

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G445	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2012
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NAME OF PROVIDER OR SUPPLIER ST VINCENT NEW HOPE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 12342 LANTERN RD FISHERS, IN 46038
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.470(j).</p> <p>Survey Date: 05/30/12</p> <p>Facility Number: 000959 Provider Number: 15G445 AIM Number: 100235240</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist,</p> <p>At this Life Safety Code survey, St. Vincent New Hope Inc. was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.470(j), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 33, Existing Residential Board and Care Occupancies.</p> <p>This one story building was determined to be nonsprinklered. The facility has a fire alarm system with smoke detection in corridors, bedrooms and all living areas. The facility has a capacity of 8 and had a census of 8 at the time of this survey.</p> <p>Calculation of the Evacuation Difficulty</p>	K0000		

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

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

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	<p>Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Prompt with an E-Score of 0.7.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/01/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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KS147	<p>483.470(j)(1)(i) LIFE SAFETY CODE STANDARD The administration of every resident board and care facility has in effect and available to all supervisory personnel written copies of a plan for protecting of all persons in the event of fire, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The plan includes special staff response, including fire protection procedures needed to ensure the safety of any resident, and is amended or revised whenever any resident with unusual needs is admitted to the home. All employees are periodically instructed and kept informed with respect to their duties and responsibilities under the plan. Such instruction is reviewed by the staff not less than every 2 months. A copy of the plan is readily available at all times within the facility. 32.7.1, 33.7.1</p> <p>Based on record review, observation and interview; the facility failed to ensure evacuation procedures for 2 of 8 clients as stated in written fire safety plans for the facility could be followed in the event of an emergency requiring evacuation. This deficient practice affects 2 of 8 clients.</p> <p>Findings include:</p> <p>Based on review of the "Fire Safety Plan" with the Regional Director during record review from 10:25 a.m. to 10:50 a.m. on 05/30/12, evacuation procedures identified in the written fire safety plan for the facility include moving clients from resident sleeping rooms and living</p>	KS147	<p><i>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice.</i></p> <p>Locks for both bedroom doors were replaced the same date as the survey 5/30/12.</p> <p><i>How will other residents be identified as having the potential to be affected by the same deficient practice and what corrective action will be taken.</i></p> <p>All residents have the potential to be affected by this practice. All resident rooms were inspected by maintenance on 5/30/12 and locks were replaced so that no further instance of locked doors would occur.</p> <p><i>What measure will be put into place</i></p>	06/15/2012			

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	<p>areas to areas of refuge inside or outside of the facility in the event of an emergency. Based on observations with the Skills Trainer during a tour of the facility from 1:50 p.m. to 2:20 p.m. on 05/30/12, Bedroom # 1 and Bedroom # 2 in the Back Hallway each have a lock on the bedroom entry door which can be unlocked from the hallway by inserting a pin into the door handle but the facility provided pin did not unlock each door when the pin was inserted ten times. Based on interview at the time of the observations, the Skills Trainer stated the facility provides a pin to unlock each door in order to move clients from bedrooms to other points of refuge in the event of an emergency requiring evacuation and acknowledged the aforementioned bedroom doors could not be unlocked with the pin provided by the facility.</p>		<p><i>or what systemic changes will be made to ensure that the deficient practices does not recur</i> Maintenance has removed the lockable doorknobs. If a resident requests a door to be locked in the future, the QMRP will assess the safety and indication at that time.</p>		