6/13 and written statements were obtained on 4/10/13. The investigative summary did not indicate where the other clients in the group home were at the time of the altercation. The investigative summary did not indicate any client interviews and did not include the abuse toward client D. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 4/27/13 OOPS (Occurrence Outside Practice Standards) form indicated at 9:30 PM, after staff prompted client I to take a shower, client I refused and instead began</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>yelling at client F, throwing a "baby doll" at client F and pulling client F's shirt and hair. Client F kicked client I to get her to turn loose of her shirt. Staff pulled client F's shirt from client I's "grip." The undated investigative summary did not indicate any client interviews. The investigative summary did not indicate a thorough investigation was conducted.</p> <p>A 5/2/13 BDDS report indicated on 5/2/13 at 4:30 PM client F was sitting in the living room watching television. Client I had just returned from the day program and heard client I's voice. Client I became upset and began yelling at client F, spitting at her and pulling client F's hair. The Body Check Sheet of 5/2/13 indicated client F obtained bruises and scratches to her right wrist and "all along" her left arm. The undated investigative summary did not indicate any client interviews.</p> <p>A 7/13/13 BDDS report indicated on 7/12/13 at 8 AM client F told client E to "Shut up!" Client F then "punched [client E] in her left shoulder." The undated investigative summary indicated 3 staff were present in the home at the time of the incident. The investigative summary indicated 1 staff was interviewed. The summary indicated no client interviews. The facility records did not indicate a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>thorough investigation was conducted.</p> <p>Client F's record was reviewed on 10/4/13 at 1 PM. Client F's Description of Target Behaviors data sheets for 2012 through 2013 indicated on 2/10/13 client F "hit another housemate." The facility records did not indicate an investigation was conducted in regard to the client to client abuse.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the GHD (Group Home Director) on 10/4/13 at 3 PM indicated all allegations of abuse were to be thoroughly investigated. The QIDP stated all clients in the group home were not always interviewed "Depending on the situation." The GHD indicated with the multiple client to client incidents involving clients I and F, all clients were not interviewed each time. The GHD indicated if the staff witnessed the incident then there was no need to interview the other clients.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D) and 1 additional client (E), the clients' ISPs (Individual Support Plans) failed to address the clients' identified training needs in regard to:</p> <p>___ Use of sharps and chemicals for clients A, B, C and D. ___ Maintaining and caring for clothing in the closet/dresser for clients B and E. ___ Maintaining personal privacy for client C. ___ Dressing in appropriately layered clothing for client E.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM.</p> <p>___ The sharp knives were stored in a locked plastic box inside a locked cabinet in the staff office. ___ Chemicals were stored in a locked hallway closet. ___ Client B had no clothes hanging in her closet. Client B's pants, shirts, underwear and pajamas were not folded and were</p>	W000227	<p>All individuals were reviewed by IDT and restrictions were removed as IDT deemed appropriate. IDT felt that the restriction to full access to all clothing for client C remained appropriate for her treatment plan. However, the Behavior Support Plan and techniques for training were revised. All staff will be retrained on all plans. All closets were cleaned and organized. A room assignment was implemented for staff to review and inspect each room daily. These room assignment will be documented and returned to manager monthly. Manager will also conduct random room checks during routine weekly visits to sites. All other clothing and belongings are maintained in client rooms. All knives and sharps are available to all residents to access as needed. All household and cleaning chemicals are available for access. Client B and E have a clothing care goal added to ISP. Client C has privacy goal added to ISP. Client E has goal to maintain skills regarding appropriate clothing. Her deteriorating neurological condition related to dementia</p>	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>mixed together in all the drawers.</p> <p>__ Client E had no clothes hanging in her closet. Client E's clothing was stored in large plastic tubs inside her closet. Three of the tubs were on the closet shelf and out of client E's reach.</p> <p>Observations were conducted at the group home on 10/3/13 between 5:15 AM and 7:30 AM. At 5:15 AM client C was walking around the group home wearing a bath robe with no under garments and her robe not secured around her. At 5:20 AM client C sat down on the couch near client D, her legs open and exposing her private area. Staff #5 prompted client C to go to the office to choose her clothing for the day to get dressed. Client C went to the office, sat down cross legged on the floor in front of a plastic tub full of shoes and began sorting through the shoes. Client C sat exposing her private area and breasts. Client A and staff #4 walked into the office to ask staff #5 a question and walked out. Staff #4 and staff #5 did not prompt client C to maintain her personal privacy.</p> <p>Client A's record was reviewed on 10/3/13 at 11 AM. Client A's 2013 CFAs (Comprehensive Functional Assessments) indicated client A required verbal and physical assistance from the staff to safely use sharps and/or chemicals. Client A's</p>		prevents any valid success in gaining independence in this area.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>8/27/13 ISP indicated no training objectives to assist client A with using sharps and/or chemicals/cleaning supplies.</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's 2013 CFAs indicated client B required verbal and physical assistance from the staff to safely use sharps and/or chemicals and to maintain her clean clothing her the closet and/or dresser. Client B's 7/29/13 ISP indicated no training objectives to assist client B with using sharps, chemicals/cleaning supplies and/or maintaining her clean clothing in her closet and/or dresser.</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's 2013 CFAs indicated client C required verbal and physical assistance from the staff to safely use sharps and/or chemicals and to maintain personal privacy. Client C's 8/15/13 ISP indicated no training objectives to assist client C with using sharps, chemicals/cleaning supplies and/or to maintain personal privacy.</p> <p>Client D's record was reviewed on 10/3/13 at 1 PM. Client D's 2013 CFAs indicated client D required verbal and physical assistance from the staff to safely use sharps and/or chemicals. Client D's</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>8/30/13 ISP indicated no training objectives to assist client D with using sharps and/or chemicals/cleaning supplies.</p> <p>Client E's record was reviewed on 10/4/13 at 12 PM. Client E's 7/29/13 ISP did not indicate any training objectives to assist client E to care for her clothing and/or to dress in appropriate layers of clothing.</p> <p>Interview with staff #3 on 10/2/13 at 6 PM indicated/stated:            __All sharps were locked in the staff office and chemicals were locked in a hall closet. "Only staff" have a key to access the sharps and chemicals.            __Clients A, B, C and D could not independently use sharps and/or chemicals. Staff #3 stated client C would not drink the chemicals but "supposedly" would try to use them in inappropriate ways.            __Client B did not have any clothing in her closet because "she takes them out and throws them on the floor, so we just put them in her dresser instead of hanging them up." Client B requires staff assistance to maintain her clean clothing in her closet and/or dresser.            __Client E's clothing was stored in large plastic tubs in her closet to prevent and/or "deter" client E from getting to her clothing and putting on layers of clothes</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>because client E "will wear multiple layers of clothing all at one time if we let her."</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) and the TL (Team Leader) were interviewed on 10/4/13 at 12:30 PM.</p> <p>__ The TL indicated clients A, B, C and D required staff assistance to use sharps and/or chemicals safely. The QIDP indicated no training objectives in regard to the use of sharps and/or chemicals.</p> <p>__ The TL indicated client C had a problem maintaining her own personal privacy and the staff were to prompt client C to keep herself covered. The QIDP indicated no training objectives to assist client C with maintaining her personal privacy.</p> <p>__ The TL indicated client E would dress inappropriately in layers of clothing if not closely supervised by the staff. The TL stated client B's and E's clothing "should be hanging up in their closets." The TL indicated after the staff would fold up client B's clothing and put it into her dresser drawers, client B would rummage through her drawers and mess the clothes up. The QIDP indicated no training objectives to assist clients B and E to care for their clothing and/or to maintain their clothing in their closets. The QIDP indicated no training objective to assist</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>client E in dressing in appropriate layers of clothing.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 3 of 4 sampled clients (B, C and D) and 1 additional client (E), the facility failed to ensure:</p> <p>__ The TL (Team Leader) followed client C's BSP (Behavior Support Plan) in regard to client C's treatment of her clothing.</p> <p>__ The staff followed client B's and C's ISPs (Individual Support Plans), dining plans.</p> <p>__ Clients D and E were offered formal and informal training opportunities and/or choices of leisure activity when time permitted.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM and on 10/3/13 between 5:15 AM and 7:30 AM. During both observations client C had no clothes in her bedroom. Client C's closet and dresser drawers were empty.</p>	W000249	<p>IDT deemed appropriate to maintain the restriction to full access to all clothing for client C. However, the Behavior Support Plan and techniques for training were revised. All staff will be retrained on all plans. There is documentation present and it has been added to the ISP. Manager and Behavior Consultant will review BSP data monthly to ensure BSP continues to be approached appropriately. All staff will be retrained on Dining plans for all individuals, including the nutritional needs, safeguards, supervision and training opportunities. Meals will be served as designated by menu. All individuals were reviewed to have appropriate meal preparation goals to be implemented. All staff reviewed these goals. Group Home Team Leader is present in the home daily to direct care and will observe 2-3 meals per week. Group Home Manager will conduct weekly observations of active treatment, meals and other care oversight. There have been 6 observations since exit and all</p>	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's BSP of 1/23/13 indicated "Per her (client C's) legal guardian's instructions, the bulk of [client C's] clothes are kept in the office.... Our long term goal is to assist [client C] to learn to take appropriate care of her wardrobe. [Client C] will keep a certain number of items in her room (exact number to be determined by the Team Leader), in both her closet and her dresser. These items will not be part of her wardrobe (that is, she is not to wear them). If after a week, the items of clothing are still in place, add another item to [client C's] closet and dresser.... If [client C] is observed not taking appropriate care of clothing items (e.g., putting them in someone else's room, leaving them in common areas of the house, etc), redirect her to put the item in an appropriate place (her room or the office).... The group home staff will record the frequency of the target behaviors on the behavior data sheet. Taking care of clothing will be monitored by the Team Leader only. Other staff should leave that area blank. The Behavior Consultant will examine [client C's] progress through behavioral observations, review of data...." Client C's record did not indicate client Client C's treatment of clothing was monitored by</p>		<p>have shown great improvement in the active treatment and implementation of dining plans. Client B has a swallow study scheduled and in the interim she recieves 1:1 dining assistance. Director will continue to visit homes monthly on a routine basis. For the 60 days post exit, Director will be present in home 3-4 times per month. All goals and informal programming will be reviewed with staff. Training opportunities and informal engagement will be implemented. Team Leader and manager will observe goals and engagement opportunities during weekly meal and medication observations.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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 TL.</p> <p>Interview with staff #3 on 10/3/13 at 6:50 PM indicated client C was not to have any clothing in her room because client C would throw her clothes away and not take care of her personal items. Staff #3 indicated all of client C's clothing was kept locked in the staff office.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the TL on 10/4/13 at 1 PM, the TL stated client C would "never have any clothes in her room because she will hide them or throw them in the trash." When asked to see the documentation in regard to the items of clothing in client C's bedroom that were referred to in client C's BSP and the data collection of client C's reaction to the clothing, the TL stated "there is no documentation that I'm aware of." The TL indicated she was not aware she was to be documenting client C's behaviors in regard to client C throwing her clothing away.</p> <p>2. Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM. During this time clients B and C were served salmon patties, macaroni and cheese, green beans, a slice of bread with margarine and fruit salad. Client B</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>used a small spoon and ate at a fast pace, taking large bites.</p> <p>__At 6 PM client C got up from the table and took her plate and cup to the music room to eat. After a few minutes staff #3 got up from the table and checked on client C and then returned to the main dining room and sat down. The staff did not supervise client C while eating her evening meal.</p> <p>__At 6:10 PM client B began coughing. Staff #1 was sitting beside client B and stood up and began patting client B on the back and stated to client B, "Are you ok? Take a drink." Client B continued to cough sporadically for the next few minutes.</p> <p>The staff did not prompt client B to take smaller bites, to dry swallow between bites or to alternate sips of liquids and bites of food. The staff did not provide client C supervision while eating her entire meal. The staff did not check clients B and C for pocketed food after eating.</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's record indicated client B was at risk for aspiration. Client B's dining plan dated 7/11/13 indicated client B was to limit foods to less than 1 teaspoon per bite, to dry swallow 1 to 2 times between bites</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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 to alternate sips of liquids and bites of food. The plan indicated the staff were to encourage client B to eat slowly and to check her mouth after eating for pocketed food.</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's dining plan dated 1/18/13 indicated client C was to be encouraged to not over stuff her mouth and chew before taking another bite. The plan indicated if client C left the table due to anxiety, the staff were to encourage client C to return to the table or finish eating in another room with staff present.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) and the LPN (Licensed Practical Nurse) on 10/4/13 at 1 PM indicated the staff were to follow client B's and C's dining plans. The QIDP indicated all clients were to be supervised whenever eating.</p> <p>3. Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM. Client E sat in a chair in the corner of the living room without activity and holding a sippy cup from 4:30 PM until 5:40 PM when staff #2 prompted client E to the dining room table for the evening meal.</p> <p>Observations were conducted at the group</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>home on 10/3/13 between 5:15 AM and 7:30 AM. Client D sat without activity on the couch in the music room from 5:15 AM through 7 AM. At 6 AM staff #5 walked through the music room, turned on some music and left the room. During this time the staff did not offer client D training and/or leisure activities.</p> <p>Client D's record was reviewed on 10/3/13 at 1 PM. Client D's ISP of 8/30/13 indicated training objectives to call his family and to drop an envelope in a box.</p> <p>Client E's record was reviewed on 10/4/13 at 12 PM. Client E's ISP of 7/29/13 indicated training objectives to mail her sister a card, to look at a picture book, to match coins to a workbook and to identify eating utensils.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/4/13 at 1 PM indicated clients should not be sitting for long periods of time without activity. The QIDP indicated the staff should have offered clients D and E training and or leisure activities.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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
W000252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on record review and interview for 1 of 4 sampled clients (C), the facility failed to ensure the staff documented client C's behavior program data as directed.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's BSP of 1/23/13 indicated "Per her (client C's) legal guardian's instructions, the bulk of [client C's] clothes are kept in the office. All group home staff have access to this office. When [client C] wakes in the morning, staff will invite her (client C) to the office to select her outfit for the day. Our long term goal is to assist [client C] to learn to take appropriate care of her wardrobe. [Client C] will keep a certain number of items in her room (exact number to be determined by the Team Leader), in both her closet and her dresser. These items will not be part of her wardrobe (that is, she is not to wear them). If after a week, the items of clothing are still in place, add another item to [client C's] closet and dresser.... If [client C] is observed not taking</p>	W000252	IDT deemed appropriate to maintain the restriction to full access to all clothing for client C. However, the Behavior Support Plan and techniques for training were revised. All staff will be retrained on all plans. There is documentation present and it has been added to the ISP. Manager and Behavior Consultant will review BSP data monthly to ensure BSP continues to be approached appropriately.	11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>appropriate care of clothing items (e.g., putting them in someone else's room, leaving them in common areas of the house, etc), redirect her to put the item in an appropriate place (her room or the office)... The group home staff will record the frequency of the target behaviors on the behavior data sheet. Taking care of clothing will be monitored by the Team Leader only. Other staff should leave that area blank. The Behavior Consultant will examine [client C's] progress through behavioral observations, review of data...." Client C's record indicated no documentation of the items of clothing that were to remain in client C's room. Client C's record indicated no documentation and/or data collection from the group home staff in regard to client C's treatment of her clothing and/or the items left in her room.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the TL (Team Leader) on 10/4/13 at 1 PM, the TL stated client C would "never have any clothes in her room because she will hide them or throw them in the trash." When asked to see the documentation in regard to the items of clothing in client C's bedroom that were referred to in client C's BSP and the data collection of client C's reaction to the clothing, the TL stated "there is no</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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
	documentation that I'm aware of." The TL indicated she was not aware the staff were to be documenting client C's treatment of her clothing.  9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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	
W000322	<p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 sampled female clients (B), the facility failed to ensure preventive medical care by failing to monitor client B for early detection of breast disease after the client's doctor decided to defer the annual Mammogram.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's record indicated client B's annual Mammogram had been deferred by the physician. Client B's record indicated no evidence of how nursing was monitoring client B for early detection of breast disease after the client's doctor decided to defer the client's annual Mammogram test.</p> <p>Interview with the LPN on 10/4/13 at 1 PM indicated nursing and/or staff did not do monthly or regular breast exams in regard to client B.</p> <p>9-3-6(a)</p>	W000322	<p>St. Vincent New Hope Medical Director reviewed the Procedure for Women's Health specific to alternatives for deferred exams. For deferred or refused treatment, the individual will be assessed by the team for risk versus benefit of further treatment. A referral to gynecology, an ultrasound breast exam or other scans may be determined appropriate given the individual's medical history, condition, representation and potential risks. Client B had her annual physical on 10/23/13 at which point her physician recommended an attempt at a mammogram. Team will schedule and attempt to complete this exam. If the exam proves too stressful for Client B, the team will determine the next approach with her physician. All other individuals were determined to have current medical exams and follow up.</p>	11/08/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 3 of 4 sample clients (B, C and D), nursing services failed to ensure:</p> <p>__ A health care plan was developed and implemented in regard to client D's diagnosis of CHF (Congestive Heart Failure).</p> <p>__ The staff notified nursing when client B experienced frequent coughing during a meal.</p> <p>__ The staff followed client B's and C's dining plans.</p> <p>__ Client B was monitored in regard to breast exams.</p> <p>__ Client C's PRN (as needed) pain medications were clarified.</p> <p>__ Client B's, C's and D's sleep patterns were monitored.</p> <p>__ Client D was monitored for side effects from antipsychotic medications.</p> <p>__ The staff observed client B take her Miralax.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM. During this time clients B and C were served salmon patties, macaroni and cheese, green beans, a slice of bread</p>	W000331	High Risk Plan was developed for CHF for client D. Client will be monitored daily by staff for particluar paramaters and weekly by nurse consultant for hydration, edema. Client D fall plan was updated to include footwear and adaptive equipment to be utilized during ambulation. All staff were trained on CHF plan, fall risk plan. Behavior consultant implemented a sleep tracking sheet for all individuals to consider sleep patterns and interruptions. Missing AIMS testing was a result of prior nurse consultant lack of completion of work. She left employment and present nurse has maintained full records, including AIMS. GH Director will continue to conduct monthly nursing chart audits to monitor continued compliance. All staff will review the medication adminsitration guidelines. Staff are aware that locking the cabinet is a standard expectation. Staff #4 recieved a verbal coaching for the variance from practice standards. Staff were retrained on strategies for Client B miralax, securing the med cabinet and securing the keys. New medication lock box for controlled substances was obtained. St. Vincent New Hope Medical Director reveiwed the Procedure for Women's Health	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>with margarine and fruit salad. Client B used a small spoon and ate at a fast pace, taking large bites.</p> <p>__At 6 PM client C got up from the table and took her plate and cup to the music room to eat. After a few minutes staff #3 got up from the table and checked on client C and then returned to the main dining room and sat down. The staff did not supervise client C while eating her evening meal. The staff did not check client C for pocketed food after eating.</p> <p>__At 6:10 PM client B began coughing. Staff #1 was sitting beside client B and stood up and began patting client B on the back and stated to client B, "Are you ok? Take a drink." Client B continued to cough sporadically for the next few minutes. The staff did not prompt client B to take smaller bites, to dry swallow between bites or to alternate sips of liquids and bites of food. The staff did not check client B for pocketed food after eating.</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's record indicated client B was at risk for aspiration. Client B's dining plan dated 7/11/13 indicated client B was to limit foods to less than 1 teaspoon per bite, to dry swallow 1 to 2 times between bites and to alternate sips of liquids and bites of food. The plan indicated the staff were to</p>		<p>specific to alternatives for deferred exams. For deferred or refused treatment, the individual will be assessed by the team for risk versus benefit of further treatment. A referral to gynecology, an ultrasound breast exam or other scans may be determined appropriate given the individual's medical history, condition, representation and potential risks. Client B had her annual physical on 10/23/13 at which point her physician recommended an attempt at a mammogram. Team will schedule and attempt to complete this exam. If the exam proves too stressful for Client B, the team will determine the next approach with her physician. All other individuals were determined to have current medical exams and follow up. Client C's PRN medications were clarified by her physician. All other clients reviewed to have appropriate PRN regimen. Behavior consultant has developed a sleep pattern tracking for all individuals in the home. Behavior consultant will review the patterns and address any interruptions or treatment plan changes with psychiatry. Some of the individuals have benefitted from the supplement melatonin and it continues to provide support. There are no additional psychiatric medications involved for sleep. All staff will be retrained on Dining</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>encourage client B to eat slowly and to check her mouth after eating for pocketed food. Client B's Aspiration/Choking/Dysphagia Plan dated 9/11/13 indicated the staff were to call the nurse if client B had persistent coughing during or after eating and/or drinking. Client B's record did not indicate the staff had notified the nurse of client B's coughing during her evening meal on 10/2/13.</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's dining plan dated 1/18/13 indicated client C was to be encouraged to not over stuff her mouth and chew before taking another bite. The plan indicated if client C left the table due to anxiety, the staff were to encourage client C to return to the table or finish eating in another room with staff present.</p> <p>Interview with the LPN (Licensed Practical Nurse) on 10/4/13 at 1 PM indicated the staff were to follow client B's and C's dining plans and were to supervise all clients while eating. The LPN stated, "No one called me about anyone having a problem eating." The LPN stated, "They should have called me" and "They should have sat with [client C] while she ate her meal."</p> <p>2. Client B's record was reviewed on</p>		<p>plans for all individuals, including the nutritional needs, safeguards, supervision and training opportunities. Meals will be served as designated by menu. All individuals were reviewed to have appropriate meal preparation goals to be implemented. All staff reviewed these goals. Group Home Team Leader is present in the home daily to direct care and will observe 2-3 meals per week. Group Home Manager will conduct weekly observations of active treatment, meals and other care oversight. There have been 6 observations since exit and all have shown great improvement in the active treatment and implementation of dining plans. Client B has a swallow study scheduled and in the interim she receives 1:1 dining assistance. Director will continue to visit homes monthly on a routine basis. For the 60 days post exit, Director will be present in home 3-4 times per month.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>10/3/13 at 11:30 AM.</p> <p>__ Client B's record indicated a diagnosis of, but not limited to, insomnia. Client B's record indicated client B's sleep patterns were not being monitored.</p> <p>__ Client B's record indicated client B's annual mammogram had been deferred by the physician. Client B's record indicated no evidence of how nursing was monitoring client B in regard to the doctor's decision to defer annual mammograms.</p> <p>Interview with the LPN on 10/4/13 at 1 PM indicated client B's sleep patterns were not being monitored. The LPN indicated nursing and/or staff did not do monthly or regular breast exams in regard to client B.</p> <p>3. Client C's record was reviewed on 10/3/13 at 2 PM. Client C's 10/1/13 physician's orders indicated client C was taking:</p> <p>__ Melatonin 6 mg every night at bedtime for sleep.</p> <p>__ Acetaminophen 650 mg every 4 hours PRN (as needed) for pain or elevated temperature.</p> <p>__ Ibuprofen 200 mg every 8 hours PRN for pain.</p> <p>__ Ibuprofen 800 mg every 8 hours PRN for pain.</p> <p>Client C's record indicated no diagnosis</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>requiring 3 medications for pain. Client C's record indicated client C's sleep patterns were not being monitored.</p> <p>Interview with the LPN on 10/4/13 at 1 PM indicated client B's sleep patterns were not being monitored. The LPN stated the three orders for PRN pain medication "should have been clarified with the physician."</p> <p>4. Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM and on 10/3/13 between 5:15 AM and 7:30 AM. During both observations client D ambulated with a rolling walker while wearing only socks on his feet over a non-carpeted smooth flooring. Client D's gait belt lay on the floor in his bedroom. During the AM observation client D ambulated with and without his helmet on. The carpet in the living room near the kitchen had a large area that was frayed where the carpet was unraveled. Client D walked over this area with his walker, catching one of the threads as he walked by.</p> <p>Client D's record was reviewed on 10/3/13 at 1 PM.</p> <p>__ Client D's record indicated client D had a diagnosis of, but not limited to, CHF (Congestive Heart Failure). Client D's 10/1/13 physician's orders indicated client</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>D was taking Albuterol and Ipratropium via a nebulizer 3 times a day for respiratory issues, Aspirin 81 mg (milligrams) a day for heart disease, Fludrocort 0.1 mg a day for hypertension, Furosemide 40 mg a day for fluid retention. Client D's physician's orders indicated client D's blood pressure was to be taken monthly and "If top number is greater than 150 or bottom number is greater than 90, wait 30 min (minutes) and repeat blood pressure. Fax to nurse by 15th - record pulse."</p> <p>__ Client D's Quarterly Nutrition Review of 6/24/13 indicated NAS (no added salt) was added to client D's diet order and for the staff to follow NAS guidelines when preparing client D's meals. The review indicated client D's weight needed to be watched closely due to his diagnosis of CHF.</p> <p>__ Client D's record indicated no nursing health care plan in regard to client D's diagnosis of CHF. Client D's record indicated client D's blood pressure, pulse, respirations and weight were monitored once a month. Client D's record failed to indicate how nursing was monitoring client D's weight, fluids, lung sounds and respiratory system and/or what the staff were to monitor, the parameters of what was to be monitored and when the staff were to call the nurse in regard to client D's diagnosis of CHF.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>__ Client D's ISP of 8/30/13 indicated client D had a history of falls. The ISP indicated when ambulating client D was to wear a hard shell helmet, specialty shoes and use a rolling walker. "Call 911 if client is non-responsive. Staff to document fall/injury on body check sheet." Client D's Fall Prevention Plan of 9/11/13 indicated no preventive strategies to prevent falls and failed to indicate how the staff were to supervise and assist client D while ambulating.</p> <p>__ Client D's 10/1/13 physician's orders indicated client D took Lunesta 2 mg and Melatonin 3 mg every night at bedtime for sleep. Client D's record indicated client D's sleep patterns were not monitored.</p> <p>__ Client D's 10/1/13 physician's orders indicated client D took Abilify (an antipsychotic medication) 20 mg qd (every day). Client D's 9/17/12 pharmacy review indicated client D was "due for another AIMS (scale used to monitor for side effects from antipsychotic medications) assessment with antipsychotic use. It was last completed 10/11. Recommend completing every 6 months." Client D's 12/27/12 pharmacy review indicated "Consumer is due for another AIMS assessment. Recommend completing one every 6 months while on an antipsychotic or Reglan (given to reduce stomach acid)." Client D's record</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>indicated an AIMS test conducted 1/28/13 and 7/23/13. Client D's record indicated no AIMS testing in 2012.</p> <p>Interview with the LPN on 10/4/13 at 1 PM indicated client D did not have a health care plan in regard to his diagnosis of CHF. The LPN stated client D's risk plans "will be updated" to include CHF and client D's falls risk plan will be revised to include preventive measures in regard to falls. The LPN indicated client D should have his shoes on and wear his helmet whenever ambulating. The LPN stated client D's sleep habits were not monitored and "will be." The LPN indicated client D's AIMS testing was conducted last in July 2013 and was to be done every 6 months.</p> <p>5. Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM. At 5:55 PM staff #1 brought a small plastic cup of powder to the dining room table and poured it into client B's sippy cup with water. At 6:15 PM client B had finished her meal and got up from the table. The sippy cup still had 1/3 of the liquid in the cup. Staff #1 picked up the sippy cup and took it to the kitchen sink and emptied the remainder of the contents.</p> <p>Client B's record was reviewed on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208		
(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>10/3/13 at 11:30 AM. Client B's October 2013 physician's orders indicated client B was to have 17 grams of Polyethylene glycol (Miralax) twice a day. Review of client B's MAR (Medication Record) for October 2013 indicated client B was to get her Miralax at 7 AM and 9 PM.</p> <p>Interview with staff #1 and #3 on 10/2/13 at 6 PM indicated staff #3 had dispensed the Miralax during the 5 PM medication pass and gave it to staff #1 to put into client B's drink during the evening meal. Staff #3 stated, "If we try to give it to her at med time, she won't drink it, so we give it to her with her meal."</p> <p>Interview with the LPN (Licensed Practical Nurse) on 10/4/13 at 1 PM indicated the staff were to observe the clients take their medications and to ensure the medications were given as prescribed by the physician and indicated on the MAR.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-6(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 27 medications observed being administered, the facility failed to ensure all medications were administered without error to client B.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM. At 5:55 PM staff #1 brought a small plastic cup of powder to the dining room table and poured it into client B's sippy cup with water. At 6:15 PM client B had finished her meal and got up from the table. The sippy cup still had 1/3 of the liquid in the cup. Staff #1 picked up the sippy cup and took it to the kitchen sink and emptied the remainder of the contents.</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's October 2013 physician's orders indicated client B was to have 17 grams of Polyethylene glycol (Miralax) twice a day. Review of client B's MAR (Medication Record) for October 2013 indicated client B was to get her Miralax at 7 AM and 9 PM.</p>	W000369	<p>All staff will review the medication administration guidelines. Staff are aware that locking the cabinet is a standard expectation. Staff #4 received a verbal coaching for the variance from practice standards. Staff were retrained on strategies for Client B miralax, securing the med cabinet and securing the keys. New medication lock box for controlled substances was obtained. Group Home Team Leader is present in the home daily to direct care and will observe 2-3 meals per week. Group Home Manager will conduct weekly observations of active treatment, meals and other care oversight. There have been 6 observations since exit and all have shown great improvement in medication administration. Director will continue to visit homes monthly on a routine basis. For the 60 days post exit, Director will be present in home 3-4 times per month.</p>	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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>Interview with staff #1 and #3 on 10/2/13 at 6 PM indicated staff #3 had dispensed the Miralax during the 5 PM medication pass and gave it to staff #1 to put into client B's drink during the evening meal. Staff #3 stated, "If we try to give it to her at med time, she won't drink it, so we give it to her with her meal."</p> <p>Interview with the LPN (Licensed Practical Nurse) on 10/4/13 at 1 PM indicated the staff were to observe the clients take their medications and to ensure the medications were given as prescribed by the physician and indicated on the MAR.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-6(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000382	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 4 of 4 sampled clients (A, B, C and D), and 4 additional clients (E, F, G and H), the facility failed to ensure all medications were secured prior to the staff leaving the medication area.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/3/13 between 5:15 AM and 7:30 AM. Upon entering the group home, the staff office door was standing open and a lanyard with keys was hanging on the door knob. A large 2 door metal cabinet was unlocked with a metal lock hanging open on the door latch. Client D was sitting on the couch in the music room just a few feet away from the open office door. Staff #4 was in the rear of the home assisting with other clients. After interviewing staff #4 at 5:25 AM, staff #4 secured the medications and the staff office.</p> <p>Interview with staff #4 on 10/3/13 at 5:25 AM indicated client A's, B's, C's, D's, E's, F's, G's and H's medications were stored in the 2 door metal cabinet in the staff office. Staff #4 indicated the keys hanging on the door knob of the staff office were the keys to the clients' medications and to the office.</p> <p>Interview with staff #5 on 10/3/13 at 6:30 AM indicated there was a box inside the medication cabinet that contained controlled medications (narcotics). Staff #5 indicated the lock to the box of controlled medications was broken and needed to be replaced. Staff #5 indicated the medication cabinet was to be locked at all times unless the</p>	W000382	All staff will review the medication administration guidelines. Staff are aware that locking the cabinet is a standard expectation. Staff #4 received a verbal coaching for the variance from practice standards. Staff were retrained on strategies for Client B miralax, securing the med cabinet and securing the keys. New medication lock box for controlled substances was obtained. Group Home Team Leader is present in the home daily to direct care and will observe 2-3 meals per week. Group Home Manager will conduct weekly observations of active treatment, meals and other care oversight. There have been 6 observations since exit and all have shown great improvement in medication administration. No errors were present during the med observations. Director will continue to visit homes monthly on a routine basis. For the 60 days post exit, Director will be present in home 3-4 times per month.	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>staff were in the office and giving clients their medications. Staff #5 indicated the staff office was to be locked at all times except when staff were in the office.</p> <p>Interview with the LPN (Licensed Practical Nurse) on 10/4/13 at 1 PM indicated the medication cabinet was to be secured at all times. The LPN indicated while passing medications if the staff needed to leave the area, the staff were to secure the medications prior to walking away from the medication cabinet. The LPN indicated she was not aware the lock on the narcotics box was broken and the staff should have had it replaced. The LPN indicated the medications were to be secured at all times and the medication keys were to be carried by the staff and never left hanging on the door knob of the office.</p> <p>This federal tag relates to complaint #IN00120779.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 1 sample client that wore eyeglasses, the facility failed to ensure and/or train client C to wear and take care of her eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM and on 10/3/13 between 5:15 AM and 7:30 AM. Client C was not observed wearing eyeglasses during both observation periods.</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's 8/15/13 ISP (Individual Support Plan) did not indicate a formal training program to assist client C in wearing and taking care of her eyeglasses.</p> <p>Interview with staff #3 on 10/2/13 at 6:50 PM indicated client C would not wear her eyeglasses and if the staff did not watch her, client C would throw her eyeglasses away. Staff #3 indicated client C's eyeglasses were kept in a drawer in the staff office.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/4/13 at 1 PM indicated client C would throw her eyeglasses and other personal items away when not supervised. The QIDP indicated client C did not have any training objectives in place to teach her to wear</p>	W000436	Client C glasses are in place and training goal to wear and store them appropriately. She will wear them for small periods of time supervised, with the hope of increasing her independence and care for them. All other clients have appropriate adaptive equipment needs in place and goals to address any refusal or mistreatment of equipment. QIDP will monitor progress with monthly case management and weekly observation at home and day program.	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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
W000455	<p>and take care of her eyeglasses.</p> <p>9-3-7(a) 483.470(l)(1) <b>INFECTION CONTROL</b> There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to ensure the clients were provided hand soap and paper towels to wash their hands after toileting.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM and on 10/3/13 between 5:15 AM and 7:30 AM. During both observations no hand soap and/or paper towels available in either bathroom for clients A, B, C, D, E, F, G and H to wash their hands with after toileting.</p> <p>Interview with the LPN (Licensed Practical Nurse) on 10/4/13 at 1 PM indicated the staff were to ensure both bathrooms in the group home were supplied at all times with hand soap and paper towels for the clients to wash their hands after toileting.</p> <p>9-3-7(a)</p>			W000455	<p>Paper towels and soap are typically present in the restrooms and the kitchen. Client C often relocates items from areas of the home. Paper towels and soap are present in the restrooms now. Director observed paper towels and soap present on 10/29/13. Group Home Team Leader is present in the home daily to direct care and will observe 2-3 meals per week. Group Home Manager will conduct weekly observations of active treatment, meals and other care oversight. There have been 6 observations since exit and all have shown great improvement in the active treatment and implementation of dining plans. Director will continue to visit homes monthly on a routine basis. For the 60 days post exit, Director will be present in home 3-4 times per month.</p>		11/08/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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
--------------------	--	---------------	---	----------------------

W000460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to ensure the clients were provided milk with their evening meal.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM. Clients A, B, C, D, E, F, G and H sat down at the table to eat their evening meal. Each client had one small cup with water. No milk was offered at the evening meal. At 6:15 PM client G had finished her meal and asked, "Can I have milk?" Staff #2 stated, "Yes, you can." Staff #2 got up, got the milk and gave it to client G. By 6:30 PM all clients had finished their meals except client E.</p> <p>Review of the undated Spring/Summer facility menu on 10/2/13 at 5 PM indicated the clients were to have 1 cup of skim or 1/2 % milk and 1 cup of water with their evening meal on 10/2/13.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional), the</p>	W000460	<p>All staff will be retrained on Dining plans for all individuals, including the nutritional needs, safeguards, supervision and training opportunities. Meals will be served as designated by menu. All individuals were reviewed to have appropriate meal preparation goals to be implemented. All staff reviewed these goals. Group Home Team Leader and Manager will conduct weekly observations of meals to address any further training or feedback needed. Director will conduct monthly visits to home to ensure continued needs and environment are addressed. First visit has occurred on 10/29/13.</p>	11/08/2013
---------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>LPN (Licensed Practical Nurse) and the TL (Team Leader) on 10/4/13 at 1 PM indicated milk should be on the table and offered at every meal. The LPN indicated the staff were to follow the facility menus to ensure the clients obtained adequate fluids and nutrients.</p> <p>9-3-8(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2013	
NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208			
(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			
W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, interview and record review for 4 of 4 sampled clients (A, B, C and D) and 4 additional clients (E, F, G and H), the facility failed to ensure the clients participated with meal preparation, to ensure client C was supervised while eating and to ensure the staff followed the clients' dining plans.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 10/2/13 between 4:30 PM and 7 PM. Salmon patties, macaroni and cheese, green beans, bread with butter and fruit salad were prepared during the evening observation for the evening meal. Staff #2 prepared the salmon patties, placed them in the oven, opened green beans and placed them in a pot on the stove. Staff #2 then prepared the macaroni and cheese. During this time client A was in and out of the kitchen, standing close to staff #2 and watching. Clients B, C, D and F sat at the dining room table playing a game of bingo with staff #1 until 5:10 PM at which time client D got up from the table, walked through the kitchen and into the music room and lay down on the couch. Client F asked to set the table and was</p>	W000488	All staff will be retrained on Dining plans for all individuals, including the nutritional needs, safeguards, supervision and training opportunities. Meals will be served as designated by menu. All individuals were reviewed to have appropriate meal preparation goals to be implemented. All staff reviewed these goals. Group Home Team Leader and Manager will conduct weekly observations of meals to address any further training or feedback needed. Director will conduct monthly visits to home to ensure continued needs and environment are addressed. First visit has occurred on 10/29/13.	11/08/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>told to wait. At 5:25 PM staff #2 asked staff #1 to get staff #3 so she could stir the noodles on the stove. Client A was standing right beside staff #2, client D was on the couch and client E was sitting in the chair in the living room. Staff #2 proceeded to make a tomato and pasta mix. Client F began setting the table. Client C got upset and went outside. Staff #2 followed her and asked her what was wrong. Client C indicated she was hungry. Staff #2 stated, "Ok, come on back in and you can set the table." Client C returned inside, the table was set and the staff brought the food to the table. Bread was brought to the table on individual plates with plastic wrap over the plates and each client's name on the plastic wrap. Clients B and D had full frontal clothing protectors placed on them. The staff pulled the clothing protector up onto the table and placed client B's and D's dishes on top of the clothing protectors so they draped from the table to around client B's and D's necks.</p> <p>__ Client E sat in a chair in the corner of the living room without activity and holding a sippy cup from 4:30 PM until 5:40 PM when staff #2 prompted client E to the dining room table for the evening meal. Staff #2 then cut up client E's food for her.</p> <p>__ At 6 PM client C got up from the table</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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 took her plate and cup to the music room to eat. After a few minutes staff #3 got up from the table and checked on client C and then returned to the main dining room and sat down. The staff did not supervise client C while eating her evening meal. The staff did not check client C for pocketed food after eating.</p> <p>At 6:10 PM client B began coughing. Staff #1 was sitting beside client B and stood up and began patting client B on the back and stated to client B, "Are you ok? Take a drink." Client B continued to cough sporadically for the next few minutes. The staff did not prompt client B to take smaller bites, to dry swallow between bites or to alternate sips of liquids and bites of food. The staff did not check client B for pocketed food after eating.</p> <p>The staff failed to include clients A, B, C, D, E, F, G and H in the meal preparation and/or provide training in meal preparation when opportunity was available. The staff failed to implement client B's and C's dining plans.</p> <p>Client B's record was reviewed on 10/3/13 at 11:30 AM. Client B's record indicated client B was at risk for aspiration. Client B's dining plan dated 7/11/13 indicated client B was to limit foods to less than 1 teaspoon per bite, to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>dry swallow 1 to 2 times between bites and to alternate sips of liquids and bites of food. The plan indicated the staff were to encourage client B to eat slowly and to check her mouth after eating for pocketed food. Client B's Aspiration/Choking/Dysphagia Plan dated 9/11/13 indicated the staff were to call the nurse if client B had persistent coughing during or after eating and/or drinking. Client B's record did not indicate the staff had notified the nurse of client B's coughing during her evening meal on 10/2/13.</p> <p>Client C's record was reviewed on 10/3/13 at 2 PM. Client C's dining plan dated 1/18/13 indicated client C was to be encouraged to not over stuff her mouth and chew before taking another bite. The plan indicated if client C left the table due to anxiety, the staff were to encourage client C to return to the table or finish eating in another room with staff present.</p> <p>Interview with the LPN (Licensed Practical Nurse) on 10/4/13 at 1 PM indicated the staff were to follow client B's and C's dining plans and were to supervise all clients while eating. The LPN stated, "No one called me about anyone having a problem eating." The LPN stated, "They should have called me" and "They should have sat with [client C]"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G458	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6068 MUNSEE LN INDIANAPOLIS, IN 46208
---	---

(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>while she ate her meal."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 10/4/13 at 1 PM, the QIDP indicated clients A, B C, D, E, F, G and H were not independent in preparing a meal and the staff were to provide training in meal preparation at every available opportunity. The QIDP indicated the staff were not to put the clients' dishes on top of the clothing protector.</p> <p>9-3-8(a)</p>			
--	---	--	--	--